UK COVID-19 PUBLIC INQUIRY

MODULE 2

WITNESS STATEMENT OF SIMON BOLTON

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1. I, Simon Bolton, make this, statement to the UK COVID-19 Public Inquiry ("**the Inquiry**") in response to a draft request, dated 24 November 2022 made under Rule 9 of the Inquiry Rules 2006 ("**the Rule 9 Request**"), made on behalf of Baroness Heather Hallett.

2. I was the Interim Chief Executive Officer ("**Interim CEO**") of the Health and Social Care Information Centre, known as (and referred to below) as NHS Digital ("**NHS Digital**"), between 4 June 2021 and 31 January 2023. I was also the Interim Chief Information Officer for NHS England[1] within the Transformation Directorate from 01 July 2022 until 31 January 2023. I joined NHS Digital from (what was) NHS Test and Trace, where I had been Chief Information Officer from August 2020.

3. I took over the role of Interim CEO of NHS Digital from Sarah Wilkinson who was Chief Executive Officer ("**CEO**") between 14 August 2017 and 3 June 2021.

4. Whilst I make this statement on behalf of (what was) NHS Digital, I do not have first-hand knowledge of all of the matters covered in this statement, in part because they cover the period prior to my tenure as Interim CEO at NHS Digital. I therefore rely on information provided by other relevant individuals who were part of NHS Digital's response to the pandemic (including, in particular, Sarah Wilkinson and Professor Jonathan Benger[2]). I have also relied upon other sources of information (including NHS Digital's Annual Reports and information published on its website to prepare this statement.

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1 NHS England is an executive non-departmental public body, sponsored by the Department of Health and Social Care

2 Acting Interim Chief Medical Officer (between 19 November 2019 and 27 April 2021) and Chief Medical Officer (between 28 April 2021 and 31 December 2022)

STRUCTURE OF THIS STATEMENT

5. In order to address the topics raised by the Rule 9 Request, this statement is structured as follows:

5.1 **Section A: NHS Digital's role, function and responsibilities**

In this section, I discuss NHS Digital's role, function and responsibilities, primarily in respect of how we operated prior to the COVID-19 pandemic and later, where requested, how this changed in respect to responding to the COVID-19 pandemic.

5.2 **Section B: NHS Digital's involvement in the UK Government's response to the pandemic**

In this section, I discuss the specific work that NHS Digital carried out in relation to the pandemic response. Where possible, I have tried to explain the limited input NHS Digital may have had in relation to core political and administrative decision-making. However, as a result of the scope of the topics raised in the Rule 9 Request, this section also covers a large number of products and services provided by NHS Digital which, to our knowledge, did not directly influence core political and administrative decision-making.

5.3 **Section C: Future risks, reviews, reports and lessons learned exercises**

In this section, I provide a response to Section C and exhibit existing evidence in relation to the lessons learned and retrospective exercises conducted by NHS Digital and other organisations where relevant.

SECTION A: NHS Digital's role, function and responsibilities

Introduction to the Health and Social Care Information Centre and its Legislative Framework

6. The official name of NHS Digital, as set out in the statutory provision establishing it (section 252 of the Health and Social Care Act 2012 ("**the 2012 Act**"[3])) was the 'Health and Social Care Information Centre'. However, the organisation came to be known (and is referred to throughout this statement) as 'NHS Digital'; this has been the case since 2016.

7. That name reflects what NHS Digital did: designing, developing, deploying and operating national digital products, platforms and information technology systems for the National Health Service ("**NHS**"); and collecting, analysing, curating, publishing and sharing health data and, to a lesser extent, adult social care data. This was for the direct care of patients (e.g. through the national digital products and systems we provided) and for secondary use purposes (such as for planning and commissioning health and adult social care services, and for research). NHS Digital was, therefore, a delivery organisation. It did not set or advise on policy. It was sometimes consulted on and advised on the potential impacts of implementing policy, as an expert in the management of national data sets and the delivery of national healthcare digital systems.

8. NHS Digital's statutory functions were principally set out in Chapters 2 and 3 of Part 9 of the 2012 Act. Its core statutory functions being summarised as:

    8.1 Establishing and operating information systems for the collection and analysis of data, where directed by the Secretary of State for Health and Social Care ("**the Secretary of State**") or NHS England under section 254, or requested by other eligible bodies under section 255 of the 2012 Act;

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3 I exhibit Part 9, Chapter 2 and 3 of the 2012 Act as SB/01 INQ000101739 as at 31 January 2023 and prior to their amendment by the Health and Social Care Information Centre (Transfer of Functions, Abolition and Transitional Provisions) Regulations 2023, on 1 February 2023 (see further below at paragraph 9)

8.2 Publishing data under section 260 of the 2012 Act and in accordance with the Code of Practice for Statistics;

8.3 Disseminating data under section 261 of the 2012 Act and other relevant legislation, including in relation to the COVID-19 pandemic, under Regulation 3 of the Health Service (Control of Patient Information) Regulations 2002 ("**COPI Regulations**");

8.4 Exercising IT system delivery functions of the Secretary of State or NHS England when directed to do so under Regulation 32 of the National Institute for Health and Care Excellence (Constitution and Functions) and the Health and Social Care Information Centre (Functions) Regulations 2013/259 ("**the NICE Regulations**"); and

8.5 Supplying digital, data and technology services under section 270(1)(d) of the 2012 Act.

9. The statutory functions of NHS Digital were transferred to NHS England on 1 February 2023 under The Health and Social Care Information Centre (Transfer of Functions, Abolition and Transitional Provisions) Regulations 2023. From that date, NHS Digital was abolished and, therefore, ceased to exist as a separate legal entity.

10. Before I address NHS Digital's role and responsibilities in greater detail, it is important to highlight that NHS Digital was a delivery organisation that, in terms of design and delivery of new services, systems or features, operated through third party 'commissions' (i.e. requests to undertake a particular piece of work or project). This is detailed further in paragraphs 20 - 23 below. Its core responsibilities for operating national systems and infrastructure and delivering national statistics and data services were prescribed in statute.

NHS Digital's structure, organisation and key decision-makers

11. At the start of the pandemic, NHS Digital was an executive non-departmental public body arranged into 8 directorates:

11.1 Strategy, policy and governance;

11.2 Product delivery (which was called 'Product Development' during the period relevant to Module 2);

11.3 Data services;

11.4 Platforms;

11.5 IT operations;

11.6 Corporate services;

11.7 Assurance and risk management; and

11.8 Cyber operations.

12. As the Interim CEO, I managed the executive team of NHS Digital's most senior staff, as shown on the 'High-level organisation chart' within the 'OrgBook' documents which I exhibit as **SB/02 INQ000083057** – **SB/10 INQ000083079**[4] (along with descriptions of the directorates). The NHS Digital Board was our most senior decision-making body, accountable to the public, Parliament, and the Secretary of State. As the Interim CEO, I was also the Accounting Officer (accountable to Parliament and the Secretary of State for NHS Digital's performance).

13. Whilst all Executive Directors within NHS Digital made important decisions during the pandemic, I consider the key officials/decision-makers[5] within NHS Digital in respect of the pandemic response between 1 January 2020 and 24 February 2022 to have been:

13.1 Sarah Wilkinson in her capacity as CEO (from 14 August 2017 to 3 June 2021);

13.2 Interim CEO: myself (from 4 June 2021 to 31 January 2023);

[4] Note that I have exhibited different versions of the 'OrgBook' documents, which cover the relevant period
[5] The senior individuals in NHS Digital who represented the organisation at a cross Arm's Length Body ("**ALB**") level

13.3 Professor Jonathan Benger in his capacity as Acting Interim Chief Medical Officer (between 19 November 2019 and 27 April 2021) and Chief Medical Officer ("**CMO**") (from 28 April 2021 to 31 December 2022)[6];

13.4 **Name Redacted** in his capacity initially as Interim Executive Director of Product Development (from January 2020 to 20 January 2021) and later as Executive Director of Product Delivery from 21 January 2021 to 30 August 2021; and

13.5 **Name Redacted** in his capacity as Executive Director of Data Services (from 1 November 2019 to 31 July 2021).

14. Details of the other NHS Digital Executive Directors (who made important albeit less strategic and more procedural decisions) in post during the period 1 January 2020 to 24 February 2022 are set out in the Org Books (exhibits **SB/02 INQ000083057 – SB/10 INQ INQ000083079**).

15. The main internal governance bodies that NHS Digital established in response to the pandemic (in addition to existing governance bodies and decision-making processes) were:

15.1 Gold Command; and

15.2 Silver Command.

16. Gold Command was established as the senior decision-making group in relation to our pandemic response. The key objectives of the twice weekly remote Gold Command meetings were to provide a prioritisation and decision-making function in relation to NHS Digital's response to the COVID-19 pandemic. Gold Command was supported by a prioritisation forum led by Jonathan Benger, CMO, which was established to make decisions about how work should be prioritised. It aimed to ensure that work was being prioritised based on the latest understanding of the most urgent clinical need. The membership and regularity of the Gold

[6] In the following paragraphs of this statement I will refer to Professor Jonathan Benger as the CMO

Command meetings changed from time to time over the period of the pandemic and consisted of:

16.1 NHS Digital's CEO;

16.2 Executive Director (IT Operations);

16.3 Executive Director (Product Development);

16.4 Chief Medical Officer;

16.5 Executive Director (Data Services); and

16.6 Solicitor and Executive Director (Privacy, Transparency, Ethics and Legal).

17. I exhibit, at **SB/12 INQ000083059 - SB/23 INQ000083075**, copies of each of the NHS Digital COVID-19 Gold reports produced by NHS Digital during the period 1 January 2020 to 20 July 2021. These were used to update key stakeholders on the organisation's contributions to the pandemic response. Details of the members of Gold Command, and how membership changed over time, can be found within these reports.

18. Silver Command started in March 2020, and was a senior group of mostly Executive Directors, Directors and Associate Directors who led the various aspects of our operational response to the pandemic. The key objective of the Silver Command meetings was to provide overall coordination, communication and alignment across NHS Digital in its response to the COVID-19 pandemic. Silver Command initially met remotely daily. Over time, Silver Command reduced to meeting three times per week and then twice weekly. During the meetings, attendees worked through updates from the various workstreams across the pandemic response, providing the latest information on work, progress, commissions, developments and highlighting issues and support needs. The Silver Command meetings continued throughout 2021 and 2022.

19. The attendees of the Silver Command meetings generally comprised the members of Gold Command (mentioned above), and the Executive Directors, Director and Associate Director workstream / function leads or

their deputies across the organisation involved in the pandemic response. The NHS Digital COVID-19 Gold reports (exhibits **SB/12 INQ000083059 - SB/23 INQ000083075**), set out the membership of Silver Command over time.

NHS Digital's relationships and collaboration with other organisations / bodies

20. NHS Digital's relationship with the Department of Health and Social Care ("**DHSC**") and NHS England during the pandemic was that of a delivery organisation, with DHSC and NHS England being commissioners of our work. NHSX was not a separate legal entity, but a joint unit of DHSC and NHS England staff established by the then Secretary of State in 2019. NHSX operated during the COVID-19 pandemic, functioning as a technology/digital-focused arm. Many of the commissions received by NHS Digital came via the NHSX team (on behalf of DHSC and NHS England, as commissioners).

21. Generally, before the COVID-19 pandemic, a commission was documented through a business case accompanied by a funding model and a work package detailing the scope of services. However, during the COVID-19 pandemic, because of the urgency of the work, in many instances we had to undertake substantial amounts of work before formal funding arrangements were in place, and scopes of work were often agreed iteratively and informally, either orally or in email communications.

22. NHS Digital was not a public policymaker, but at times was asked by NHS England and/or DHSC for its perspectives or views in relation to the delivery areas for which NHS Digital was responsible or would be commissioned to deliver. NHSX was the conduit for providing any advice to ministers relating to policy. NHS Digital did, on occasion, feed into draft documentation prepared by NHSX for that purpose. However, NHS Digital would not always have sight of the final draft material that would go to ministers or senior civil servants.

23. NHS Digital collaborated with a range of other public bodies in response to the COVID-19 pandemic, in the following general ways (further detail

is provided below where I discuss the key activities NHS Digital was involved in as part of the response to the COVID-19 pandemic):

23.1 Public Health England ("**PHE**"), which became the UK Health Security Agency ("**UKHSA**") from October 2021, by collecting and sharing data which they required to support their response to the pandemic, supporting the digital and data parts of the NHS Test and Trace programme and their work launching and running the COVID-19 App;

23.2 The Department for Work and Pensions ("**DWP**") and the Department for Education ("**DfE**") in relation to the COVID-19 isolation note service and obtaining data about carers (DWP) and children (DfE) to support the COVID-19 Vaccine Programme cohorting of vaccination groups;

23.3 Government Digital Services ("**GDS**") within the Cabinet Office in relation to the Shielded Patient List ("**SPL**") for which they were the lead Government Department, and in relation to their operation of the GOV.UK Notify text messaging service;

23.4 Ministry of Housing, Communities and Local Government (now known as the Department for Levelling Up, Housing and Communities) in relation to the SPL and access to SPL data by local authorities;

23.5 The National Institute for Health Research ("**NIHR**") in relation to the COVID-19 Vaccine Registry (see further below at paragraph 190);

23.6 The Information Commissioner's Office ("**ICO**"), as part of the ICO Regulatory Sandbox in relation to the COVID-19 Vaccine Registry. We also worked with the ICO as part of an Information Governance Expert Advisory Group established to support COVID-19 Risk Stratification (explained in more detail below at paragraphs 178 - 182) and the General Practice Data for Pandemic Planning and Research ("**GDPPR**") data collection (explained more below at paragraphs 137 - 141);

23.7 The Office for National Statistics ("**ONS**"). NHS Digital worked closely with and shared various datasets with the ONS for the purposes of statistics and statistical research. A joint public health dataset accessible through the ONS secure data environment was established with the ONS and Health Data Research UK ("**HDRUK**") to support health research into COVID-19;

23.8 The NHS Business Services Authority ("**NHS BSA**"), which operated the Prescription Payment Verification assurance function to ensure that the prescription delivery services provided to patients who were shielding and required prescription delivery support were operating effectively and ensured that public funds assigned for COVID-19 services to patients were being managed appropriately. It also operated a text message function to patients who were on the SPL; and

23.9 Many different researchers (including public bodies) during the pandemic to provide access to data for research. The researchers we shared data with and the research this related to are set out in the NHS Digital data release registers which were published on our website (discussed further below at paragraph 85).

Devolved administrations

24. NHS Digital was the national provider of information, systems and services to the NHS in England only. Nonetheless, it collaborated with colleagues in the devolved administrations in a number of ways, including:

24.1 Sharing information with Wales and Scotland about individuals on the SPL who were registered with a General Practitioner ("**GP**") in England but resident in Wales and Scotland, and sharing the SPL clinical methodology used in England;

24.2 Collecting and sharing COVID-19 test data with Scotland, Wales and Northern Ireland in relation to the COVID-19 national testing service;

24.3 Implementation and management of an integration solution to support the exchange of data between England, Scotland, Wales and Northern Ireland to ensure citizens could demonstrate their vaccination status and receive vaccines in multiple home nations;

24.4 Enabling residents of Wales to use the COVID-19 Pass service in the NHS App;

24.5 Establishing an online UK wide COVID-19 Vaccine Registry (see further below at paragraph 190); and

24.6 Sharing a demo environment of the COVID-19 Population Risk Assessment Service (see further below in relation to risk stratification) with Scotland.

25. The relevant bodies within each of the devolved administrations with whom NHS Digital collaborated can be identified from the formal section 255 request letters[7] which were published on our website (Exhibit **SB/24 INQ000101761**, Exhibit **SB/25 INQ000101762** and Exhibit **SB/26 INQ000101763** in relation to Scotland, Wales and Northern Ireland, respectively).

Regional and local administrations

26. NHS Digital collaborated with regional/local administrations in a number of ways including:

26.1 Providing private dashboards containing test results aggregated to various geographies to local authorities and their public health teams. This action was later migrated to UKHSA; Exhibit **SB/85 INQ000194049** provides a list of Local Authorities provided access to private dashboards

26.2 Providing local authorities with data flows about those on the SPL in their areas. Exhibit **SB/86 INQ000194050** provides a list of Local Authorities who received SPL data flows; and

[7] With respect to formal section 255 requests, see further below at paragraphs 33 - 37.

26.3 Various other data flows were put in place in response to the COVID-19 pandemic (as set out in the data release registers, Exhibit **SB/58 INQ000101795** to Exhibit **SB/75 INQ000101812**, discussed further below at paragraph 85 85).

27. In relation to other key partners (including private companies):

27.1 NHS Digital routinely worked in partnership with a large number of third-party private sector suppliers to deliver its systems and services. During the COVID-19 pandemic, we increased the number and proportion of third-party suppliers and resources to meet the delivery demand, secured through a combination of existing contractual arrangements and new procurements. The use of contracted resource to deliver items of work did not differ in the COVID-19 period (in terms of contractual basis and governance) but was more extensive and accelerated action was required; I exhibit a list of third-party contracting organisations to NHS Digital in support of delivery activity through the period in question as **SB/27 INQ000101764**;

27.2 Specifically, in June 2020, NHS Digital was asked to take on lead responsibility and ownership of the commercial arrangements of the National COVID-19 Testing Programme. Key service providers/suppliers were: Deloitte Digital; Aire Logic Limited; Axiologik Limited; Baringa Partners LLP; Hippo Digital Limited; the Mastek Group; X-Lab Ltd and NHS Business Services Authority;

27.3 NHS Digital's Dashboards Team (see further below in Section B) was initially supported by Goldman Sachs (on a pro bono basis), with other key suppliers being Aire Logic Limited, TrueCue (Concentra Analytics Ltd) and Tableau Software LLC;

27.4 We worked closely with the University of Oxford on the development of the QCovid® risk prediction calculator which formed part of the COVID-19 Population Risk Assessment Service and Clinical Risk Assessment Tool for Clinicians

developed and operated by NHS Digital (both discussed further below);

27.5 We worked closely with HDRUK as part of the Health Data Research Alliance generally, but also specifically in relation to:

(a) Facilitating access to data for research into COVID-19 including the establishment of the General Practice Extraction Service ("**GPES**") Data for Pandemic Planning and Research ("**GDPPR**") data collection; and

(b) Support for COVID-19 related clinical trials.

Overview of NHS Digital's responsibilities and functions

28. In this section, I will provide a high-level overview of the roles and responsibilities NHS Digital had within the health and adult social care system relevant to our response to the COVID-19 pandemic.

29. NHS Digital's role and responsibilities in relation to the pandemic response was based on its role and responsibilities generally within the health and social care system:

29.1 NHS Digital functioned as the national information and technology partner to the health and care system:

(a) NHS Digital built and ran core information technology and data infrastructure, platforms and live services on which the NHS depended. These services were required to be provided at the highest levels of performance, stability reliability and security;

(b) It provided a centre of excellence in cyber security, offering technical expertise and services to help organisations across the NHS protect and defend systems from cyber threats; and

(c) It designed and developed digital products and services that helped NHS and care staff do their work and that put people in control of their health and care.

29.2 NHS Digital functioned as the national safe haven for patient data. This involved securely and transparently collecting, analysing, publishing and sharing national health and adult social care datasets, including the publication of national health and adult social care statistics and provision of data access services that supported the planning and commissioning of care and health research. This enabled NHS Digital to provide the data, statistics and dashboards I refer to throughout this statement.

29.3 In relation to its role as a national statistics provider, NHS Digital was a large independent producer of statistical publications across health and care in England, producing around 80 series of publications, comprising around 300 individual publications a year. Publications were drawn from record level administrative datasets, surveys, clinical datasets and collections and covered the health of the population, patients' interactions with different care settings (including primary, secondary, mental health and social care), and cross-cutting areas such as workforce. NHS Digital was not the only producer of health and care statistics across England, with a number of other organisations producing statistics including NHS England, ONS, DHSC and UKHSA. These organisations worked closely together where statistics were on similar themes.

30. It is equally important to set out what NHS Digital's role and responsibilities did not include, in particular:

30.1 It did not develop or set policy. That is the role of DHSC, NHS England, and during the pandemic, NHSX;

30.2 It was not a regulated healthcare provider. It did not therefore provide clinical services or advice (i.e. provision of a formal professional opinion regarding what a specific individual or group

should or should not do to preserve or improve health) to the public or to other organisations; and

30.3 It did not commission healthcare services. This is the role of NHS England and, during the pandemic, Clinical Commissioning Groups.

LEGAL FRAMEWORK, GOVERNANCE AND INTERNAL PROCESSES FOR PROCESSING OF DATA

31. In this section of the statement, I will provide a high-level overview of the governance and legislative framework within which NHS Digital operated, as well as an overview of its internal governance processes, which ensured that processing of data was done responsibly, transparently and lawfully. In Section B of this statement, I will focus on how that framework and these processes changed as part of the pandemic response.

i) DHSC Remits for NHS Digital

32. As mentioned in paragraph 12, NHS Digital was accountable to the Secretary of State. DHSC set out the Government's objectives for NHS Digital via Remits which also outlined the operating context for NHS Digital, its accountability and funding flows.

ii) Legislative framework

33. NHS Digital's functions as the national safe haven for patient data were its functions in relation to the collection, analysis, publication and dissemination of data where it was directed or requested to establish information systems under section 254 or section 255 of the 2012 Act.

34. When we established information systems to collect data, we generally issued and published Data Provision Notices to those organisations from whom we needed to collect the required data. These Data Provision Notices were issued under section 259 of the 2012 Act, which required the organisations covered by the Data Provision Notice to provide the data specified, in the form, manner and in accordance with timescales set out in the Data Provision Notice. Providing data under section 259

does not breach any duty of confidence owed in respect of the data[8]. Section 259, therefore, enabled NHS Digital to collect confidential patient data.

35. NHS Digital was obliged to publish information that it obtained under section 254 or section 255 of the 2012 Act, unless it was prohibited from doing so in the circumstances set out in section 260(2) of the 2012 Act. One such circumstance was where data would identify individuals. NHS Digital did, however, publish aggregate anonymous statistical data obtained from the data it collected and analysed, in a range of statistical publications, management information and official statistics.

36. NHS Digital was also obliged to publish information about the data it obtained under section 264 of the 2012 Act. During the pandemic, information about what data had been obtained was published in various Data Provision Notices which were published on our website. Further information about the data that could be requested by other organisations was made available through the Data Access Request Service ("**DARS**") website pages (see further below at paragraph 38.1).

37. NHS Digital was only able to disseminate, or share data, where it had a power to do so under section 261 of the 2012 Act or any other legislation and where to do so would not breach the common law duty of confidence. In practice, this meant that a lot of data NHS Digital shared or provided access to were de-identified data where sharing data would not have breached confidentiality. In some cases, the recipient of the data had a legal basis to process confidential patient data, in which case NHS Digital could share identifiable data. For example, NHS Digital shared identifiable data with clinical trials where the patient had consented to this as part of participating in the clinical trial. In addition, personal data could only be shared where both NHS Digital and the recipient of the data had a legal basis under the UK General Data Protection Regulation ("**UK GDPR**").

[8] See section 259(10)

iii) Internal processes

38. Within NHS Digital's organisational structure, the Data Services Directorate had primary responsibility for data collection, analysing and linking data, publishing (including providing reliable statistics and insights) and sharing data. This directorate's services which related to NHS Digital's safe haven functions included:

38.1 DARS, which considered and approved requests for access to NHS Digital data by authorised organisations and users for planning, commissioning and research purposes. This could be through disseminating datasets or providing secure access to data within an NHS Digital trusted research environment. Information about what data were available through this service was published on our website;

38.2 Production of statistics, dashboards and open data products. Our statistical publications, dashboards and open datasets enabled important insight across health and care and could be used to inform national and local decisions about the provision of healthcare services. Data and statistical products which we made available were published on NHS Digital's website;

38.3 DigiTrials - supported clinical trials that were developing new treatments to improve health and care. We provided secure access to patient data to help authorised trials reach and benefit as many people as possible;

38.4 The National Disease Registration Service ("**NDRS**")[9] which was transferred to NHS Digital from PHE on 1 October 2021 before PHE closed down and was replaced by UKHSA. The NDRS collected, analysed, published and shared data on cancer, rare diseases and congenital anomalies. This helped the NHS, researchers and industry partners to understand, treat and plan for those diseases. I understand that prior to its transfer to NHS

[9] Comprising the National Cancer Registration and Analysis Service (**"NCRAS"**) and the National Congenital Anomaly and Rare Disease Registration Service (**"NCARDRS"**)

Digital, the NDRS undertook several research and data projects to assess the impact of the pandemic on patient outcomes. Information in relation to this work was available through our website.

39. When we published or made data available, we made it clear in writing what the limitations of the data were. It was not NHS Digital's role to make recommendations on how the data could be used or what actions should be taken in response to that data by any other person or organisation.

40. The DARS service considered requests for access to data for planning, commissioning and research purposes. All requests for access to data through this service had to meet robust published DARS standards and no data were shared unless:

    40.1 There were appropriate legal bases under the common law duty of confidentiality and UK GDPR for access or dissemination;

    40.2 Appropriate ethical approvals were in place for research;

    40.3 There was a benefit to health and social care through the identified use of the data;

    40.4 The data requested were necessary and proportionate for the purpose of use; and

    40.5 The recipient entered into an overarching Data Sharing Framework Contract and a specific Data Sharing Agreement ("**DSA**").

41. This process ensured that NHS Digital provided the least amount of data, in the least identifiable form, that enabled the requestor to meet their stated purpose. The DARS function was subject to additional assurance from the Independent Group Advising on the Release of Data (**"IGARD"**). IGARD provided advice on DARS standards, precedent data request applications and individual data request applications. They provided advice to DARS and the NHS Digital Senior Information Risk Officer

("**SIRO**"), who was responsible for decisions on data sharing through DARS.

SECTION B: NHS Digital's involvement in the UK Government's response to the pandemic

Introduction to NHS Digital's response to the pandemic

42. In this section, I summarise NHS Digital's involvement in the UK Government's response to the pandemic. I also try to address the specific questions raised in the Rule 9 Request as to the services and data provided by NHS Digital throughout the pandemic.

43. This statement is not intended to be an exhaustive or detailed account of each and every data service, product or system provided or facilitated by NHS Digital in response to the pandemic. However, I will attempt to cover those matters set out by the Inquiry in the Rule 9 Request, to the extent those matters are relevant to NHS Digital. Where the Inquiry has specifically asked NHS Digital about matters in which NHS Digital was not involved, I have indicated as such in the statement.

44. I understand that the Inquiry is interested in the extent to which data, statistics and analysis provided by NHS Digital informed core political and administrative decision-making.

45. In relation to data we shared with other organisations, as mentioned above, while NHS Digital scrutinised the proposed purpose of data sharing to ensure it was appropriate and there was a legal basis for data to be shared, and ensured that data were shared pursuant to a DSA, it did not know how the outputs from the data which were used and analysed by the data recipient (e.g. published research) were subsequently used to support decision making by recipient organisations or others.

Advice into DHSC and to the Government

46. From the enquiries I have been able to make, I understand that NHS Digital did not provide any advice or briefings on the public health and

COVID-19 legislation and regulations proposed and enacted by the Government. As referred to below, we did work with NHSX and Government Legal Department ("**GLD**") on the content of COVID-19 Directions and the NHS Digital COPI Notice.

Paragraphs 17 and 18 of the Rule 9 Request

47. I provide responses to paragraphs 17 (list of key meetings) and 18 (list of correspondence with ministers or senior civil servants) of the Rule 9 Request as Appendices 5 and 6 respectively. The Appendices outline the clarifications to the Rule 9 Request which were agreed with the Inquiry and provide a high-level summary of the approach taken to producing the lists. As explained in the respective Appendices, reasonable and proportionate searches have been undertaken to identify the key meetings and correspondence identified in the lists. However, given the need to take a proportionate approach, the lists should not be considered to be fully exhaustive of all key meetings and correspondence.

48. In relation to paragraph 17 (list of key meetings), as is explained in Appendix **5, meetings have been considered key where:**

    48.1 the meetings concerned core decision-making in relation to the response to COVID-19, **rather than the delivery or implementation of those key decisions; and**

    48.2 the NHS Digital officials who attended were substantively involved in those meetings.

49. As a result, only one series of key meetings has been identified. As I explained, NHS Digital was a delivery organisation and, therefore, had no real role in core decision-making and did not set or advise on policy. Accordingly, and as can be seen from the Tier 2 meeting index in Appendix 5, although NHS Digital officials attended a large number of meetings in which core political and administrative decision-makers were in attendance, generally speaking our role was not substantive, or it would relate to delivery or implementation only. Within the healthcare system, NHS Digital was rightly perceived as the subject matter expert on issues relating to the collection and sharing of data, and the design

and deployment of digital products, platforms and systems. Individuals from NHS Digital were, therefore, often invited to join meetings to ensure that our expertise was available if it was required. However, from my own experience and, I understand, those individuals who participated in the process (described in detail in Appendix 5) used to generate the list of key meetings, our actual involvement in meetings was either limited or confined to operational or technical matters.

50. Investigations did not identify any meetings NHS Digital staff attended with COBR.

Involvement in advisory groups and committees

51. From the enquiries I have been able to make to date, I provide below, a summary of NHS Digital's involvement in advisory groups and committees.

52. Representatives of NHS Digital attended a number of advisory groups and committees during the pandemic in varying capacities. Details in relation to each are set out below. Given our role as a delivery organisation, our involvement was predominantly around delivery viability, cost and risk.

Scientific Advisory Group for Emergencies ("SAGE")

53. I am aware that Jonathan Benger, in his capacity as NHS Digital's CMO during the relevant period, has already provided the Inquiry with information about his involvement in a sub-committee of SAGE. I am aware that Jonathan Benger presented a research paper to SAGE that described the relationship between ethnicity and outcome from COVID-19 infection, exhibited as **SB/28 INQ000101765**. This was one of several research studies considered by SAGE during the meeting (the minutes of which will be available to the Inquiry separately). The data presented were also placed into the public domain through NHS Digital's website, on 10 June 2020.

UK Senior Clinicians' Advisory Group ("UKSCAG")

54. I am aware that, in his capacity of CMO of NHS Digital, Jonathan Benger was a member of UKSCAG. Having discussed this with Jonathan Benger, I understand that he was involved in a discussion with the UKSCAG at the start of the COVID-19 pandemic about non-pharmaceutical interventions ("**NPIs**"). Jonathan Benger has informed me that he did not offer any advice or opinion as to whether NPIs should be used because they were not within his area of expertise.

55. I also understand from Jonathan Benger that the UKSCAG was not a decision-making body. However, it was an influential group chaired by Chris Whitty. It was set up for the Chief Medical Officers of the four nations to come together to share information and to get clarity and consistent information. It soon involved NHS England and Public Health England. Jonathan Benger was invited to join the group for a variety of reasons, partly due to his role at NHS Digital but also because he was known by NHS England and they wanted his clinical advice. Therefore, his contributions to this group encompassed both NHS Digital related work and his wider clinical expertise.

National Incident Response Board ("NIRB")

56. I am aware that, in his capacity of CMO of NHS Digital, Jonathan Benger[10] was a member of NIRB.

57. NIRB was led by NHS England and was attended by a number of its senior representatives as well as NHSX and Jonathan Benger. NIRB's purpose was to make operational decisions about the NHS's national response based on the available information. It considered matters such as hospital admissions, ongoing service delivery and staffing, the availability of beds and oxygen, and how to create the Nightingale hospitals. NIRB did not make policy decisions: its decision-making functions were centred on operational matters.

58. I understand that whilst Jonathan Benger did not play a central role within NIRB, he contributed to discussions and provided some advice around

[10] Jonathan Benger was Acting Interim Chief Medical Officer between 19 November 2019 and 27 April 2021 and Chief Medical Officer between 28 April 2021 and 31 December 2022.

digital technology and data. For example, Jonathan advised NIRB in relation to the use and potential benefits of (what became known as) Oximetry @home[11].

Sub-group of the New and Emerging Respiratory Virus Threats Advisory Group ("NERVTAG")

59. I am aware that, in his capacity of CMO of NHS Digital, Jonathan Benger was a member of this sub-group which was convened to identify risk factors in the population and apply risk stratification tools to identify individuals who might benefit from accelerated vaccination, additional treatments and/or protective measures. Further information in relation to risk stratification can be found below. Jonathan Benger's role in this sub-group was to support and advise on matters relevant to data provenance and data quality, and to facilitate the provision of requested data sets (within the legal frameworks detailed above).

Clinical Risk and Governance Panel

60. I also understand that Jonathan Benger contributed to a Clinical Risk and Governance Panel that was chaired by the Care Quality Commission's Chief Inspector of Hospitals, **Name Redacted** and supported by the Academy of Medical Royal Colleges. This Panel considered emergency care planning, including how NHS Digital could assist parts of the NHS emergency care system which had, as a consequence of the pandemic, significant pressures placed upon it because of demand. This Panel was established to advise the NHS England National Medical Director, Professor Steve Powis, on the out of hospital phase of care (principally 111 and 999 services) during the COVID-19 pandemic.

COVID-19 Therapeutics Clinical Review Panel

61. Later in the COVID-19 pandemic, in his capacity as NHS Digital CMO, Jonathan Benger also became a panel member of DHSC's COVID-19 Therapeutics Clinical Review Panel, which was intended to determine

[11] COVID Oximetry @home involves the remote monitoring of patients with COVID-19 symptoms. Patients use a pulse oximeter, a small monitor clipped to their finger, to measure their oxygen saturation levels three times a day. They record their results using one of the following: smartphone app, web portal or paper diary

which at-risk patient cohorts would be eligible for COVID-19 therapies. NHS Digital's role in this panel was to advise on the ability of NHS Digital to identify from the available data people who might meet particular diagnostic criteria.

62. From the enquiries that have been made with key senior individuals (who would have been the most likely to attend any such groups or committees), I am not aware of any other advisory groups or committees related to COVID 19 attended by NHS Digital officials.

The nature and spread of COVID-19

63. NHS Digital had very little, if any, involvement in informing the UK Government's initial understanding of the nature and spread of COVID-19 between 1 January 2020 and 26 March 2020. Jonathan Benger was, however, involved in the discussions taking place within UKSCAG during this period where this was discussed as referred to above (in the context of consideration being given to the use of NPIs).

64. The primary responsibility for collecting and analysing data on the nature, spread and transmission of COVID-19 rested principally with PHE at the beginning of the COVID-19 pandemic and subsequently from October 2021, UKHSA. NHS Digital did provide data to PHE to support their work on household transmission (referred to as HoSTED) and published some public-facing dashboards (as detailed below in the section headed Dashboards) that provided some indication of prevalence (based on 111 and 111online data and confirmed positive tests). However, in neither of these cases was NHS Digital responsible for providing advice on the data and any actions to be taken in response.

Description of key materials in relation to the pandemic response

65. DLA Piper UK LLP's ("**DLA Piper**") letter to the Module 2 Inquiry Legal Team dated 7 December 2022 confirmed the approach agreed with the Inquiry in respect of paragraph 38 of the Rule 9 Request. I understand it was agreed that, in order to meet paragraph 38 of the Rule 9 Request, it would be sufficient for NHS Digital to explain the types of documents it

holds and the basis on which those documents are stored (such as the systems used and the sites where the documentation is located).

66. NHS Digital, in the course of its activities during the period, created a variety of records and information as part of its response to COVID-19. Following the announcement of the Inquiry, NHS Digital put into effect a legal hold on COVID-19 response related information to ensure preservation of such material. Information is held in a variety of formats including Microsoft Office 365 (MS O365) suite of documents (including Word, PowerPoint, and Excel files), Adobe file formats, intranet web pages, external website pages, and specific formats on various information systems.

67. NHS Digital used a very wide range of information systems in addition to the MS 0365 suite. For example, general corporate information is stored in various IT systems including:

67.1 individual and group email accounts, One Drive, SharePoint folders and MS Teams channels. SharePoint and Teams were predominantly used as record repositories for all MS O365 type records;

67.2 financial information, which is held in the Financial Management system Tagetik;

67.3 commercial management information about procurement and contracts is held in a combination of the Atamis procurement system, SharePoint, MS Teams and email folders;

67.4 service management information about the national and corporate IT systems is held in the IT system Service Now and previously in an IT system called Cherwell. Information is also held in an IT system called Confluence; and

67.5 general management and project information is held at project, programme, directorate, sub-directorate and team levels in SharePoint and MS Teams sites, and within team email account folders.

68. Programmes and services may also hold relevant information in additional IT systems, including the following:

68.1 nstances of Customer Relationship Management (CRM) system, a contact data and document management system. This was used by the Contact Centre and the Data Access Request Service (DARS);

68.2 Confluence sites, a collaboration workspace Information repository. For example, this was used by programmes and services to document their operational and programme specific information; and

68.3 JIRA instances, which is Atlassian's Agile delivery project management system. This was used by programmes and services to record, prioritise and track items of work.

69. It should be noted that systems in common use to manage projects and programmes, like Confluence and JIRA, hold complex information structures and links which are not readily exportable into another repository. However, if required, specific information can be readily discovered and retrieved within those native systems.

70. Each team within NHS Digital adapted and developed its own documentation creation and storage methodology, to suit its functions and activities, preferred ways of working and approach to online/remote collaboration. As such, there was no standard document creation and storage methodology across NHS Digital as an organisation.

71. What would be considered to be key documentation will vary by team, but could include for example, programme description documents, briefing papers (for example programme board papers and minutes), decision logs, delivery roadmaps, risks and issues logs and key partner supplier contracts (where relevant). It may also include certain reports, briefing papers and updates provided to Silver Command, the Executive Management Team, the CEO, committees of the Board and the Board.

72. Copies of the majority of Executive Management Team, Board Committee and Board papers, including agendas, minutes and papers for the Relevant Period, are held in a single document repository called Virtual Board Room.

73. There is no single NHS Digital corporate record repository, or corporate record classification scheme, which would enable all potentially relevant records to the Inquiry to be identified or retrieved. As a result, there is no index of all potentially relevant records held, nor a reasonable or proportionate way to produce one. Given the variety of corporate systems in which documentation is held, and the variability of each team's project methodology, NHS Digital has not attempted to create a single repository of all documents that could be potentially relevant to the Inquiry.

74. However, NHS England has identified record keepers for each of the NHS Digital COVID-19 programmes of work and within each Directorate for COVID-19 work and has information as to where programme documentation is stored, what material may be considered relevant, and which individuals can access and search for relevant documentation. This is to ensure that relevant documentation can be identified and retrieved to support specific information requests as required.

75. A series of internal records and information management assurance audits are in the process of being conducted for key business areas relevant to the Inquiry. These have been designed to confirm the ability, in conjunction with their respective record keeper, to identify and retrieve records and information. Given the likely longevity of the Inquiry, these audits are also looking at knowledge transfer such that records and information identification and retrieval will be resilient to changes of personnel.

Changes to the legislative framework and internal processes for health data as part of the pandemic response

76. In response to paragraph 15 of the Rule 9 Request, in this section I will summarise the changes to the legislative framework for dealing with health data during the pandemic response period as they related to the

work of NHS Digital, and how NHS Digital adjusted its internal processes in order to more quickly and flexibly respond to health data requests.

COVID-19 Pandemic – changes made to the legislative framework for NHS Digital's sharing of health data

77. Directions made under section 254 and requests made under section 255 of the 2012 Act for NHS Digital to establish information systems were generally very specific and required specific data to be collected for specific purposes (referred to as a "collect once, use once" approach). The internal processes associated with agreeing with the requester the purpose for the information system, the data to be collected and analysed, consulting with providers of the data and those who would use it and documenting and approving the direction, generally took a number of months. Similarly, the process of agreeing a Direction under Regulation 32 of the NICE Regulations to exercise IT system delivery functions on behalf of the Secretary of State or NHS England took time whilst the specification and funding for what was to be delivered was fully agreed.

78. At the outset of the pandemic, it was clear that NHS Digital would need to be able to act more quickly and flexibly than the standard processes for establishing information systems and agreeing directions and requests under section 255 would enable. In particular, it was recognised that there would be an urgent need for new IT systems and products to be developed and existing IT systems and products to be changed to respond to the pandemic. It was also recognised that new data collections or data linkages would be required urgently for different purposes to support the NHS response to the pandemic and that a "collect once, use many times" approach to establishing information systems for COVID-19 would be required. In discussions between our Privacy, Transparency, Ethics and Legal ("**PTEL**") Team, the NHSX Data Policy Team and the GLD, it was therefore agreed that new COVID-19 directions would be produced which would enable NHS Digital to: (i) collect new data and analyse and link that to other data, including existing data NHS Digital already held under other directions and requests; and (ii) establish and

develop IT systems, for various COVID-19 purposes, which broadly followed the purposes set out in Regulation 3 of the COPI Regulations.

79. NHS Digital worked with the NHSX Data Policy Team, GLD and the NHS England Directions Team on the drafting of two new COVID-19 framework directions, one to be issued by the Secretary of State and the other to be issued by NHS England. In addition, following consultation with NHS Digital, the Secretary of State issued a notice under Regulation 3(4) of the COPI Regulations to NHS Digital requiring it to share data it had obtained, for COVID-19 purposes. NHS Digital's PTEL Team also worked with the NHSX Data Policy Team and GLD to agree the form and content of the Regulation 3(4) notice. On 17 March 2020, NHS Digital was therefore issued with:

79.1 A Direction from the Secretary of State under section 254, requiring NHS Digital to establish and operate information systems to collect and analyse data for COVID-19 purposes, and develop and operate information and communication systems to deliver services for COVID-19 purposes (which I exhibit as **SB/29 INQ000101766** together with the subsequent amendment letter dated 31 March 2020 **SB/30 INQ000101767** and the amendment letter number 2 dated 17 February 2022 **SB/31 INQ000101768**);

79.2 A Direction from NHS England under section 254, in mirror terms to the above (which I exhibit as **SB/32 INQ000101769** together with the subsequent amendment letter dated 31 March 2020 **SB/33 INQ000101770** and the amendment letter number 2 dated 14 February 2022 **SB/34 INQ000101771**); and

79.3 A notice under Regulation 3(4) of the COPI Regulations requiring NHS Digital to share confidential patient data with organisations entitled to process this under the COPI Regulations for COVID-19 purposes (exhibit **SB/35 INQ000101772** together with the subsequent extended COPI notices dated 29 July 2020 **SB/36 INQ000101773**, 27 January 2021 **SB/37 INQ000101774**, 27 August 2021 **SB/38 INQ000101775** and 10 February 2022 **SB/39 INQ000101776**) together ("**the NHSD COPI Notice**").

80. The two COVID-19 directions above ("**COVID-19 Directions**") and the NHS Digital COPI Notice provided NHS Digital with a clear and flexible legal framework for collecting, analysing and linking data, developing and changing IT systems and products, and sharing data at pace.

81. NHS England was also issued with a notice under Regulation 3(4) of the COPI Regulations in similar terms to NHS Digital. A more general notice which applied to other health bodies and organisations covered by Regulation 3(3) of the COPI Regulations, was also issued by the Secretary of State under Regulation 3(4).

82. Together, these three COPI Notices provided a new legal gateway to share and use confidential patient data for a wide range of COVID-19 purposes, and, in the experience of NHS Digital during the pandemic, provided a clear and very helpful legal basis to enable sharing of data much more quickly than would otherwise have been the case. This is because the sharing of confidential patient data is a complex area, as the law of confidence is a common law concept, where guidance and policy needs to be carefully considered to establish whether there is a legal basis to process the data without patient consent. Having a clear statutory framework under Regulation 3 of the COPI Regulations, together with a definition of COVID-19 purposes that organisations could easily understand and a notice requiring data to be shared, removed significant complexity from data sharing decisions.

83. The COPI Notices also provided a transparent and clear statutory gateway as an alternative to consent or approval under Regulation 5 of the COPI Regulations to enable NHS Digital (and other organisations) to share data for COVID-19 purposes without breaching any duty of confidence to patients.[12]

[12] Where a COPI Notice doesn't apply and confidential patient data is processed for purposes other than direct care of a patient, express patient consent is required, or approval is required from the Secretary of State or the Health Research Authority with support from the Confidentiality Advisory Group (**"CAG"**) under Regulation 5 of the COPI Regulations (Regulation 5 approval is often referred to as a 'Section 251 consent', which is the power for the Secretary of State to permit confidential patient data to be shared for medical purposes without patient consent is contained within section 251 of the National Health Services Act 2006). The process of obtaining this approval can also take significant time and requires an application to be submitted to CAG, who may require that various conditions are in place before they recommend approval

84. It is important to note that personal data collected, analysed and linked under the COVID-19 Directions, and shared using COPI Notices, were still subject to all the requirements of the UK GDPR. This included being transparent about the data that was being processed and the purpose of use, carrying out Data Protection Impact Assessments ("**DPIA**") where required, ensuring that personal data was shared and used securely and ensuring that there was a legal basis under UK GDPR for processing and sharing personal data.

85. To support the discharge of our obligations under UK GDPR in relation to transparency, NHS Digital continued to disclose details of data shared in our published data release registers (exhibits **SB/40 INQ000101777 – SB/75 INQ000101812**[13] and **SB/76 INQ000101813**[14]) and we also established an Information Governance Hub on the COVID-19 pages of our website where we provided a specific COVID-19 Transparency Notice and additional information to the public about key programmes of work involving the processing of their personal data.

COVID-19 Pandemic – information governance process changes

86. Given the scale of work being delivered by NHS Digital involving the processing of patient data, the PTEL Team established a core team of mostly senior Information Governance ("**IG**") specialists who were dedicated to providing IG support on all COVID-19 work, called the COVID-19 Red Team.

87. The PTEL Team supported other Directorates and programme teams by providing IG advice, carrying out and documenting DPIAs and drafting Transparency Notices, as part of a package of work alongside developing and agreeing the content of requests made by devolved authorities under section 255. In addition, the new COVID-19 Directions provided a legal basis for information systems to be established and new IT systems to be developed and changed outside of standard processes. The PTEL team, working with the Caldicott Guardian[15] and the SIRO, therefore

[13] Monthly DARS data release registers from January 2020 to December 2022
[14] COVID-19 (non DARS) data release register which covers the period from 20 March 2020 until 6 May 2022
[15] A Caldicott Guardian is a senior person responsible for protecting the confidentiality of people's health and

established a new process for approving the collection, linkage and analysis of data and development of IT systems to ensure NHS Digital had appropriate records of all of the data that was being processed, why the data was being processed and to enable us to comply with our UK GDPR obligations in relation to personal data that was processed. This is referred to here as the PTEL Approval Process.

88. However, it also quickly became clear that a fast-track process for sharing data was needed outside the standard DARS process to support urgent data sharing associated with some of the significant COVID-19 digital and data programmes (such as the SPL, the digital and data workstream of NHS Test and Trace and the Vaccination programme) which involved sharing new data that had not been onboarded into the DARS process. There were also a number of urgent requests to share data for COVID-19 purposes that needed to be approved much more quickly than the DARS processes could manage. The PTEL Approval Process, therefore, also included fast track approval for data sharing where standard DARS processes would not have been appropriate.

89. The PTEL Approval Process had to consider requests for new data collections, analysis, linkage and sharing of data at speed, whilst providing adequate assurance that the processing was within the scope of and complied with the COVID-19 Directions, COPI Notices and UK GDPR. This process involved senior IG specialists including the Data Protection Officer reviewing requests for data use, and together with the Caldicott Guardian providing advice and recommendations to the SIRO and relevant Executive Directors on approval of the processing (which was often subject to certain conditions being met, such as Transparency Notices being published and DPIAs being fully documented). All disseminations of data approved through the PTEL Process were published on a separate COVID-19 (non-DARS) data release register, which was published on the same webpages as the DARS data release register. Data shared through this process was also subject to letters of

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care information and making sure it is used properly. All NHS organisations and local authorities providing social services must have a Caldicott Guardian. NHS Digital's Caldicott Guardian during the relevant period was Arjun Dhillon.

release which set out the legal basis and terms on which data was shared.

90. The changes I have outlined concerning the legal basis for sharing under the COVID-19 Directions and COPI Notices were the result of UK Government's actions. By contrast, the changes concerning NHS Digital's internal PTEL Approval Process were made on our own initiative.

91. As the result of all of these changes, NHS Digital was able to more rapidly collect, analyse and share data while ensuring that data protection standards were maintained. It should be noted that this temporary approach, in particular for non-DARS data sharing approvals, was only sustainable through the peaks of the pandemic. It demanded high levels of urgent work, consideration and approvals, often involving the same small group of IG specialists and senior approvers working extremely long hours. Over time, as work returned to more steady state levels, most new dissemination requests and extension requests for planning, commissioning and research purposes returned to the standard DARS processes.

Overview of specific activities by NHS Digital in response to the pandemic

92. The Inquiry has requested an overview of the role played by each of NHS Digital's four core delivery directorates in relation to the pandemic response. Those directorates are as follows:

92.1 Product Delivery (previously known as the Product Development Directorate);

92.2 Data Services;

92.3 IT Operations; and

92.4 Platforms and Infrastructure.

93. In paragraph 12 above, I refer to and exhibit the 'OrgBook' documents[16] which provide descriptions of these directorates (and the other directorates within NHS Digital).

94. Detailed descriptions of the activities undertaken by each of those directorates in relation to the pandemic response can be found in NHS Digital's Annual Reports for each of 2019-2020, 2020-2021 and 2021-2022 (exhibited at **SB/77 INQ000083067**, **SB/78 INQ000083077** and **SB/79 INQ000083080** respectively). I will, therefore, not repeat those details here but will instead summarise the broad activities that were undertaken by each of the four core delivery directorates.

Directorate Response – Product Delivery

95. NHS Digital's Product Delivery Directorate designed and delivered new and updated digital products and technology services commissioned by NHSX, NHS England, NHS Improvement, PHE, UKHSA and DHSC to help citizens, patients and clinicians across primary, secondary and adult social care.

96. The updating of existing products and services, and the provision of new COVID-19 products and technology services by our Product Delivery Directorate played an important role in the response to COVID-19. These products and services included, but were not limited to, the following:

96.1 Provision of COVID-19 information on the NHS.UK and NHS 111 online websites, and updating NHS Pathways[17] to support NHS 111 and NHS 111 online;

96.2 Updating the existing NHS App[18] to reflect significantly increased usage during the pandemic and to add specific COVID-19 functions (such as the ability to view details of COVID-19 vaccinations, the incorporation of the COVID-19 Pass Service and the ability for users to update their contact details);

[16] See exhibits SB/02 INQ000083057– SB/10 INQ INQ000083079
[17] NHS Pathways is a clinical tool used for assessing, triaging and directing the public to urgent and emergency care services and is the 'engine' that drives 111 online
[18] NHS Digital was not involved in the development of the separate COVID-19 App (used to support the Test and Trace programme), see paragraph 117.

96.3 Delivery of a service to allow citizens to look up their NHS number;

96.4 Delivery of a service to allow citizens to obtain an isolation note when required to self-isolate;

96.5 Delivery of digital and technology services and provision of specialist technology programme delivery capability for NHS Test and Trace;

96.6 Provision of the data and technology solutions and provision of specialist technology programme delivery capability to support NHS England in its delivery of the COVID-19 Vaccination programme; and

96.7 Provision of COVID-19 risk stratification services (discussed further below).

Directorate Response – Data Services

97. Our Data Services Directorate played an important role in the response to the COVID-19 pandemic by ensuring that data, products and services were available to support direct care, delivery of health and care services, research into the effects of and treatments for the virus, and the public's understanding of disease prevalence.

98. This was achieved through new data collections (e.g. Situation Reports to show activity in hospital and community settings; testing and vaccination information; creation of new COVID-19 data products; sharing of data with authorised users; introducing a range of dashboards; delivering cohorting services (e.g. SPL for England, Covid Oximetry@Home[19]); and rapid expansion of NHS DigiTrials (which provides support for all phases of clinical trials i.e. feasibility, recruitment, outcomes and follow-up). All of this activity was enabled by the COVID-19 Directions and the COPI Notices, detailed above.

[19] COVID Oximetry @home involves the remote monitoring of patients with COVID-19 symptoms. Patients use a pulse oximeter, a small monitor clipped to their finger, to measure their oxygen saturation levels three times a day. They record their results using one of the following: smartphone app, web portal or paper diary. NHS Digital's primary role was to deliver Oximetry @home data and digital architecture, and to collect data for service utilisation

Directorate Response – IT Operations and Cyber Security

99. The IT Operations and Cyber Security directorate managed and supported the range of live services operated by NHS Digital for the health and care system, as well as ensuring the cyber security of those services against threats and potential vulnerabilities.

100. During the pandemic, this directorate introduced additional services at great pace, alongside maintaining the availability, performance and security of existing services. As regards the pandemic response, the key services included:

100.1 Accelerated and extensive rollout of Microsoft Teams across the NHS to support remote working;

100.2 Through the IT Operations Centre, supporting the National COVID-19 Testing System and the COVID-19 vaccination service. The IT Operations Centre provided critical real-time information and workflows to guide preventative action and keep services and data available;

100.3 Working with the National Cyber Security Centre to help combat malicious cyber activities, which increased because of the disruption caused by COVID-19. During 2020-2021, NHS Digital identified and blocked an average of 21 million malicious attempts every month across the NHS;

100.4 Establishing the COVID-19 Cyber Defence Operations Centre, which provided protective monitoring and incident management coverage to over 50 services which made up the COVID-19 Test and Trace capability;

100.5 Supporting the Nightingale hospitals through the provision of connectivity, cybersecurity and clinical informatics advice and support (see further below at paragraph 132 132); and

100.6 Publishing guidance for staff across health and care on secure remote working (including for returning staff) and cyber awareness.

Directorate Response – Platforms and Infrastructure

101. The Platforms and Infrastructure directorate provided the core platforms that connected digital services across the health and care system.

102. Some of the key activities undertaken by the Platforms and Infrastructure Directorate in connection with the response to the COVID-19 pandemic included:

102.1 During the first wave of the pandemic, establishing the Access Logistics Hub to support the rapid roll-out of remote working solutions to help NHS staff to communicate effectively during the pandemic;

102.2 Supporting connectivity upgrades for 350 NHS premises that needed more capacity to support their pandemic response, and delivered connectivity to 150 vaccination sites;

102.3 Expanding the content of patients' Summary Care Records (**"SCRs"**) as part of the response to the pandemic through automatically uploading the additional information part of the SCR to the Spine[20]. This enabled additional information (such as more detailed medical histories, suspected or confirmed COVID-19 status, vaccine information and care plans) to be available on 52 million patients' SCRs which, in turn, enabled clinicians to access important medical information about patients who were accessing health services;

102.4 Delivering a number of changes to support Test and Vaccinations work including increasing the capacity of the Spine service to handle a 65% increase in volume;

[20] The Spine supports the IT infrastructure for health and social care in England, joining together over 23,000 healthcare IT systems in 20,500 organisations

102.5 Carrying out detailed analysis in collaboration with the ONS to help understand how accurate and complete the English citizens' demographic records held nationally for the NHS in the Personal Demographic Service were, for use in COVID-19 vaccinations; and

102.6 Adding support for virtual smartcards, to avoid the need for clinicians to bring a physical smartcard card into care settings (to access national systems) where this might be difficult when using personal protective equipment.

Other Directorates

103. NHS Digital's other directorates during the period 1 January 2020 to 24 February 2022 were:

103.1 Assurance and Risk Management;

103.2 Strategy, Policy and Governance; and

103.3 Corporate Services.

104. These directorates supported the activities of the core delivery directorates, rather than undertook their own activities (independent from the other directorates) as regards the pandemic response.

Key activities undertaken by NHS Digital in response to the COVID-19 pandemic

105. In the following sections, I provide more details on the key activities undertaken by NHS Digital in response to the COVID-19 pandemic, including the specific activities that the Inquiry has requested information about in the Rule 9 Request.

106. It is worthy of note that NHS Digital regularly published information in relation to its activities in response to the COVID-19 pandemic. In addition to information in its Annual Reports, it also published the COVID-19 Gold Reports on its website, as well as maintaining information about the

products and services it developed and provided during the pandemic on its website.

107. For ease of reference, and in order to ensure that this statement addresses each of the areas on which the Inquiry has requested information, these key activities are grouped as follows:

107.1 Development of existing products or services – the activities undertaken by NHS Digital in order to update products or services which were in operation prior to the pandemic, to reflect either increased demand or additional content/functionality as a result of the pandemic;

107.2 Provision of information – activities undertaken in response to the pandemic which were primarily aimed at making information and data available to the health system, the general public and/or relevant interested parties;

107.3 Products and services – specific products and services developed or supported by NHS Digital to support the response to the pandemic; and

107.4 Other key activities – other activities undertaken by NHS Digital in connection with the pandemic response, including those activities not addressed above but in respect of which the Inquiry has raised specific questions.

108. These groupings are used in this statement to assist the understanding of these activities. This terminology was not used by NHS Digital at the time.

(1) DEVELOPMENT OF EXISTING PRODUCTS OR SERVICES

109. In this section, I give more details of the following key activities undertaken by NHS Digital to update existing products or services as a consequence of the COVID-19 pandemic:

109.1 updating of the NHS.UK website including the creation of the COVID-19 Hub;

109.2 development of the NHS App;

109.3 services supporting critical and emergency care; and

109.4 the GPES.

NHS.UK website and COVID-19 hub

110. In early 2020, NHS Digital began to redirect activity in all its core delivery areas to support the response to the COVID-19 pandemic. One of the key areas that was critical to preventing the NHS from being overwhelmed was the development of the NHS.UK website in order to provide information and advice to the public in respect of the COVID-19 pandemic.

111. In March 2020, NHS.UK and 111 online had been promoted as the digital face of the pandemic response. Millions of people had been using the NHS.UK website to try to access information and guidance on how to self-manage COVID-19 and to find the most appropriate care.

112. One of NHS Digital's strategic focus areas in response to the pandemic was to provide digital channels for citizen guidance and triage. The COVID-19 'hub' (which NHS Digital referred to as COVID-19 content/services) on NHS.UK was one of these digital channels that NHS Digital developed to provide this service. As part of this initiative, NHS Digital built systems to support the integration of COVID-19 services within the NHS.UK website. NHS.UK was used to provide people with up-to-date health information and guidance on COVID-19 as well as to provide those affected by COVID-19 the treatment they required.

113. The NHS Digital NHS.UK team worked closely with PHE in early 2020 to develop and align COVID-19 content to the evolving case definitions. The source of the clinical information and advice was PHE. However, NHS Digital did play a role in the translation of this clinical information and advice from PHE (which was often very technical) into language that the general public would understand using an established style guide[21].

[21] All clinical information and advice on NHS.UK was approved by NHS Digital's CMO and PHE

114. This dedicated COVID-19 content on the NHS.UK website was accessed approximately 80 million times between the start of February and mid-May 2020. This included a patient facing YouTube video which was scoped, filmed and released within 24 hours to address COVID-19 FAQs. The video was viewed more than 7 million times. A summary of some of the key COVID-19 services on the NHS.UK website in the earlier period of the pandemic response is as follows:

114.1 In March 2020, NHS Digital was commissioned to build a survey tool to capture details of clinicians returning to work to support the pandemic response;

114.2 On 4 April 2020, NHS Digital rolled out a COVID-19 Status Checker. This was a new survey to centrally gather data on how COVID-19 was affecting individuals who were displaying symptoms. There were 220,000 responses by 9 April 2020;

114.3 The "Health-at-Home" service was launched on NHS.UK by NHS Digital on 9 April 2020 to support the NHSX social media campaign, encouraging the use of online health services, by linking patients to all online NHS services. The central landing page on NHS.UK was developed to provide information on how to remotely contact GPs, order repeat prescriptions, manage long-term conditions and maintain wellbeing. It also directed patients to relevant COVID-19 information and services;

114.4 In May 2020, NHS Digital continued to facilitate the provision of up to date health information on the NHS.UK website by expanding the case definition for COVID-19 in line with UK Chief Medical Officer ("**UK CMO**") guidance and to reflect new symptom definitions. Additionally, NHS Digital deployed a new landing page on NHS.UK to direct citizens with COVID-19 symptoms to booking services for drive-through testing and home testing kits; and

114.5 In June 2020, content was enhanced on NHS.UK to reflect new Government guidance, including changes to requirements for social distancing and the use of face coverings . NHS Digital also

developed a new functionality which allowed for repeat prescriptions to be ordered through NHS.UK.

115. The NHS.UK website continued to deliver a number of new digital services during 2020-2021. These included:

115.1 enabling citizens to register on the COVID-19 Vaccine Registry (see below at paragraph 190 190), through NHS.UK. This functionality enabled over 500,000 citizens to volunteer to be considered for COVID-19 vaccine clinical trials[22]; and

115.2 a service to allow citizens to look up their NHS number ahead of booking their COVID-19 vaccination. By March 2021, over one million citizens had successfully retrieved their NHS number using the service.

116. There were nearly 1 billion visits to the NHS.UK website by people seeking information about COVID-19 during 2020 - 2021. NHS.UK's social media channels saw a 979% increase in 'impressions' (which is effectively the number of unique people who see your content), with over 700 million impressions over the course of the year, and 5.33 million page views of information about mental health support.

NHS App

117. It is important to distinguish between the NHS App and the NHS COVID-19 App. The latter was the official contact tracing app for England and Wales, and NHS Digital had no role in its development[23].

118. The NHS App had been launched in 2018. The NHS App itself was operated by NHS Digital but not all services which it offered were operated by NHS Digital. The NHS App can be compared with a department store in the sense that NHS Digital provided the department store and operated the doors and security which allowed members of the public to come in, but once inside, there were different services, like concessions in a department store. Some of these concessions were

[22] Over 500,000 citizens as of June 2021
[23] Although NHS Digital was involved in the assurance of the NHS COVID-19 App from a data protection compliance perspective

operated by NHS Digital, but some were operated and provided by third parties, with NHS Digital only providing the 'door' into the third-party service.

119. When the pandemic began, the NHS App already allowed people to book or cancel GP appointments, order repeat prescriptions, view their GP record, make organ donor registrations, change their preferences about the use of their data, and access health and care advice from NHS 111 online and the NHS.UK website.

120. From March 2020 onwards, the NHS App was central to the initial pandemic response, functioning as one of NHS England's key channels for patient support and advice during the COVID-19 outbreak.

121. NHS Digital was involved in a number of developments to the NHS App to assist in the pandemic response and many of these improvements were already on the delivery roadmap for the NHS App but were accelerated significantly due to the pandemic. Developments included:

121.1 Introducing the ability to nominate pharmacies for electronic prescriptions, enabling users to specify where prescriptions were sent (3 April 2020);

121.2 Launching a secure messaging service between patients and GP practices, which went live on 9 April 2020, allowing short messages to be sent relating to non-urgent issues;

121.3 Integrating a third-party triage service - which was completed for 1,000 GP practices on 27 April 2020 (with another 2,500 to follow), which allowed patients to submit symptoms via an online consultation form and request support;

121.4 The provision of a "View your COVID-19 Vaccine Record" service to see details of your COVID-19 vaccinations; and

121.5 The launch of the NHS COVID Pass service in May and June 2021 for international and domestic use respectively. The COVID Pass allowed individuals to provide evidence of their vaccination

status in a secure manner. NHS COVID Pass was primarily run by NHSX on behalf of DHSC, but NHS Digital was commissioned to provide support in relation to certain elements (for example, integration of the NHS COVID Pass with the NHS App, NHS.UK, and NHS login).

122. Throughout this period, NHS Digital needed to increase capacity in order that the NHS App could cope with the significant number of new users. At the beginning of the COVID-19 pandemic, i.e. 1 January 2020 there were: i) 698,516 instances of the NHS App having been downloaded; ii) 186,229 NHS App authenticated uses;[24] iii) 232,339 fully authenticated login users[25]; and 414,497 login accounts created but not fully authenticated.

123. At the end of the first phase of the COVID-19 pandemic, i.e. 31 July 2020, these figures had increased to: i) 2,703,549 downloads of the NHS App, ii) 988,509 NHS App authenticated uses, iii) 1,049,269 fully authenticated login users and iv) 1,731,888 login accounts created but not fully authenticated.

124. Towards the end of the COVID-19 pandemic, i.e. 28 February 2022, there were: i) 30,272,787 downloads of the NHS App, ii) 26,330,424 NHS App authenticated uses, iii) 24,370,346 fully authenticated login users, iv) 38,688,143 login accounts created but not fully authenticated and v) 248,034,846 COVID-19 2D Passes generated.

125. A significant amount of work, specifically around ensuring the service could scale, was completed to ensure that the NHS App's architecture could handle the increased volume of users.

Support for critical care and emergency care

126. NHS Digital had a number of data sets that were used to understand the impact of COVID-19 on hospital activity and to look at outcomes for particular cohorts (either for population-level analysis or follow-up for

[24] Fully authenticated NHS App users have proved their identity to the highest level and can use the full functionality of the service. For further information see https://nhsconnect.github.io/nhslogin/user-journeys/
[25] Fully authenticated login uses have fully matched their identity back to their GP practice and can where the practice has enabled the functionality to view their GP record

particular clinical trials). I provide some examples in this section but this is not an exhaustive list of our data sharing in support of critical care and emergency care. It is also important to note that, historically, our data has been shared for secondary uses (i.e. not for direct care of patients) and the vast majority of datasets collected by Data Services were not shared in real-time but collected over days or weeks (or sometimes months) so it is not usually appropriate for provision of direct care.

127. The Hospital Episode Statistics ("**HES**") data sets are the most widely shared (and record activity in critical care, emergency, outpatient and hospital admissions). Dissemination of these data sets is detailed in the DARS data release register[26].

128. HES was used to collect the Critical Care Minimum Dataset ("**CCMDS**") submitted by hospitals. The CCMDS contains 34 data items on periods of care in adult critical care units, of which 14 data items are mandatory for submitters.

129. In assisting with the wider response to the COVID-19 pandemic and its impact on emergency care, NHS Digital supplied data to a number of external bodies and research institutions including:

129.1 The Pandemic Research Infection Emergency System Triage ("**PRIEST**") study by the University of Sheffield. The aim of the study was to evaluate and optimise the triage of people using the emergency care system (for example, 111 and 999 calls, ambulance conveyance, or hospital emergency departments) with suspected respiratory infections during the COVID-19 pandemic; and

129.2 An application by the University of Oxford to access data held by NHS Digital to conduct observational epidemiological studies with a view to informing the national public health response to COVID-19 and the vaccines[27].

[26] See Exhibits SB/40 INQ000101777 – SB/75 INQ000101812
[27] Although it is not clear whether these studies were completed

130. NHS Digital was also able to provide information about the care provided in emergency departments through the Emergency Care Data Set ("**ECDS**"), which was a national data set relating to urgent and emergency care. The ECDS collected information about why people attended emergency departments and the treatment they received.

131. The ECDS was already in existence prior to the pandemic. It was developed by NHS Digital in collaboration with the Royal College of Emergency Medicine, DHSC, NHS England, PHE, NHS Improvement, NHS Providers and other parties.

132. In addition to the provision of data, NHS Digital also supported the Nightingale hospitals through the provision of connectivity, cybersecurity and clinical informatics advice and support. The support provided differed for each Nightingale hospital, depending on what they needed help with, but generally included one or more of the following:

132.1 cyber security advice;

132.2 the provision of NHS mail accounts;

132.3 the provision of smartcards and readers; and

132.4 ensuring the prioritisation of connectivity of the Nightingale hospitals (using NHS Digital's existing telecoms supplier relationships).

General Practice Extraction Service

133. GPES is a service that was operated by NHS Digital that collects specific data, in the form of an extract from General Practice patient record systems for a wide range of purposes including providing General Practice payments. This service was in existence for several years before the pandemic.

134. A COVID-19 At Risk Patients extract was established to collect data that was required for direct care purposes during the pandemic.

135. The first collection was carried out on 18 March 2020 and was used to identify people who were eligible for a flu vaccination, as early indications suggested that this same population would be vulnerable to COVID-19. A subsequent collection quickly followed in April 2020 once the list of 6 conditions was released by the Chief Medical Officer defining people who were clinically extremely vulnerable ("**CEV**"). A third version was established to include the identification of patients for prioritisation for the COVID-19 vaccination.

136. These, and further collections of the At Risk Patients extract ensured that key initiatives such as the SPL, risk stratification, the vaccinations programme and subsequently the COVID-19 Therapeutics Service, had the data they required.

137. In May 2020, NHS Digital established a new GPES extract of General Practice data for the purposes of enabling planning, commissioning and research into the COVID-19 pandemic. This collection was known as GPES Data for Pandemic Planning and Research (GDPPR). The collection was established to respond to the intense demand for General Practice data to be shared in support of vital planning and research for COVID-19 purposes, including under the general legal notice issued by the Secretary of State under Regulation 3(4) of the COPI Regulations. NHS Digital was requested by the joint co-chairs of the Joint General Practitioners IT Committee ("**JGPITC**") (of the British Medical Association ("**BMA**") and the Royal College of General Practitioners ("**RCGP**")) to provide a tactical solution during the period of the COVID-19 pandemic to meet this demand and to relieve the growing burden and responsibility on GPs.

138. NHS Digital undertook considerable work with the BMA and RCGP to define the governance arrangements and worked with HDRUK to create technical specifications for GP system suppliers to extract the data.

139. The first data extract for this new dataset was requested by NHS Digital in May 2020 and evolved to become a national record level dataset covering 58 million patients' records.

140. Data extraction was run on a fortnightly basis from 17 July 2020, after the initial bulk extract had completed, to collect any new, relevant data. The GDPPR service took pressure off GPs by centralising the collection and sharing of General Practice data for COVID-19 planning, commissioning and research.

141. The GDPPR dataset was stored securely and available to those with a legal basis to access it, through DARS. As part of establishing the dataset with the BMA and RCGP, it was agreed that applications for access to the GDPPR dataset would be subject to independent advice from IGARD and from representatives of the BMA and RCGP who formed a Professional Advisory Group. Details of all data released from this dataset were published in the NHS Digital Data Uses Register.

(2) PROVISION OF INFORMATION

142. In this section, I provide an overview of the following key activities undertaken by NHS Digital aimed at making information and data in relation to the COVID-19 pandemic available to the health system, the general public and/or relevant interested parties[28]:

142.1 Provision and maintenance of COVID-19 dashboards:

142.2 Provision of information to the COVID-19 data store operated by NHS England;

142.3 Establishment of the Public Health Research Database in partnership with ONS;

142.4 Collection of information and production of aggregated COVID-19 Situation Reports (aggregated activity reporting); and

142.5 Information as to the impact on at-risk and vulnerable groups.

Dashboards

[28] This section does not include the whole range of new data collections or research environments provided by NHS Digital in response to the pandemic. Rather, the focus of this section is on those matters which the Inquiry has specifically identified in the Rule 9 Request

143. NHS Digital was commissioned by NHS England to develop a number of dashboards in the period of Spring 2020 to Spring 2022, some of which were public-facing and openly accessible and some which were developed for specific health and care use and were only available to approved users with a legal basis to access them and subject to specific terms of use (private and secure dashboards). These dashboards were rapidly established to assist a broad range of needs, and in summary, comprised three types of dashboards:

143.1 public dashboards (which, for example, provided an indication of COVID-19 prevalence at a neighbourhood level);

143.2 private dashboards (for example dashboards for local directors of public health); and

143.3 secure dashboards (for example GP practice-level dashboards accessible by clinicians to enable access to information relating to specific vulnerable populations including patient-level data).

144. Commissions for dashboards came from a variety of sources, including requests made directly to NHS Digital's Executives, as well as NHS Digital's own programmes which also instructed the Dashboards Team to build specific dashboards, including for example, the Vaccination and Test programmes. The content and presentation of the dashboards were agreed with commissioners prior to publication. The data presented in the various Dashboards created by the Dashboards Team are set out in Appendix 1.

COVID-19 data store

145. The COVID-19 data store was not procured, designed, developed or operated by NHS Digital. It was procured, designed, developed and operated by NHS England, which is the controller under UK GDPR for all of the personal data it processed. Information about what data it contained, who accessed the data and how the data was used, is held by NHS England. The data store is provided by Palantir (acting under instruction from NHS England) using a platform which is called Foundry.

146. Pseudonymised data was provided to the COVID-19 data store by NHS Digital. Requests received by NHS Digital went through the previously described process of approvals. The data released by NHS Digital to the COVID-19 data store is recorded in the publicly available data release registers[29].

Public Health Research Database

147. The COVID-19 Public Health Research Database is a research asset that was established by NHS Digital and the ONS (and commissioned by Health Data Research UK and SAGE in 2020). This was just one of the research/collaboration assets that NHS Digital was involved in establishing in response to the pandemic.

148. The COVID-19 Public Health Research Database was established to enable approved researchers to analyse whether particular illnesses, conditions or societal circumstances meant specific groups of people were less or more likely to be affected by COVID-19, enabling the UK to tailor its approach to those groups to save lives and reduce the impact and spread of the virus.

149. The database, accessible through the ONS Secure Data Store, provided safe and secure access to linked census, mortality and health data to support COVID-19 studies. The information that researchers had access to about people in the database was anonymised.

150. The COVID-19 Public Health Research Database was created from certain health data which NHS Digital already shared with the ONS for its own use for statistical purposes. NHS Digital worked with the ONS to establish data sharing and governance arrangements and NHS Digital was part of the approval route for researchers accessing this database.

Situation Reports ("SitReps")

151. SitReps consisted of aggregate, activity-level data collected by NHS Digital from health and care providers (e.g. hospitals, community providers) at the request of NHS England. NHS Digital collected the data,

[29] See Exhibits SB/40 INQ000101777 SB/76 INQ000101813

aggregated it to national level and shared it with NHS England. The data was used by NHS England as part of its response to the pandemic.

152. The SitRep data that was collected included information which we understood was required by NHS England and the Government to understand the demands placed on the national health care system by COVID-19. This information either did not already exist or needed to be collected more quickly and efficiently to facilitate responsive strategic decision-making by NHS England and others.

153. Each report covered different service settings and provider types, including data reporting the availability of critical care beds. The list of categories covered in the SitReps can be found at Appendix 2. Those categories which hold information on critical care bed occupancy are identified in Appendix 2. The data required for each of those categories were set out in the templates to the COVID-19 Situation Reports Data Provision Notice.

Information as to the impact on at-risk and vulnerable groups

154. The Inquiry has asked NHS Digital to provide details of any role NHS Digital played in the assessment of the impact of COVID-19 emergency response measures, including NPIs, on at-risk and vulnerable groups, including but not limited to, those groups with a protected characteristic under the Equality Act 2010 and groups with existing health inequalities. To the best of my knowledge, NHS Digital did not play a significant role in the assessment of the impact of emergency response measures on such groups.

155. There were some examples of analysis that NHS Digital was commissioned to undertake such as:

155.1 the impact of shielding on care home residents, to support a National Audit Office review; and

155.2 the investigation of what available hospital data could show about the impact of shielding measures for people on the SPL.

156. NHS Digital also established a COVID-19 ethnicity dataset as part of its DARS offer to support COVID-19 research.

(3) PRODUCTS AND SERVICES

157. In this section, I give an overview of the following specific products and services developed or supported by NHS Digital to support the response to the COVID-19 pandemic:

157.1 Access Logistics Hub;

157.2 Test and Trace;

157.3 The Shielded Patient List (SPL);

157.4 Risk Stratification (including the use of the QCovid® tool);

157.5 COVID-19 Vaccinations;

157.6 Research and Clinical Trials; and

157.7 Social care activities.

Access Logistics Hub

158. On 4 April 2020, our Access Logistics Hub was established to help organisations rapidly access services and products (such as software, broadband services, and physical and digital smartcards) to support their pandemic response. This Hub enabled NHS Digital to rapidly scale up the provision of remote working solutions to the NHS staff in the very early stages of the pandemic.

159. During the first wave of the pandemic (i.e. January 2020 – July 2020), the Access Logistics Hub supported the roll-out of Microsoft Teams to 1.25 million new users and 20,000 new NHSmail accounts to over 9,000 sites. This helped NHS staff to communicate effectively during the pandemic.

160. Within the same time period, NHS Digital deployed 60,000 physical smartcards, 20,000 smartcard readers, more than 2,100 Remote Access

Solutions[30] to NHS staff and facilitated the introduction of a virtual smartcard solution to enable secure access to key digital services for the disrupted and expanded health and care workforce.

Test and Trace

161. NHS Digital was responsible for delivery of certain digital services for the NHS Test and Trace programme. These almost entirely related to the 'Test' functions of the programme and not the 'Trace' functions.[31] NHS Digital's principal role in Test and Trace was to ensure that the digital infrastructure supporting the Test element (referred to in this statement as Test) was reliable and capable of withstanding the rapid expansion required.

162. It is worth noting that NHS Digital's role in supporting the Test function involved working with NHS England and Government parties, as well as third party suppliers (such as Deloitte). NHS Digital also worked with a broad range of suppliers and service providers to ensure an integrated end-to-end system of digital infrastructure for managing the Test programme, from booking a test to communicating test results back to the end user.

163. Test Digital[32] (a team created by NHS Digital to deliver the Test programme work) was responsible for:

    163.1 Developing and maintaining the public-facing sections of GOV.UK and NHS.UK websites for obtaining, registering and supporting tests;

[30] Remote Access Solutions provide staff with managed and secured access to network services and/or business applications from remote locations. In this instance, essentially enabling NHS staff to access their corporate network and IT systems over the internet whilst working remotely

[31] NHS Digital did provide limited support to the 'Trace' functions through the provision of dashboards

[32] Initial key members of Test Digital joined from existing NHS Digital teams, whilst the team was further augmented by independent contractors and consultants from third party suppliers such as Aire Logic Limited, Axiologik Limited, Baringa Partners LLP, Hippo Digital Limited and the Mastek Group. Test Digital was initially responsible for managing a Deloitte Digital team which delivered public-facing digital services in response to the pandemic, and also provided some public facing resources in addition to their supplier responsibilities

163.2 Supporting 119 contact centre activities, the operation of test sites and the tracking of test samples;[33]

163.3 Tools which supported service evaluations (i.e. how well tests performed);

163.4 The ordering platform[34], used by organisations / institutions to order tests; and

163.5 Systems which processed test registrations and results, sent notifications to users and stored test data to be forwarded on.

164. An overview of the key developments in the Test programme, so far as NHS Digital were involved, is set out in Appendix 3.

165. Many of these developments required significant infrastructure changes. Between March 2020 and March 2021, NHS Digital delivered 400 major software releases in relation to the Test programme work, which rapidly expanded the system's capability and coverage. By March 2021, the Test programme had processed more than 110 million test results, with the daily load on the infrastructure regularly reaching 1.5 million tests.

166. NHS Digital has been asked by the Inquiry to outline any issues encountered by it in relation to the reliability and robustness of the digital infrastructure of Test and Trace. I understand that whilst there were routine issues that occurred, as you might expect with any new infrastructure, NHS Digital did not encounter any major issues with the reliability and robustness of the digital infrastructure which underpinned Test and Trace.

SPL (the Shielded Patient List)

167. DHSC and the Chief Medical Officer for England ("**CMO England**") issued an initial commission to NHS Digital on 17 March 2020 to create the SPL[35]. This service was set up to identify people who were likely to

[33] Members of the public can call 119 if they have questions or need help with COVID-19 vaccinations, testing and NHS Covid Pass
[34] Using the Salesforce Group's customer relationship management software
[35] The formal commission was received on 9 July 2020

be clinically extremely vulnerable (CEV) to COVID-19 to enable appropriate interventions and support to be delivered. NHS Digital provided the SPL for England, to enable other organisations to support and protect those who were shielding.

168. The SPL included patients:

168.1 who were registered with a GP Practice in England or with the English prison service; and/or

168.2 who had received care in an English hospital[36]; and

168.3 were either identified nationally using clinical methodology as being at high risk (see further below) or were identified as at high risk or as CEV by their GP or hospital clinician;

168.4 It also included individuals resident in England identified by devolved administrations as being at high risk.

The classification of CEV

169. Between March 2020 and September 2021, the four UK CMOs, together with a small number of senior clinicians from ALBs, identified and regularly reviewed the underlying clinical conditions which were considered to put people at high risk of complications from COVID-19 infection. I understand from Jonathan Benger that he was involved in the discussions and decision around the original criteria for SPL agreed by the UKSCAG and ultimately approved by the UK CMOs. I understand that Jonathan Benger also had some involvement in agreeing subsequent updates to the criteria (which were determined by a larger group of individuals).

170. NHS Digital developed a clinical methodology; a ruleset to identify patients who met these clinical conditions based on coded information in their health records. This clinical methodology was based on the criteria defined by the UK CMOs and updated as appropriate to reflect the

[36] Irrespective of whether they were resident in the UK

guidance provided by the UK CMOs. The clinical methodology was also shared with the devolved administrations. Information relating to the SPL was available on NHS Digital's website, together with data that shows distribution by age, gender and location to support planning and research at local and national level.

171. Later in 2020, the CMO England also determined that other individuals not already identified may have been at risk of significant vulnerability to COVID-19 if they had a combination of certain clinical and demographic factors. Whilst it would be for the CMO England to state the basis of this determination, NHS Digital understands that the results of a clinical research project undertaken by the University of Oxford[37], and similar research from other academic groups played a part in this determination.

The creation of the SPL and dissemination of data

172. Over the life of the SPL service, NHS Digital was instructed by DHSC to share the SPL with appropriate data recipients to enable the provision of direct care and support for CEV individuals through an evolving COVID-19 national response. As such, from March 2020 to September 2021, NHS Digital shared relevant information from the SPL with organisations who had responsibilities for providing care and support to patients, including:

172.1 GP practices about their own patients on the SPL;

172.2 NHS hospitals about their own patients on the SPL;

172.3 healthcare staff in prescribed places of detention (for example prisons) about their own patients on the SPL;

172.4 mental health providers about their own patients on the SPL;

172.5 NHS England and Clinical Commissioning Groups;

[37] Whilst the initial definition of the CEV was based solely on medical conditions, further evidence and the introduction of the QCovid® tool (further details provided at paragraphs 178allowed the Government to introduce non-clinical factors such as ethnicity, gender and postcode to improve identification of those most at risk from COVID-19. Therefore, in February 2021 NHS Digital developed a set of clinical rules in line with the findings of the work carried out in respect of QCovid® to identify an additional 1.5 million patients to be added to the SPL

172.6 GDS within the Cabinet Office, who ran the CEV service; and

172.7 local authorities.

173. Details of organisations that received relevant iterations of the SPL together with an explanation for the purpose of its use (as understood by NHS Digital at the time of release) are detailed in **Appendix 4**. It is important to note that the dissemination of the SPL evolved through 2020 and 2021 and not all those organisations listed were provided with all iterations of the SPL[38].

174. The SPL was generated on a regular basis[39] from 20 March 2020[40] to 29 September 2021 and was issued to health and care providers and other agencies across national and local government responsible for supporting shielded patients[41]. A schedule of all the versions of the SPL and the dates they were released can be provided to the Inquiry if so requested. Oversight of the SPL was via the Shielding and Risk Stratification Oversight Group ("**SARSOG**"), led by DHSC with representatives including NHS England, NHS Digital and Ministry of Housing, Communities and Local Government. SARSOG was responsible for the governance of risk stratifications, as well as shielding and the SPL.

175. In January 2022 the SPL service transferred from the SARSOG to a clinical oversight group, chaired by Dame Dr Jenny Harries OBE (as Senior Responsible Owner) with representation from the DHSC, NHS England, UKHSA, NHS Digital and others. This covered both the SPL and a new programme of work called the Enhanced Protection Programme (**"EPP"**), an initiative set up by DHSC, UKHSA and NHS

[38] As noted in paragraphs 77-85 the COVID-19 Directions allowed for collection and dissemination of confidential information to persons or organisations who required it for COVID-19 Purposes and where it would be lawful for NHS Digital to do so. The COPI Notice provided NHS Digital with a legal gateway to share data with the organisations listed in this section of my statement. On 13 April 2020, a transparency notice was published on the NHS Digital website in respect of the SPL, this has been updated as necessary to reflect any changes to collections or distribution of data. As noted in paragraph 85, Exhibits **SB/40** INQ000101777 - SB/76 INQ000101813 –are NHS Digital's published data release registers which provide further details about how NHS Digital shared the SPL with different organisations.

[39] On average this was done on a weekly basis however, some releases took longer to produce.

[40] The first release of SPL was issued on 20 March 2020 (3 days after NHS Digital was initially commissioned to carry out this work)

[41] Data dissemination was underpinned by the COPI Notice or the 2012 Act, see paragraphs 77 - 85 for more details about the release of data by NHS Digital more generally and during the COVID-19 pandemic.

England to identify and support those individuals who remained vulnerable post-vaccination[42]. This EPP clinical oversight group oversaw the decommissioning of the SPL service, considered lessons learned, and agreed transitional / replacement models of support for those who continued to be considered at risk from COVID-19 aligned with therapeutic and vaccination programmes.

176. The EPP governance structure provided additional inter-programme oversight between COVID-19 therapeutics and COVID-19 vaccinations, to support consistent definitions for at risk conditions. In 2022, NHS England commissioned NHS Digital to develop tools to enable patient cohorting based on certain clinical criteria. Patients identified under such cohorts could be targeted for specific therapeutic and antiviral drugs[43].

177. On the instruction of DHSC, NHS Digital continued to maintain the national SPL infrastructure in a "warm standby" state[44] from October 2021 to June 2022. At the end of June 2022, with the approval of the EPP clinical oversight group, the SPL warm-standby service was decommissioned, data infrastructure switched off and data archived by NHS Digital in line with NHS Digital's records management responsibilities. Static public dashboards were retained and published at the request of DHSC[45]. These dashboards represent a static record of the data as at the end of shielding in September 2021. This is for the purposes of supporting ongoing enquiries in relation to the former CEV population.

Risk Stratification (including use of QCovid®)

178. I understand from Jonathan Benger that as the pandemic progressed, understanding of the risk factors for hospitalisation and death improved as observational research evidence became available. As a result of this NERVTAG convened a sub-group[46] to identify risk factors in the

[42]NHS Digital's role relates to the identification of cohorts (see paragraph 185.1185.1)
[43] Data released in respect of these tools was recorded in the DARS data release register (see exhibits **SB/40 INQ000101777 – SB/75 INQ000101812**)
[44] NHS Digital kept the SPL digital national infrastructure in place and was tested to ensure that it could be restarted to produce an up to date list of high risk patients if required at short notice
[45] This information is planned to be withdrawn at the end of March 2023
[46] The NERVTAG sub-group had a preliminary meeting on the 18 May 2020 and held its first meeting on 20 May 2020

population and apply risk stratification tools to identify individuals who might benefit from accelerated vaccination, additional treatments and/or protective measures (this is the sub-group Jonathan Benger was involved in). The sub-group was predominantly made up of leading researchers working in the area and able to analyse relevant data. Jonathan Benger's role was to support and advise the group on matters relevant to data provenance and data quality, and facilitate the provision of requested data sets (within the legal frameworks detailed at paragraphs 77 - 85 above). Professor Julia Hippisley-Cox of Oxford University became the chair of the sub-group.

179. To formalise this work, in May 2020 DHSC commissioned NHS Digital to develop the digital infrastructure to support a more sophisticated approach to identifying individuals with increased vulnerability to COVID-19, given the evolving understanding of the various clinical and non-clinical determinants (including ethnicity). DHSC also commissioned Oxford University to develop, using data provided by NHS Digital, the underlying risk calculator for this digital infrastructure, based on a combination of specific characteristics (such as age, sex, ethnicity, medical conditions etc). The risk calculator developed by Oxford University was called QCovid®, and became the coronavirus risk prediction model which underpinned the NHS Digital provided risk stratification service.

180. In December 2020, NHS Digital started to assess the potential use of the Oxford University QCovid® risk calculator to support the prioritisation of CEV for COVID-19 vaccination.

181. The NHS Digital team developed and operated the digital infrastructure and two tools using QCovid® as the central 'decision engine':

181.1 A Clinical Risk Assessment Tool: which was used by clinicians, typically during a 1-1 consultation where the clinician entered data about the patient into a web-based application, then discussed the resulting risk score (which was calculated using QCovid®) and any mitigation with the patient.

181.2 A COVID-19 Population Risk Assessment Service tool: which was operated centrally by NHS Digital[47]. The tool pulled minimised and relevant data from NHS Digital datasets, securely ran the data through the QCovid® model, producing a risk score for each record. In February 2021, this tool was used to conduct a population risk assessment which resulted in an additional 1.5 million high risk people being added to the SPL. The tool also allowed vaccine prioritisation of people at risk based on both clinical conditions and wider demographics. These individuals were prioritised ahead of purely age-related groups for vaccination booking, in accordance with Joint Committee on Vaccination and Immunisation (**"JCVI"**) guidance on vaccine prioritisation.

182. The Clinical Risk Assessment Tool enabled individuals, with clinical support, to understand their personalised risk of catching and being hospitalised or dying from COVID-19. The tools operated throughout England, and the Defence Medical Services worldwide, and are registered with the Medicines and Health products Regulatory Agency (**"MHRA"**) as medical devices.

Vaccinations

183. The NHS COVID-19 vaccination programme has been and continues to be delivered by NHS England. NHS Digital was commissioned by NHS England in August 2020 to support the COVID-19 Vaccination programme through the provision of a workstream related to the technology and data elements of the Vaccination programme (**"Tech & Data Workstream"**).

184. As part of its commission, NHS Digital took responsibility for the overall management of this Tech & Data Workstream from NHSX in October/November 2020. DHSC, PHE, NHSX, the JCVI and the Vaccine Deployment Programme all had input into the commission.

[47] A demo environment of this tool was shared with Scotland

185. The role that NHS Digital played in relation to the vaccine programme can be summarised as follows:

185.1 using NHS Digital held data, identifying groups of people with shared characteristics (termed 'cohorts') who were eligible for vaccination, based on guidance from the JCVI and NHS England on how cohorts should be constructed;

185.2 managing NHS South Central West Commissioning Support Unit (the supplier commissioned by NHS England to provide the National Immunisation Management System (**"NIMS"**)). This system was used to notify members of the public (initially by letter, but subsequently by text message and/or email notifications) who satisfied the criteria of the defined cohorts, of their vaccine eligibility;

185.3 providing a National Booking Service (**"NBS"**) (which NHS Digital launched on 9 January 2021) that enabled members of the public registered with a GP in England to book vaccination appointments, and staff/volunteers at vaccination sites to manage and check-in members of the public for appointments. Mass vaccination sites used the NBS whilst smaller sites (such as GP-run sites) tended to use local booking systems;

185.4 coordinating and providing technical assurance of third-party systems to capture and manage vaccination events;

185.5 providing and/or managing data flows between relevant parties (such as NHS England, GPs and patients) and NHS Digital, and ensuring that data was shared securely;

185.6 overseeing the clinical safety, quality and security of the products and solutions NHS Digital provided and interacted with regarding the vaccination programme;

185.7 implementing and managing data flow to the NHS England COVID-19 data store to support national performance reporting by NHS England; and

185.8 implementing and managing an integration solution to support the exchange of data between home nations (Scotland, Wales, Northern Ireland, and the Isle of Man) to ensure citizens could obtain Covid Passes and receive vaccines in multiple home nations.

186. NHS Digital's clinicians provided clinical safety assurance to the Tech & Data Workstream to ensure compliance with regulatory standards in relation to data flow and the NBS. This assurance functionality was continuously independently reviewed and approved by NHS Digital's Clinical Safety Group (**"CSG"**) within the over-arching clinical governance framework of NHS Digital. In particular, compliance for the Tech and Data workstream was assessed against the regulatory standard DCB0129 for Clinical Risk Management and its Application in the Manufacture of Health IT Systems.

Research and Clinical Trials

187. NHS Digital was a joint creator of the NHS DigiTrials service (**"DigiTrials"**), along with the University of Oxford, IBM and Microsoft.

188. DigiTrials was launched prior to the pandemic in October 2019 as part of a Health Data Research UK programme and, supported by the NIHR and the Association of Medical Research Charities, aimed to help researchers quickly and accurately gather information about possible trial cohorts (i.e. potential trial participants who met certain criteria). Prior to this, researchers would have had to gather responses from multiple NHS Trusts to identify potential participants.

189. DigiTrials was at an early stage of development at the beginning of 2020 and was only funded to develop this trial feasibility service. However, the team rapidly accelerated development of other services during the pandemic. These allowed researchers to use data held in our central systems to identify suitable participants and ask them whether they wanted to participate in research, to communicate with participants in their research studies and to use data held by NHS Digital to identify outcomes of interest.

190. In particular, DigiTrials developed and administered the COVID-19 Vaccine Registry working closely with NIHR. This was a database of individuals who had registered via NHS.UK to volunteer to be contacted about opportunities to participate in COVID-19 Vaccine trials. This enabled suitable trial cohorts to be easily and rapidly identified and quickly recruited.

191. The team also worked closely with other organisations who were conducting trials relating to the COVID-19 pandemic to facilitate fast access to NHS data, including sharing many completely new datasets collected to support the pandemic response. This included the RECOVERY trial, the world's largest trial of COVID-19 treatments. To date, the trial has identified 4 treatments (dexamethasone, tocilizumab, Baricitinib and Regeneron's monoclonal antibody combination) for COVID-19.

192. A further example is the Real-Time Assessment of COVID Transmission (**"REACT"**) study, which I understand was established in May 2020 by Imperial College London on behalf of DHSC. It provided monthly estimates of the prevalence of the virus and bi-monthly estimates of the prevalence of antibodies to the virus in the general population of England (using data collected from home test kits).

193. NHS Digital provided demographics data to Imperial College London to enable recruitment of a nationally representative cohort of participants for the REACT study. NHS Digital also provided health records of participants who provided their consent. These records were linked to study data to advance understanding of the risks of infection and reinfection with COVID and people's future health following a COVID-19 infection.

194. The DigiTrials team also supported recruitment into another important COVID-19 clinical trial, the PRINCIPLE trial, which aimed to find COVID-19 treatments that could be taken at home to avoid hospitalisation. Although the study commenced in April 2020, the participant numbers over the first 6 months were low because it was hard to find and engage with patients in the community when they were feeling unwell. The

window for recruiting relevant participants following a positive COVID-19 test was only seven to ten days. By providing the PRINCIPLE team with a daily flow of COVID-19 test data records as well as access to the Summary Care Record, NHS Digital helped them to identify suitable trial participants and enable efficient and safe prescribing of trial treatment, resulting in recruitment into the trial doubling to 200 per week. DigiTrials also provided outcomes data to enable the trial to quickly and efficiently analyse their results.

195. On 30 July 2021, DHSC commissioned NHS Digital to develop a full DigiTrials service which allowed the service to use routinely collected NHS data to:

195.1 Widen the diversity of those given the opportunity to participate in clinical trials;

195.2 Enable faster, more efficient and effective trial set-up; and

195.3 Increase overall recruitment to clinical trials.

196. The recruitment service was initially limited to four trials. One of these, the REGAIN trial, was a randomised controlled trial testing intensive treatment against light touch exercises and behaviour intervention for participants with long COVID. This trial was conducted by the University of Warwick. The trial was at risk of failing as they could not recruit through acute NHS Trusts and were at risk of losing their funding. Through DigiTrials they recruited over 300 people in 2 months - enabling the trial to complete and report results.

197. The DigiTrials programme board minutes covering the period between January 2020 and May 2021 were published on our website.

Social care activities

198. The Social Care Programme was created by NHS Digital, under direction and funding from DHSC, to provide support to local government, the NHS and the wider adult social care sector to improve the digital maturity of adult social care and support the integration of services at a local level.

The Social Care Programme ran from April 2016 to March 2021 and funded over 100 projects.

199. From March 2020, the programme was directed by NHSX, which had responsibility for adult social care data and technology, except for statutory data collections. Social care digital transformation delivery was continued by NHSX on the closure of the Social Care Programme in March 2021.

200. In the first half of 2020, much of the work of the Social Care Programme related to understanding of the impact of the pandemic on the existing projects it was funding. In broad terms, some projects accelerated their work to support the pandemic, some reported delays, some re-scoped their work, while others paused all activity (primarily due to limiting capacity and means for testing and uptake among frontline staff and service users).

201. NHS Digital also undertook projects supporting the collection of data from adult social care, and providing remote monitoring in care settings, as further detailed below.

Data collection in adult social care

202. In March 2020, NHS Digital was approached by the Care Software Providers Association (**"CASPA"**) to explore the possibility of NHS Digital collecting data on COVID-19 in social care. This was intended to enable central Government to receive a daily report to include anonymised, but geographic, data relating to COVID-19 information within care home and domiciliary care settings where IT systems within CASPA were operational (**"the Care Providers"**). This included data such as the number of people receiving care who had COVID-19 and the number of staff with COVID-19.

203. The Care Providers covered approximately 30 to 40% of the social care sector. As a consequence of that limited coverage, DHSC decided that the data proposed to be collected by NHS Digital from the Care Providers could not be used for accurate situation reporting and/or for COVID-19 management. Accordingly, at the end of March 2020, NHS Digital was

directed by NHSX to collect data from the Care Providers for exploratory purposes only, with the project to be subject to further review.

204. From May 2020 to March 2021 NHS Digital collected data amounting to over 100,000 care records per day from the Care Providers. NHS Digital presented its evaluation of the data collected to DHSC and NHSX in March 2021. As stated above, this data was collected for exploratory purposes only, to assess the viability and value of this dataset. This data was not disseminated beyond NHS Digital or used by us in any of the data activities in support of the pandemic response.

205. NHS Digital's evaluation concluded that the project was an effective way to collect data directly from Care Providers, which could be used for purposes such as capacity planning. NHS Digital did not collect any further data after March 2021 (as requested by DHSC and NHSX).

Social Care: Remote Monitoring within Care Provider Settings

206. In June 2020, NHSX commissioned NHS Digital to explore whether there would be benefits to the use of advanced remote monitoring technology in care homes and other residential settings. The aim of this project was to explore possible digital interventions to reduce face-to-face contact, thereby reducing the risk of infection, whilst also saving staff time.

207. Seven IT suppliers were involved in deploying remote monitoring technology across several residential settings. A range of technologies provided were tested, including acoustic monitoring sensor devices which used artificial intelligence to detect abnormal behaviour of residents, and send alerts to care staff's mobile devices. This technology allowed quicker and more targeted response at night-time, thereby saving lives and preventing serious falls. It also prevented unnecessary interventions and gave residents greater privacy and dignity.

208. NHS Digital reported its final recommendations to NHSX in June 2021. The project found that there were clear qualitative benefits to be gained by utilising advanced remote resident monitoring technology for the delivery of social care within care provider settings. NHS Digital recommended that more work be undertaken to quantify the technology's

effectiveness in order to justify a business case for widespread scale-up across the whole care provider sector.

(4) OTHER

209. In this section, I address the two remaining areas that the Inquiry has raised specific questions about, namely the Capacity Planning and Analysis System (**"CPAS"**) and behavioural management.

CPAS

210. In April and May 2020, NHS Digital (in conjunction with a team of researchers from the University of Cambridge and using data from PHE) undertook preliminary development of CPAS. This was a planning and analysis system, intended to use machine learning/artificial intelligence to support hospitals to predict Intensive Care Unit demand for ventilators, beds and equipment.

211. After the work had started, it was discovered that, in parallel, NHS England had been undertaking similar work to develop an equivalent system and were closer to a deployable solution so NHS Digital's work on CPAS was ceased and learning shared with the NHS England team. NHS Digital was not involved in the development and operation of the system ultimately used by NHS England.

Behavioural management

212. The Inquiry has asked NHS Digital to provide a high-level summary outlining to what extent NHS Digital was involved in the provision of advice and briefings on the use of behavioural management, the use of public communications, and the maintenance of public confidence in the response to the COVID-19 virus. To the best of my knowledge, NHS Digital had no such involvement.

SECTION C: Future risks, reviews, reports and lessons learned exercises

213. Before substantively addressing the topics in Section C, I take the opportunity to explain:

213.1 The scope of this section (with reference to the instructions in the Rule 9 Request, the Provisional Outline of Scope for Module 2 and NHS Digital's limited involvement in the matters covered by Module 2);

213.2 The approach adopted in producing this section in circumstances where my personal experience (by virtue of my role and tenure period) does not extend to all the matters covered in Section C.

214. As set out in paragraph 7, NHS Digital was a delivery organisation. It did not set or advise on policy. It was sometimes consulted on and advised on the potential impacts of implementing policy, as an expert in and in the context of the management of national data sets and the delivery of national healthcare digital systems.

215. In determining information which should be included in this witness statement, I had regard to the introduction to the Rule 9 Request, which makes clear that "Module 2 is concerned with key decision-making in relation to the response to Covid-19, rather than the delivery or implementation of those decisions. Module 2 is therefore focussed on the provision by NHS Digital of data, statistics and analysis which informed core political and administrative decision-making." I also considered paragraph 40 of the Rule 9 Request, which reiterates that the Section C requests relate to "the lessons which NHS Digital has learned from the UK's response to the Covid-19 pandemic, in so far as is relevant to any of the issues raised in the Provisional Outline of Scope for Module 2."

216. This section is framed in line with those restrictions on the scope of Section C requests to NHS Digital. It does not analyse NHS Digital's operational delivery or implementation of programmes during the pandemic and is focused on issues in the Provisional Outline.

217. Whereas the Rule 9 Request makes clear that it is focused on the provision by NHS Digital of data, statistics and analysis "which informed core political and administrative decision-making", at paragraph 45 it is explained that we had limited knowledge of how outputs from data were used by recipients. As NHS Digital had very limited direct involvement in such decision-making and limited knowledge of how decisions were made using data it provided, it will be a matter for other organisations to confirm to what extent and how NHS Digital's output informed core decision-making.

218. However, in order to provide a meaningful response to Section C of the Rule 9 Request, I will address the Inquiry's requests with reference to data/statistical output which I consider to have been most likely to have informed some decision-making.

Approach adopted in this section

219. As I explained at paragraphs 7, 22 and 30 NHS Digital had a limited role in supporting decision-making, and did not develop policy.

220. As I only joined NHS Digital in June 2021, I have no personal experience of what worked well, as well as any difficulties and challenges encountered by NHS Digital, in the "particular focus" period identified in the Rule 9 Request (1 January 2020 to 26 March 2020). The extent of formal 'lessons learned' documentation (given the pressures of actual pandemic response) undertaken by NHS Digital was limited; those which were created are listed and exhibited at paragraph 259 . Lessons learned activities within NHS Digital focused on the opportunity to learn and apply improvements to our operational delivery, internal governance and reporting to our commissioners, not on how decision making by our commissioners, in particular ministers, could be improved.

221. In order to mitigate the limitations on my personal knowledge, I have reviewed such 'lessons learned' material as was formalised and sought the input of former senior NHS Digital staff who were 'in role' during the relevant period, including Sarah Wilkinson (my direct predecessor and the Chief Executive Officer during the initial pandemic response).

222. The information provided does not necessarily represent my personal experience (given the limitations identified above) but is accurate to the best of my knowledge (based on the above process having been undertaken). This is not intended to be a formal retrospective exercise or to be exhaustive, but a proportionate response to the wide-ranging Section C topics, limited in scope by the instructions within the Rule 9 Request.

Pre-existing constraints

223. The following were pre-existing constraints that applied prior to the pandemic period that impacted NHS Digital's capability:

223.1 Whilst NHS Digital had in-depth capabilities in relation to technology and information, including unique capability in some areas, such teams often had limited resources that are challenging to scale at pace.

223.2 Datasets have their own form, components, characteristics and may be gathered over different periods. Whilst the characteristics of datasets were well known and understood for their intended purpose, it is challenging to rapidly consider, plan and mobilise for an alternate use of that same dataset. The component elements and the level of quality and currency required in a dataset is dependent on the purpose of that data use. This is particularly so when data collected for secondary use purposes (i.e. purposes beyond the direct care of patients, such as to support payments), is to be used for a direct care purpose, where higher levels of completeness, timeliness and quality are critical to ensure clinical safety.

223.3 NHS Digital operated the General Practice Extraction Service ("**GPES**"), which involved collecting specific data items from General Practice patient record systems for specific purposes - a "collect once, use once" approach with a transactional cost associated with each extract, which required GP system suppliers to undertake work to enable each extract. The GPES system was

constrained by its existing capacity, the technology it used to collect data and the resource this required from both GP system suppliers and from within NHS Digital to support the development and collection of data extracts. Prior to the pandemic, NHS Digital had not previously collected GP data for general planning and commissioning purposes i.e. a "collect once, use many times" approach, although a programme developing that capability was under way before the pandemic. There was, therefore, no centralised national repository of GP data for general planning and commissioning use at the beginning of the pandemic.

223.4 Prior to the pandemic, there was some lack of clarity as to division of roles and responsibilities between NHSX and NHS Digital for the delivery of technical projects, which was being resolved prior to the pandemic, but this process had not concluded. To note, the Laura-Wade Gery ("**LWG**") review, in considering the NHS 'operating model' in respect of NHSX and NHS Digital, recognised the issues which arose from the split of responsibilities across different organisations, concluding that:

223.5 "The NHS's current operating model, with responsibilities split across the teams at NHSEI, NHSX and NHSD, together with the fragmented and uneven technology capability in the wider service, reflects previous practice and does not support the nature and scale of the transformation ahead of the NHS. Furthermore, the role and capacity of the national bodies in supporting technology delivery in ICSs, trusts and other healthcare organisations is not clear and not sufficient relative to the transformation agenda facing the health service."

224. Conversely,

224.1 NHS Digital was fortunate in that it had considerable digital, data and technology expertise, which were key to scaling work. In common with the wider Information Communications and Technology ("**ICT**") sector, NHS Digital was also experienced in

agile improvement and scope change management and was experienced in iterative development of its products.

224.2 NHS Digital was able to develop existing core platforms, products and national systems already in place, including the NHS App, NHS login, 111online, NHS Pathways, NHS.UK, the Electronic Prescription Service, cyber capability, the Health and Social Care Network and national datasets including the Personal Demographic Service ("**PDS**") and collection capability through the GPES and in the Data Processing Service ("**DPS**") platform. Although many of the existing capabilities had to be expanded/scaled, NHS Digital was only able to do so because of the infrastructure put in place and work done before the pandemic.

224.3 NHS Digital's strong relationships and existing commercial frameworks with suppliers were particularly important when work had to be carried out at pace, as it was possible to quickly bring in contractors to increase capacity and access specialist expertise under those frameworks.

224.4 NHS Digital entered the pandemic with good relationships with professional representative bodies, such as the Royal College of General Practitioners, ("**RCGP**") the British Medical Association ("**BMA**") and the Academy of Medical Royal Colleges ("**AOMRC**"), which helped the organisation to build consensus on the collection and use of data throughout the pandemic.

Challenges

225. NHS Digital faced the following broad challenges during the pandemic period.

Scale and pace

226. The pandemic substantially increased the demands on NHS Digital for services and required systems and services to be delivered quickly. When a programme needs to be delivered urgently, it typically requires

more resources than initially planned, such as additional staff, equipment, or funding. NHS Digital had to allocate resources quickly and effectively across multiple competing priorities. Urgent programmes required coordination across multiple teams, departments and organisations, whilst still being required to consider and address risks relating to quality, safety, and compliance. The urgency of the work required by NHS Digital did not diminish the need for effective risk management and a thorough understanding of the components and risks involved, as well as planning and mitigation strategies.

Impact on workforce

227. The pandemic had an impact on our staff and our suppliers' resources. There was a shift to remote working due to lockdowns and social distancing measures. In common with the whole country, the pandemic caused significant stress and anxiety for our staff and impacted on their family circumstances. Against this background, NHS Digital staff (and contractors) worked consistently long hours over a prolonged period to ensure that commitments could be met and delivery could be achieved in urgent timescales. This impact on staff was particularly challenging in areas that consisted of small teams with specific subject matter expertise that was in demand.

How we approached these challenges in relation to collection, analysis and dissemination of health data and statistics

Overview

228. I reiterate that, as a delivery organisation, NHS Digital did not have a role in developing policy. We have only a limited knowledge of the reliance placed by Government on our work in this area. However, we anticipate that NHS Digital's response to the challenges of the collection, analysis and dissemination of health data and statistics to be most relevant here for the Inquiry.

229. I should first make clear that there were many other programmes and practices within NHS Digital which worked well, particularly during this

challenging time, but are not mentioned in this statement as they appear to me to be less relevant to the issues in Module 2.

Use/provision of statistics on COVID-19

230. For the purposes of this witness statement, I identify 'statistics' (as distinct from data') as: open aggregated data that can be used and shared by anyone for any purpose, made publicly available in accordance with the Code of Practice for Statistics and under NHS Digital's statutory functions to publish data.

231. NHS Digital's role in respect of statistics is summarised in paragraphs 23.7 and 29.3 as well as referencing other organisations providing health and care statistics across England. Other organisations had a remit to produce statistics on specific aspects of COVID (for example PHE/UKHSA around infections and NHS England around hospital admissions). Where NHS Digital had data sources that were relevant to COVID (such as 111 data around people calling or visiting the website with COVID symptoms) we published these via public dashboards. However, most of NHS Digital's core statistics did not specifically cover COVID and were drawn from rich detailed data sets covering longer periods and multiple sources, including multiple care domains.

232. Due to those features of NHS Digital's statistics work, apart from the discrete COVID-related collaborations/data sharing identified above, the scope of NHS Digital's work on statistics did not change greatly over the pandemic. NHS Digital's statistical work could be used to infer the impact of COVID on key health and care services, for example numbers of GP appointments and proportion seen in person, along with numbers of patient contacts with other health and care services. The frequency of data gathering was adjusted for some statistics to enable analysis. For example, a very detailed survey on prevalence of children's mental health conditions started to be collected annually in the period.

233. Some statistical publications not specifically related to COVID were postponed over the period. The postponements were due to either NHS Digital's prioritisation of pandemic response activities and/or practical

restrictions during the pandemic (e.g. where gathering survey data for the Health Survey for England required in person interaction).

234. NHS Digital did not provide advice on the use of health data and statistics in public health communications by the UK Government. Any limitations of data and statistics were made clear at the point of data release or publication by NHS Digital, but it had no direct input on how the data was interpreted or how those limitations were used or communicated.

Situation Reports ("SitReps")

235. NHS Digital, commissioned by NHS England, stood up the new, COVID-19 SitRep collections reporting across a broad spectrum of activity. The SitRep data that was collected included information which we understood was required by NHS England and the Government to understand the operational impact placed on the national health care system by COVID-19. This information either did not already exist or needed to be collected more quickly and efficiently to facilitate responsive strategic decision-making by NHS England and others. This was a challenge due to the resource demand on the specialist teams.

The Shielded Patient List ("SPL") and cohorting

236. The pandemic presented the challenge of urgently needing to create a national data cohorting capability for direct care purposes. Creating this capability was challenging. New approaches had to be set up quickly and relevant data sets identified, and their characteristics and limitations considered at rapid pace.

237. SPL was the first example of national cohorting for direct care purposes and an unprecedented programme which was established extremely rapidly with the first SPL release on 20 March 2020, 3 days after NHS Digital was commissioned to carry out this work. I provide more information about the challenges associated with the creation of the At Risk Patient extract required to create the SPL below. As NHS Digital's two retrospectives on the SPL programme have been provided to the Inquiry, I do not intend to repeat the observations made there (to a large extent dealing with SPL operational matters) in this statement.

238. Overall, we consider that the process of SPL's creation, while challenging, worked well. Multiple new data flows were established, and a process was set up to ensure SPL data was regularly updated. This required significant efforts by a small team of experts to consider the complex relative merits of various source data sets, data components, data architecture and systems across different organisations and implementing a new service at pace.

Data analysis

239. In line with normal practice, data analysis work[48] was internally focused (to ensure we were producing high quality data products) rather than being intended for decision-making by Government. NHS Digital's role in the healthcare system was not to provide data modelling.

DARs and data sharing

240. NHS Digital shared data with many organisations including Government departments. As the result of COPI Notices, COVID-19 Directions and internal approval process changes (including the new Privacy, Transparency, Ethics and Legal Approval Process to deal with urgent requests), we consider that NHS Digital was able to collect and share data (as well as build systems) while ensuring that data protection standards were maintained. The arrangements put in place supported the balance between collecting and providing data promptly and doing so fairly, lawfully and transparently.

241. I understand from colleagues who were involved in advising on data protection matters during the pandemic that considerations of the common law duty of confidentiality, commercial confidentiality, and data privacy/legislation did not stop or significantly slow down essential data sharing (due to the legal framework (COPI Notices and COVID-19 Directions) and systems we put in place to ensure speedy but lawful data collection and dissemination. That said, there were on occasion complex data protection issues which needed careful consideration, and which did impact on the systems put in place to ensure compliance with data

[48] The distinction between data and statistics is set out at paragraph 230 of this statement.

protection laws. There were no additional hurdles in sharing data with the devolved nations as we already had statutory mechanisms in place to facilitate this, which we used.

242. A significant challenge from the outset of the pandemic was dealing with the very large increase in the volume of urgent requests to collect and share data, which had to be triaged/prioritised and then (as appropriate) fulfilled.

243. In respect of prioritising data sharing requests, in addition to internal triage, we worked closely with Health Data Research UK and the Health Research Authority to ensure we were appropriately prioritising research requests. This involved building on and strengthening existing partnership arrangements. We also worked closely with NHSX on prioritising data access requests. This and the many data requests being made to multiple organisations across the central system led to NHSX establishing a central front door for all data access requests which were then triaged and allocated to the most appropriate organisation.

244. The commission and introduction of new dashboards and open data sets helped to address some research requests for data and helped streamline the provision of aggregated data, because where NHS Digital made the data available through these means, there was no need for requesters to make discrete data requests.

245. The drastic acceleration of data access work during the peaks of the pandemic, while important and necessary at the time, is not one which is sustainable as a baseline for the longer term, not least due to the impact on staff. It demanded high levels of urgent work, consideration and approvals, often involving the same DARS caseworkers, small group of Information Governance specialists and senior approvers working extremely long hours. These skills are not easy to acquire and are very difficult to scale at pace. Over time, as work returned to more steady state levels, most new dissemination requests and extension requests for planning, commissioning and research purposes returned to the standard DARS processes. The viability (albeit at associated cost) of implementing

temporary specialist arrangements to deal with peaks in demand for data is a lesson learned by NHS Digital.

246. However, the pandemic experience in this area underlined the limitations and demands of a complex, manual and resource-intensive process for collecting, extracting and sharing data in a crisis. This experience has since prompted work toward developing the NHS Digital trusted research environment to provide access to data within NHS Digital infrastructure and streamlining data access processes, including developing more precedents to follow when considering data access requests and producing more standardised (and less bespoke) datasets.

GPES At Risk Patients Extract

247. The GPES service was operated by NHS Digital for several years before the pandemic, but in the absence of a general GP data repository, the challenge was using it at speed to meet data needs during the pandemic, including the establishment of the SPL.

248. As described at paragraph 167, the first COVID-19 data extract was the At Risk Patient Extract required to establish the SPL. This was used to identify people who were eligible for a flu vaccination, which was in line with the UK Chief Medical Officer ("**UK CMO**") early indications of those likely to be most clinically vulnerable to COVID-19. This extract was requested from GP System Suppliers by NHS Digital and provided on 18 March 2020. A second much more significant extract was then developed urgently over the course of the next month to reflect the additional risk factors that were identified by the UK CMO as likely to make certain people more clinically vulnerable to COVID-19. The development of this second extract was very challenging as it required extensive and deeply expert clinical input to translate the UK CMO definitions into the appropriate medical terminology and a technical specification for the data to be extracted by GP system suppliers. This was a very intense phase of activity involving a small team who worked exceptionally long hours over a three-week period to define the specification. The data was uploaded to NHS Digital over a period of three days in April 2020 and the extract then updated weekly.

Subsequent versions of the extract were developed and implemented to reflect additional at-risk patients from 2020 to 2022 (with this weekly extract remaining in place today). The extract is significant and, together with the GP Data for Pandemic Planning and Research extract which I mention below, continues to impact on the capacity of GPES.

GP Data for Pandemic Planning and Research

249. It was also clear early in the pandemic that there was an urgent need for GP data to support more general COVID-19 planning and research. This led to an intense demand for GP data being requested from General Practice to be shared in support of vital planning and research for COVID-19 purposes. NHS Digital was, therefore, requested by the joint co-chairs of the Joint General Practitioners IT Committee ("**JGPITC**") (of the BMA and RCGP) to provide a tactical solution during the period of the COVID-19 pandemic to meet this demand and to relieve the growing burden and responsibility on GPs. As a result, NHS Digital established a new national GP data collection, the GP Data for Pandemic Planning and Research ("**GPDPPR**") collection as described earlier in this statement. We undertook considerable work with the BMA and RCGP to define the governance arrangements over access to the data.

250. The GPDPPR collection provided, for the first time, a centralised primary care data repository for planning and research. It was based on a "collect once, use many times" principle for COVID-19 purposes. This was a significantly important resource for the pandemic response, particularly in clinical research and remains in place. GP data on a national scale provided considerable utility in support of the pandemic response, which was a positive lesson learned from the pandemic, together with the ability to reduce burden on GP practices through a centralised national GP dataset.

251. However, there was still no comprehensive national GP dataset which could be accessed for non-COVID purposes and there remained constraints on the GPES technology, capacity, cost and data collection methodology, which was used by NHS Digital to collect GP data, as indicated above. In 2021, NHS Digital was therefore commissioned by

NHSX to recommence the GP Data for Planning and Research ("**GPDPR**") Programme which had been paused when the pandemic started and was designed to introduce a replacement technology solution for GPES.

252. The GPDPR programme would have collected a standard national GP dataset into NHS Digital, to be linked with data from other care settings to meet commissioning, service planning, GP payment and research needs. The programme was launched in July 2021 but faced privacy objections from concerned pressure groups and was paused. As a result, and to address these concerns, ministerial commitments setting out additional safeguards which would be put in place before the programme re-commenced, were made. The commitments include ensuring access to GP data is via a national Trusted Research Environment (now referred to as a Secure Data Environment) and building greater patient and public awareness and understanding of NHS data use.

Other matters: NHS England's data store

253. The Inquiry has asked NHS Digital about its involvement in the Data Store.

254. The COVID-19 data store was procured, designed, developed and operated by NHS England (the data controller for all personal data held in the store). Pseudonymised data was provided to the COVID-19 data store by NHS Digital. Requests received by NHS Digital went through the approvals process, including consideration by IGARD in a number of cases, and were recorded in publicly available data release registers.

Other matters: Digital infrastructure/technology and miscellaneous issues

255. We did not carry out any studies or polls in respect of the public perception of the accuracy or quality of NHS Digital's health data, statistics or methodologies. While some data was made available through dashboards and open data sets, much of the data/statistics we provided was to other organisations (who might then use such statistics for their own reports or products). We also did not carry out any formal exercises to identify lessons in respect of data, statistics or digital

infrastructure/technology internationally (although individual staff involved in programmes may well have read about approaches in other countries). The focus of our limited resources was on pandemic response, rather than studying public perception or international practice; such work would ordinarily fall to others.

Lessons learned exercises.

256. NHS Digital as a delivery organisation was focussed on continuous improvement and learning lessons regarding its collection, analysis and dissemination of data, and its implementation of digital, data and technology products, platforms, systems and services. This development and improvement was an ongoing activity for NHS Digital and its staff. It did not as an organisation comment on policy or policy development, and had not conducted any lessons learned exercises on this topic.

257. The Inquiry may wish to have regard to others' recommendations contained in:

257.1 The LWG review referenced in paragraph 259.5 259.5;

257.2 The Goldacre Review, which was commissioned by the Secretary of State for Health and Social Care in February 2021 and published in April 2022. Professor Ben Goldacre was independently tasked to investigate how the efficient and safe use of health data for research and analysis could benefit patients and the healthcare sector. Professor Goldacre was also a non-executive Director of NHS Digital from 1 April 2021 but he was commissioned by the Secretary of State independently and outside of this role to carry out the review;

257.3 The strategy published by the Department of Health and Social Care: "Data saves lives: reshaping health and social care with data" ("**the Data Strategy**"); and

257.4 Improving health and social care statistics: lessons learned from the COVID-19 pandemic, published by the Office for Statistics Regulation;

Consideration and potential recommendations which the Inquiry may consider

258. NHS Digital has no recommendation to make in relation to policy making of government which is the scope of this Module 2. In relation to NHS Digital's provision of supporting data and information services, the following details potential recommendations that the Inquiry may wish to consider in relation to the provision of services going forward.

258.1 Earlier in this statement, I set out the background and importance of the GDPPR to respond to the intense demand for General Practice data to be shared in support of vital planning and research for COVID-19 purposes. There currently remains no ongoing 'collect once, use many times' access to GP data for general planning, commissioning and research purposes, nor a single data repository through which to efficiently, effectively, and at scale access GP data and link to other data resources. We consider such access to GP data would be essential in the event of another pandemic and recommend that facilitating greater access to GP data through a national approach, including technical solutions to replace GPES, continue to be progressed within NHS England. Speeding up and improving controlled access to GP data would provide considerable benefits to the NHS and adult social care, especially during any future pandemic. In respect of this recommendation, I also refer to pages 122 and 123 of the Goldacre Review which draws out the benefits of a national GP dataset (see Appendix 7 to this statement).

258.2 During the pandemic, we used health data on a national scale in new ways and at an unprecedented pace. We committed at the start of the pandemic to be transparent about how we were using patient data and we worked to build public and professional trust and support for our use of health data. Trust is essential in enabling us to further the demonstrable benefit we gained when we securely and responsibly used data during the pandemic. However, public trust and confidence in the way in which data is used can be fragile. This is a lesson learned from the GPDPR

Programme that was paused in July 2021. We note the commitments outlined in the Data Strategy which, when implemented, will support the building of public trust and confidence in how the NHS uses and shares data. We also recommend that future Government data collection, use and sharing initiatives and projects (inside and outside health and adult social care) include building public and stakeholder trust in their delivery plans from the start, working with representative bodies and engaging with the public to understand and address concerns they may have about data use, to be more transparent about that data use and to ensure that the benefits of greater data use are clear.

258.3 The Goldacre Review makes the case for the importance of trusted research environments (more generally known as secure data environments) to enable efficient and trustworthy use of NHS datasets. The Department of Health and Social Care has also committed in the Data Strategy to implementing secure data environments. We consider that the capability to make linked datasets at population scale available to approved users within such environments would improve access to data and the speed of analysis in any future pandemic as well as enabling a wide range of more general planning and research activities to improve health and care.

259. I exhibit existing evidence in relation to the lessons learned and retrospective exercises conducted organisationally by NHS Digital and external persons/organisations (where relevant), as follows:

259.1 NHS Digital SPL Retrospective dated June 2020 (exhibit **SB/80 INQ000101817**);

259.2 NHS Digital SPL Closure Retrospective dated June 2022 (exhibit **SB/81 INQ000101818**);

259.3 House of Commons Committee of Public Accounts: COVID-19 Supporting the Vulnerable During Lockdown. Fifty-Third Report of Session 2019-2021[49] (exhibit **SB/82 INQ000101819**);

259.4 National Audit Office Protecting and Supporting the Clinically Extremely Vulnerable During Lockdown dated 10 February 2021(exhibit **SB/83 INQ000101820**); and

259.5 Independent report by Laura Wade-Gery, Putting Data, Digital and Tech at the Heart of Transforming the NHS, published 23 November 2021 (exhibit **SB/84 INQ000101821**).

Closing remarks

260. I trust that this statement will assist the Inquiry's understanding of NHS Digital's role, function and responsibilities, (both prior to and in response to the COVID-19 pandemic), provide a helpful overview of the work that NHS Digital carried out in relation to the pandemic response, the challenges faced by NHS Digital (within the scope of Module 2) and its perspective on potential recommendations for the Inquiry to consider.

261. I believe that the facts stated in this witness statement are true and accurate to the best of my knowledge and belief. I understand that proceedings for contempt of court 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 in its truth.

Signed:

Personal Data

Simon Bolton

Date: 09 June 2023

[49] Ordered by the House of Commons to be printed 15 April 2021

Appendix 1 – Dashboards and the data they presented

1. In Spring 2020, the Dashboards Team created a public dashboard which showed the total number of "NHS Pathways" triages of calls received through calls to 111 and / or 999 (as well as online assessments in 111 online) which resulted in a potential COVID-19 diagnosis[50].

2. Also in Spring 2020, the Dashboards Team created a public dashboard illustrating SPL data which contained breakdowns of the numbers of patients included in the SPL by location, ethnicity, gender and age band. In addition, private dashboards were created illustrating SPL data for NHS England and other users.

3. The Dashboards Team also created a dashboard for both first and second vaccination uptake, broken down by the same demographics of location, ethnicity, gender and age band.

4. In Summer and Autumn 2020, the Dashboards Team developed the public "Coronavirus in your area" dashboard, which used data provided by local authorities to NHS Digital to show the 7-day COVID-19 case rate per 100,000 people across the UK, allowing people to see how many COVID-19 cases were present in their local area.

5. In Summer/Autumn 2020, NHS Digital also built a variety of Test and Trace dashboards which monitored testing rates in different locations and were used by over 70% of local authorities. These dashboards were not public.

6. In Summer 2021, NHS Digital launched the GP COVID-19 Vaccination Dashboard (accessible via a purpose-built secure platform requiring an NHS smartcard to access). This dashboard was designed to enable Primary Care Networks to increase vaccination uptake across their local communities. It provided: a visualisation of COVID-19 vaccine uptake across patients registered to practices; metrics showing progress to date; and patient contact information to arrange a first vaccination dose or get a pending or overdue second dose booked in. The dashboard was also

[50]This dashboard was not based on the outcome of actual tests of COVID-19

updated to include invitation lists for those eligible for an Autumn booster dose.

Appendix 2 – SitReps

1. SitRep categories:

    1.1 COVID-19 Daily NHS Provider SitRep;

    1.2 COVID-19 Daily Patient Discharge SitRep;

    1.3 COVID-19 Daily NHS Provider Mental Health and Learning Disability and Autism (**"MHLDA"**) SitRep;

    1.4 COVID-19 Weekly Independent Provider SitRep;

    1.5 COVID-19 Daily Independent Provider MHLDA SitRep;

    1.6 COVID-19 Weekly NHS Provider SitRep;

    1.7 COVID-19 Daily Community Discharge SitRep;

    1.8 COVID-19 Community Health Services SitRep;

    1.9 COVID-19 NHS Staff Lateral Flow Testing SitRep;

    1.10 COVID-19 Long COVID Assessment Clinic Activity SitRep.

2. Sitrep categories holding information on the availability and occupancy of critical care beds during the pandemic:

    2.1 COVID-19 Daily NHS Provider SitRep

    2.2 COVID-19 Weekly Independent Provider SitRep;

    2.3 COVID-19 Daily NHS Provider Mental Health and Learning Disability and Autism ("MHLDA") SitRep;

    2.4 COVID-19 Daily Independent Provider MHLDA SitRep;

3. Sitrep categories with linked information on the availability and occupancy of critical care beds during the pandemic through discharge information:

    3.1 COVID-19 Daily Patient Discharge SitRep

    3.2 COVID-19 Daily Community Discharge SitRep;

Appendix 3 - Overview of key events in the Test programme.

1. April 2020 - NHS Digital was asked by DHSC to support the design, delivery and operation of the digital services underpinning COVID-19 testing, specifically the Pillar 2 National COVID-19 Testing System.[51] NHS Digital helped DHSC to establish the research, design and delivery assurance of the testing services provided by the digital test suppliers. This work initially focused on helping hospital staff and key workers to get tested, either through a test centre or home testing channels;

2. April 2020 - NHS Digital delivered a service for essential workers to request and book PCR tests at drive-through test centres, mobile units, or to order home kits, online (thereby increasing access to COVID-19 testing);

3. 22 June 2020 – GPs were able to see the test results of their patients, and historic tests results (results which took place before June 2020) were also sent to GP systems, including matching missing or incorrect demographic data for 1.7 million results;

4. 15 July 2020 – Individuals were able to register test kits through the Pillar 2 National COVID-19 Testing System, which enabled them to be notified of their test result via email or SMS, and allowed contact tracing;

5. 12 August 2020 - Hospitals gained the ability to pre-order home test kits for patients with scheduled elective care;

6. 26 August 2020 – NHS Digital developed a bulk upload feature for organisations to register residents or staff to be tested in larger quantities;

7. 14 September 2020 – NHS Digital built a platform to enable people to register for an Antibody test kit to identify if they had previously had COVID-19;

[51] The Pilar 2 Testing System involved swab testing for the COVID-19 virus in the wider population with tests either processed in a lab or more rapidly via lateral flow tests

8. 25 October 2020 – NHS Digital developed functionality to support cohort pooling. This functionality allowed the grouping of samples from multiple individuals into a single vial for analysis and reporting; and

9. 16 November 2020 - Test sites and other test settings started using Lateral Flow Devices ("**LFD**") for testing in addition to polymerase chain reaction ("**PCR**") tests. NHS Digital developed functionality which enabled recording of LFD test results.

Appendix 4 - Dissemination of the SPL

The Cabinet Office

1. The Cabinet Office (Government Digital Services) received the list for the purpose of delivering the government's extremely vulnerable persons service, which provided additional support to clinically extremely vulnerable (CEV) people (including food parcels) as well as to the local authorities affected by national and local restrictions. This sharing ceased on 17 September 2021, based upon the government's announcement of the end of shielding in England.

2. Supermarkets did not receive the SPL. When patients registered with the government's extremely vulnerable persons service, they were able to request support for food deliveries. It was this information that flowed to supermarkets and/or food distributors.

Local authorities

3. Local authorities received the list to identify CEV people and to provide targeted support as part of the local pandemic response. This included offering help, social care and support in coordination with other relevant organisations.

4. Local authorities were permitted to link SPL data with local authority NHS Test and Trace data to identify people who were CEV who had come into contact with people/a person recorded by NHS Test and Trace. They could also identify people who were CEV who were directed to isolate by the NHS Test and Trace Service. In both cases, this was to offer them appropriate advice and direct care.

NHS clinical commissioning groups ("CCGs")

5. CCGs received the list for the purpose of providing GP practices with support, and patients in their CCGs area with support and care.

Capita

6. Capita received the list for the purpose of distributing letters to patients on the SPL, on behalf of NHS England and Improvement, as their data processor.

APS Group Limited

7. APS Group received the list for the purpose of distributing letters to patients on the SPL, on behalf of DHSC as their data processor.

NHS Business Services Authority

8. The NHS Business Services Authority received the list for the purpose of sending text messages to patients on the SPL, on behalf of DHSC as their data processor.

9. NHS Business Service Authority also operated the Prescription Payment Verification assurance function and following direction by NHS England and Improvement, included those functions for shielded patient pharmacy, post payment verification. This was to ensure that the prescription delivery services provided to previously CEV patients, who were shielding and required prescription delivery support were operating effectively, and to ensure that public funds assigned for COVID-19 services to patients were being managed appropriately.

Gov.Notify

10. On behalf of DHSC and NHS England and Improvement, NHS Digital's data processor Gov.Notify, received the list for the purpose of sending letters, emails and text messages to patients previously identified as CEV.

11. Emails were used in addition to letters to ensure patients received timely information on their risk status, shielding policy, advice and guidance.

NHS England and Improvement and TPP Group Ltd

12. NHS England/NHS Improvement and TPP received the list for the purpose of identifying patients on the SPL who were in the detained estate and who needed advice, support, and care.

NHS England and Improvement

13. Data was disseminated to NHS England and Improvement for the purposes of strategic commissioning. Data was pseudonymised and held in the NHS England data warehouse - the National Commissioning Data Repository (**"NCDR"**). It was also held in the NHS England COVID-19 Data Store.

14. Data was also disseminated to NHS England and Improvement for the purposes of providing an SPL feed into the COVID-19 vaccination programme (using the National Immunisation Management System which was operated by NHS England). This supported the JCVI who identified that patients who are CEV should be offered a priority vaccination.

National Services Scotland

15. National Services Scotland (**"NSS"**) was responsible for the Scottish SPL. The purpose of sharing this information was so that NSS could contact Scottish residents who were identified as CEV as a result of direct care received in the NHS in England, to provide them with details of support they could obtain locally from Scottish local authorities where they were resident, including food parcels.

NHS Wales Informatics Service

16. NHS Wales Informatics Service (**"NWIS"**) was responsible for the Welsh SPL. The purpose of sharing this information was so that NWIS could contact Welsh residents who were identified as CEV as a result of direct care received in the NHS in England, to provide them with details of support they could obtain locally from Welsh local authorities where they were resident, including food parcels.

Redbridge CCG

17. Redbridge CCG was responsible for the 111 call handling systems for London. The purpose of sharing this information was to support an NHS England and Improvement pilot programme, so that patients on the SPL who called 111 and required referral to an emergency department would be flagged as being on the SPL - enabling clinicians to make appropriate care arrangements.

Mental health providers

18. Mental health providers were responsible for mental health services commissioned by CCGs. The purpose of sharing this information was to support an NHS England and Improvement policy, so that patients on the SPL in receipt of mental health services from the provider could be proactively contacted and have their care plans reviewed.

PHE

19. Data was disseminated to PHE for the purposes of COVID-19 vaccination programme surveillance. PHE had a role in monitoring the delivery, safety and effectiveness of immunisation programmes in England and required the SPL data to improve the data set in order to analyse the impact of COVID-19 vaccines for people previously identified as CEV.

NHS Trusts

20. The SPL was shared with NHS Trusts to identify relevant patients who needed advice on shielding and to validate that they should be on the SPL.

DHSC

21. Data was disseminated to DHSC's service provider, Paragon, for the purposes of supplying a vitamin D supplement to those who were CEV and who had registered for a free vitamin D supplement between December 2020 and February 2021 via the 'Get Vitamin D Supplements' service.

University of Oxford

22. SPL data was shared with the University of Oxford, for the development and validation of a risk prediction QCovid® risk calculator to estimate short term adverse outcomes from COVID-19. This was a risk stratification tool to support national shielding policy.

Appendix 5 - NHS Digital – Paragraph 17 of the Rule 9 Request

"Please provide a list of key meetings between NHS Digital and core political and administrative decision-makers in the UK Government relating to the response to Covid-19, and provide a summary of what was discussed at each meeting. Please provide an explanation as to whether NHS Digital made its own record of any such meetings it attended with core political and administrative decision-makers in the UK Government."

1. DLA Piper's letter to the Module 2 Inquiry Legal Team dated 3 February 2023 detailed NHS Digital's proposed approach in respect of paragraph 17 of the Rule 9 Request: "[NHS Digital] proposes to provide a summary of the types and categories of key meetings with core political and administrative decision-makers attended by NHS Digital officials. For instance, for recurring meetings the summary would address the frequency and date ranges of such meetings, the regular attendees and the broad topics addressed through those meetings. The summary would not, however, list out the dates of each individual meeting or provide an overview of the particular items discussed at each such meeting". This approach was agreed by the Module 2 Inquiry Legal Team on 9 February 2023.

2. For the reasons set out in more detail above, NHS Digital officials only attended a very small number of meetings which could be considered key in respect of core decision-making. Following a meeting with the Module 2 Inquiry Legal Team on 10 March 2023, it was agreed that, in addition to providing a list of key meetings, NHS England would also provide a list of all COVID-19 related meetings between the key NHS Digital individuals (as defined in paragraph 7 of this Appendix 5) and a subset of core political and administrative decision-makers in office between 1 January 2020 and 24 February 2022, regardless of whether such meetings were considered to be key in respect of core decision-making. A list of individuals, to constitute the subset of core political and administrative decision-makers, was provided by the Module 2 Inquiry Legal Team on 10 March 2023 and comprises the individuals whose names appears in bold text in the Schedule to Appendix 5.

Tier 1 and Tier 2 meeting indexes

3. In this appendix:

   3.1 the list of key meetings, in response to paragraph 17 of the Rule 9 Request, is referred to as the 'Tier 1 meeting index'; and

   3.2 the list of all COVID-19 related meetings with the subset of core political and administrative decision-makers (as identified by the Module 2 Inquiry Legal Team on 10 March 2023) is referred to as the 'Tier 2 meeting index'.

Creation of the Tier 1 and Tier 2 meeting indexes

4. Further details are set out below of the approach taken by NHS Digital in respect of:

   4.1 identifying the relevant individuals from NHS Digital who were most likely to have contact with core political and administrative decision-makers;

   4.2 confirming the names of core political and administrative decision-makers in office between 1 January 2020 and 24 February 2022 ("the Relevant Period");

   4.3 the searches carried out to identify meetings between these individuals and the work undertaken to determine whether such meetings would constitute key meetings in respect of core decision-making.

Introduction

5. It is not possible to speak to everyone who worked for NHS Digital during the Relevant Period who may have attended meetings with core political and administrative decision-makers in the UK Government in order to determine whether any of those meetings were key meetings and such an approach would be disproportionate in terms of both time and costs. As such, NHS Digital (in respect of work carried out before the merger) and NHS England have taken a reasonable and proportionate approach

to determine what key meetings took place by identifying those individuals within NHS Digital who were most likely to have contact with core political and administrative decision-makers. The approach taken (a high-level summary of which is detailed below) involved an electronic document review exercise, together with meetings with NHS Digital officials to determine which meetings identified as part of the document review may be considered key.

6. Whether a meeting was key or not was considered in the context of Module 2 and individuals considered whether they were substantively involved in meetings which concerned core decision-making in relation to the response to COVID-19, rather than the delivery or implementation of those decisions.

Identification of relevant individuals from NHS Digital

7. NHS Digital determined that the individuals who were most likely to have had contact with core political and administrative decision-makers during the Relevant Period were individuals who were either the key decision makers and/or had greatest oversight of NHS Digital's response to the COVID-19 pandemic (namely members of NHS Digital's Gold Command). The individuals identified are:

7.1 Sarah Wilkinson – Chief Executive Officer (14 August 2017 – 3 June 2021);

7.2 Simon Bolton – Interim Chief Executive Officer (4 June 2021 – 31 January 2023);

7.3 Jonathan Benger – Acting Interim Chief Medical Officer (19 November 2019 – 27 April 2021) and Chief Medical Officer (28 April 2021 – 31 December 2022);

7.4 **Name Redacted** – Interim Executive Director of Product Development (January 2020 - 20 January 2021) and Executive Director of Product Delivery (21 January 2021 – 30 November 2021);

7.5 **Name Redacted** – Executive Director of Data Services (1

November 2019 – 31 July 2021);

7.6 Name – Deputy Chief Executive Officer and Executive Director of IT Operations (4 May 2020 – 1 August 2021) ; and

7.7 Jackie Gray – Executive Director of Privacy, Transparency, Ethics and Legal (January 2019 - 31 January 2023).

8. In addition to the above, when preparing NHS Digital's first draft corporate statement in response to the Rule 9 Request, it became apparent that Name Redacted (Chief Technology Officer between 6 August 2019 and 21 January 2022) may have also attended meetings with Ministers and senior civil servants. As such, NHS Digital also included Name Redacted in its list of individuals for this response. We call these individuals the 'Key NHS Digital Individuals'.

Identification of the core political and administrative decision-makers in the UK Government during the Relevant Period

9. NHS Digital asked the DHSC and the Cabinet Office to provide a list of Ministers, Permanent Secretaries and Director Generals (and where possible to provide details of their roles and relevant email addresses) in post during the Relevant Period (this included those at Number 10). Details of the relevant names and contact details provided to NHS Digital are set out in the Schedule to Appendix 5[53]. For completeness, and due to their potential significance, Professor Chris Whitty and Sir Patrick Vallance were also added to this list of names. We call these individuals the Key Government Decision Makers.

10. On 10 March 2023, the Module 2 Inquiry Legal Team provided a list of individuals (all of whom were included within the existing list of Key Government Decision Makers) to be used for the purposes of creating the Tier 2 meeting index.

[52] Mr Rose sadly passed away on 1 August 2021
[53] Note NHS Digital were provided with lists of Permanent Secretaries, Director Generals, Ministers and the names of additional individuals who were considered relevant by DHSC and Cabinet Office

Collection of documents

11. NHS Digital collected the mailboxes (including the calendars) of the Key NHS Digital Individuals. Both Sarah Wilkinson and Simon Bolton had two NHS Digital mailboxes, one being a CEO specific mailbox.

12. Following the collection process, NHS Digital became aware that the content of some of the documents from Sarah Wilkinson's CEO mailbox were not fully recoverable. This was the result of an issue relating to the migration of archived emails from one system to another, which led to a proportion of archived emails not transferring to the new system. For the affected documents, basic information such as the sender and recipient, subject heading and sent dates/times remain available. As such, the affected documents have been able to form part of the exercise described below. NHS England has undertaken investigations to identify where copies of the affected documents can be found in other mailboxes of former NHS Digital individuals. The vast majority of those documents are available, either in full or in part, in such mailboxes.

13. The e-disclosure processing[54] of all mailboxes was carried out by DLA Piper and included the following:

    13.1 Extracting text and electronic metadata from the collected data sources;

    13.2 Application of global deduplication to remove any exact duplicates of files;

    13.3 Application of optical character recognition to make documents searchable that could not otherwise be searched (such as scanned PDFs); and

    13.4 Upon completion of the processing, uploading of the native files

[54] NHS Digital extracted data between the date range of 1 January 2020 to 30 June 2022 for all NHS Digital Individuals except Jonathan Benger (whose entire mailbox was extracted and then processed by DLA Piper). For all other NHS Digital Individuals DLA Piper applied the date parameters of 1 November 2019 to 30 June 2022 when processing the data. Note that a small number of documents were corrupt or otherwise inaccessible due to password protection and as such were not reviewable. Given the volumes, it was not considered proportionate to try to locate the passwords for these documents as they were unlikely to add anything substantial to this response

and text files were uploaded to an e-disclosure platform, RelativityOne, for keyword searching, filtering, culling and assessment.

Searches and methodology used to create the index of key meetings

Electronic Searches

14. The following search parameters were applied to the data collected:

    14.1 date range of 1 January 2020 to 30 June 2022;

    14.2 all meeting invites from the Key Government Decision Makers to the Key NHS Digital Individuals; and

    14.3 all meeting invites to Key Government Decisions Makers[55] from the Key NHS Digital Individuals;

    14.4 Meetings sent to Key Government Decision Makers were not treated as being sent to an individual if that individual was only copied (cc or bcc). Meetings from Key Government Decision Makers were included if the Key NHS Digital Individuals received them as either a to, cc or bcc; and

    14.5 any automatic replies, or declines of meetings, were excluded.

15. The searches noted at paragraph 14 of this appendix were used to create an initial index of meetings for each of the NHS Digital Key Individuals.

Tier 1 meeting index - Identification of key meetings with NHS Digital Key Individuals

16. The draft indexes produced as a result of the steps detailed in paragraph 14 of this appendix were considered with the NHS Digital Key Individuals[56] (either through calls with those individuals or by comments

[55] Note that both email addresses and names were used for the searches described at paragraphs 14.2 and 14.3 and 4.3. However, during the process we identified some additional email aliases for the Secretary of State, Lord Bethell and Matthew Gould which were incorporated into the searches (further details in relation to this is noted in the statement below)

[56] With the exception of Pete Rose, who is sadly now deceased. NHS England personnel reviewed the lists

via email). This exercise needs to be considered in the context of the time that has elapsed between now and the Relevant Period and that the individuals' consideration of the indexes were based only on the recollection of those individuals at the time. Therefore, as noted above, final indexes should not be considered to be exhaustive. However, it is considered that reasonable and proportionate steps have been taken to provide as complete a response as reasonably possible.

17. These discussions with the NHS Digital Key Individuals were focused on identifying the following from the draft indexes provided:

    17.1 The name, type or category of meetings which were considered key[57] ;

    17.2 The frequency and broad date ranges of those meetings;

    17.3 Details of regular attendees;

    17.4 The broad topics addressed; and

    17.5 Whether the individuals thought that NHS Digital may have made its own record or minutes of the meetings.

18. The information obtained from these discussions was used to produce an updated index of key meetings which covered the Relevant Period[58]. I exhibit the Tier 1 meeting index at **SB/87 INQ000202009.**

19. Where key meetings have been identified, NHS England has not identified or reviewed agendas, meeting papers and minutes that may have been provided in relation to the meetings and/or types of meetings identified.

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generated with respect to Pete Rose to identify: i) whether any meetings were not related to COVID-19 and ii) whether any of the meetings may have been key. These lists were also considered by DLA Piper alongside the information obtained from other individuals during this process which was then applied to the list generated for Pete Rose, and meetings that NHS Digital had determined to not be key through discussions from others were removed. This process resulted in no key meetings being identified for Pete Rose

[57] As noted above, this was considered in the context of Module 2 - individuals considered whether they were substantively involved in meetings which concerned core decision-making in relation to the response to COVID-19, rather than the delivery or implementation of those decisions.

[58] As such, this is not an exhaustive index of meetings that took place with core political and administrative decision-makers

Creation of the Tier 2 meeting index

20. The Tier 2 meeting index was created by running searches against the mailboxes of the Key NHS Digital Individuals, using the same criteria as used for the searches used to create the Tier 1 meeting index, save that only meeting invites to and from the subset of Key Government Decision Makers (as identified by the Module 2 Inquiry Legal Team on 10 March 2023) were considered.

21. DLA Piper reviewed the initial index of meetings identified by the above search and carried out the following manual tasks:

    21.1 Removed duplicate entries in respect of the same meeting. Although duplicates are removed by RelativityOne, it can only remove exact duplicates (at a metadata level). Therefore, some documents that appeared to be identical remained in the list and had to be manually removed. Examples of the types of duplicates manually removed are: invitations or invite forward notifications relating to the same meeting (for instance, where more than one Key NHS Digital Individual had been invited), meeting acceptances and meeting cancellations.

    21.2 Grouped together recurring meetings so that only one entry is provided, together with details of:

        (a) The frequency (where it was possible to determine) of the meeting;

        (b) The attendees (taken from the scheduling information available from the data); and

        (c) The broad date range in which these meetings took place.

    21.3 Removed any meetings that had been identified as not relating to COVID-19 during the process carried out to produce the Tier 1 meeting index.

22. NHS England has not identified or reviewed agendas, meeting papers

and minutes that may have been provided in relation to the meetings and/or types of meetings identified.

23. The meetings identified as a result of the process outlined above are listed in the Tier 2 meeting index which I exhibit at **SB/88 INQ000202010**.

Records of meetings and limitations on exercise to identify meetings

24. The Inquiry has requested that NHS Digital confirm if it made its own record of meetings with core political and administrative decision makers. Due to the time period covered by this request, and the number of individuals involved, it has been necessary to identify meetings using the search processes detailed above. Those searches did not identify whether or not the NHS Digital individuals involved made or retained NHS Digital records or minutes of the meetings attended. Generally speaking, as the meetings were convened by organisations other than NHS Digital, enquiries made so far have shown that the primary records and minutes of those meetings would be held by organisations other than NHS Digital. However, if there are any particular meetings the Inquiry is interested in, NHS England would be happy to undertake further targeted searches to identify any records or minutes that may have been created by NHS Digital individuals who attended those meetings.

25. The following additional points should be noted about the electronic document review process adopted to initially identify meetings for the purposes of the Tier 1 meeting index and the Tier 2 meeting index:

    25.1 Many of the meetings identified as part of the electronic document review exercise were meetings organised by other bodies. Full details of those meetings and other attendees may not be held by NHS Digital. In particular, most of the diary meeting records held by NHS Digital simply show who was invited to the meeting. NHS Digital does not have a record of who actually attended each meeting. As such, any meeting identified in either the Tier 1 or Tier 2 meeting indexes should be considered in the light of this (for example, the Tier 1 and Tier 2 meeting indexes may not reflect a complete list of actual or regular attendees, including the NHS

Digital attendees).

25.2 Meetings may have been removed from diaries (in the normal course of work, for example when recurring meetings were cancelled) and as such, these would not have been identified in the above process.

25.3 Meetings and emails may have been deleted prior to a legal hold being put in place (and in the normal course of work). As such, these would not have been identified.

Schedule: List of Permanent Secretaries and Director Generals provided by DHSC and the Cabinet Office – which are referred to in this witness statement as Key Government Decision Makers.

Number	Name	Email Addresses
Permanent Secretaries and Director Generals		
1.	Shona Dunn	Shona.Dunn@dhsc.gov.uk
2.	David Williams	david.williams@dhsc.gov.uk
3.	Chris Wormald	chris.wormald@dhsc.gov.uk
4.	Lee McDonough	Lee.McDonough@dhsc.gov.uk
5.	Matthew Style	matthew.style@dhsc.gov.uk
6.	Jonathan Marron	Jonathan.Marron@dhsc.gov.uk
7.	Ros Roughton	Rosamond.Roughton@dhsc.gov.uk
8.	Michelle Dyson	michelle.dyson@dhsc.gov.uk
9.	Steve Oldfield	steve.oldfield@dhsc.gov.uk
10.	Clara Swinson	clara.swinson@dhsc.gov.uk
11.	Paul Kissack	paul.kissack@dhsc.gov.uk
12.	Madelaine McTernan	Madelaine.McTernan@beis.gov.uk
13.	Nick Elliott	Nick.elliot@beis.gov.uk
14.	Andy Brittain	Andy.Brittain@dhsc.gov.uk
15.	Matthew Gould	Matthew.Gould@dhsc.gov.uk
16.	James Bowler	james.bowler@cabinetoffice.gov.uk
17.	Simon Case	cabinet.secretary@cabinetoffice.gov.uk
18.	Lord Mark Sedwill	Mark.sedwill@cabinetoffice.gov.uk
19.	Simon Ridley	simon.ridley@cabinetoffice.gov.uk
20.	Mark Sweeney	mark.sweeney@cabinetoffice.gov.uk
21.	Jessica Glover	jessica.glover@cabinetoffice.gov.uk

22.	Kathy Hall[59]	kathy.hall@cabinetoffice.gov.uk
23.	Rob Harrison	rob.harrison@cabinetoffice.gov.uk
24.	Kate Josephs	kate.josephs@cabinetoffice.gov.uk
Ministers		
25.	Matt Hancock	psmatthancock@dhsc.gov.uk; PSMattHancock.Archive@dhsc.gov.uk matt.hancock@digital.dhsc.gov.uk
26.	Sajid Javid	PSSajidJavid@dhsc.gov.uk
27.	Edward Argar	Psmsh@dhsc.gov.uk; Desert.Sonoran@dhsc.gov.uk
28.	Jo Churchill	Psmsh@dhsc.gov.uk psjochurchill@dhsc.gov.uk Desert.Mojave@dhsc.gov.uk PSPHPCDiary@dhsc.gov.uk PSP@dhsc.gov.uk
29.	Nadine Dorries	Psmsh@dhsc.gov.uk psjochurchill@dhsc.gov.uk Desert.Mojave@dhsc.gov.uk PSPHPCDiary@dhsc.gov.uk PSP@dhsc.gov.uk
30.	Lord Bethell	PSBethell@dhsc.gov.uk
31.	Nadim Zahawi	minister.zahawicorrespondence@dhsc.gov.uk
32.	Helen Whately	flower.thistle@dhsc.gov.uk pshelenwhately@dhsc.gov.uk msc@dhsc.gov.uk

[59] It is understood that Kathy Hall held the role of Director General of the Covid Task Force from 15 October 2020 to March 2022. Accordingly, searches for calendar and invites and correspondence involving Ms Hall have been conducted using a start date of 15 October 2020

		MSC.Diary@dhsc.gov.uk
33.	Gillian Keegan	Psgilliankeegan@dhsc.gov.uk
34.	Maggie Throup	Psmaggiethroup@dhsc.gov.uk
35.	Maria Caulfield	Psmariacaulfield@dhsc.gov.uk
36.	Nicola Blackwood	River.Trent@dhsc.gov.uk
37.	Caroline Dinenage	No email address provided.
38.	Boris Johnson	contact@borisjohnsonoffice.com
39.	Stephen Barclay	stephen.barclay.mp@parliament.uk psstevebarclay@cabinetoffice.gov.uk
40.	Michael Gove	psmichaelgove@cabinetoffice.gov.uk michael.gove.mp@parliament.uk
41.	Dominic Raab	dominic.raab.mp@parliament.uk ps.lordchancellor@justice.gov.uk
42.	Michael Ellis	psmichaelellis@cabinetoffice.gov.uk michael.ellis.mp@parliament.uk
43.	Penny Mordaunt	pspennymordaunt@cabinetoffice.gov.uk; penny.mordaunt.mp@parliament.uk
Other senior individuals		
44.	Ben Warner	No email address provided.
45.	Clare Brunton	No email address provided.
46.	**Name Redacted**	No email address provided.
47.	**NR**	No email address provided.
48.	**Name Redacted**	No email address provided.
49.	**Name Redacted**	No email address provided.
50.	**Name Redacted**	No email address provided.
51.	William Warr	No email address provided.

52.	Professor Chris Whitty	No email address provided.
53.	Sir Patrick Vallance	No email address provided.

Appendix 6 - NHS Digital – Paragraph 18 of the Rule 9 Request

"Please provide a list of written correspondence between NHS Digital and ministers or senior civil servants in the UK Government relating to the response to Covid-19"

1. DLA Piper's letter to the Module 2 Inquiry Legal Team dated 7 December 2022 confirmed the approach agreed with the Inquiry in respect of paragraph 18 of the Rule 9 Request. "NHS Digital will identify the individuals most likely to have had contact with ministers and senior civil servants (meaning Permanent Secretaries and Director Generals) and conduct searches to identify substantive correspondence. NHS Digital will also undertake additional enquiries to identify any additional key correspondence which may not be caught by the searches to be undertaken."

2. Further details are set out below of the approach taken by NHS Digital in respect of the searches carried out to identify substantive correspondence. Details of the approach taken by NHS Digital in respect of i) identifying the Key NHS Digital Individuals, ii) confirming the names of the Key Government Decision Makers in the Relevant Period and iii) the collection of documents, can be found in Appendix 5.

Introduction

3. NHS Digital (in respect of work which was carried out before the merger) and NHS England have taken a reasonable and proportionate approach to identify written correspondence between Key NHS Digital Individuals and Key Government Decision Makers relating to the response to COVID-19 during the Relevant Period. A high-level summary of the approach taken has been detailed below.

Searches carried out to identify substantive correspondence

4. The following search parameters were applied to the data collected which had been sent to or from the Key NHS Digital Individuals:

    4.1 date range of 1 January 2020 to 30 June 2022;

4.2 all emails to Key Government Decision Makers from Key NHS Digital Individuals; and

4.3 all emails from Key Government Decision Makers to Key NHS Digital Individuals;

Please note that both email addresses and names were used for this search[60] . Emails were not treated as being sent to an individual if that individual was only copied (cc or bcc) to the communication in question.

Review

5. A team of paralegals reviewed the resulting communications to identify and remove correspondence which did not relate to COVID-19[61]. The Key NHS Digital Individuals[62] were sent draft indexes of their correspondence with Key Government Decision Makers and were given the opportunity to remove any non-COVID entries or to identify any obvious gaps or missing items.

Results

6. The correspondence identified as a result of the process outlined above is detailed in the Index of Correspondence **SB/89 INQ000202011**. This index also provides details of names of the individuals receiving the correspondence and the relevant email subject heading. It does not include legally privileged correspondence.

[60] As noted above, during the process we identified some additional email aliases for the Secretary of State, Lord Bethell and Matthew Gould which were incorporated into the searches.

[61] In respect of the documents referenced in paragraph 12 of Appendix 5, this exercise was conducted by reference to the subject titles of documents and by reviewing the contents of the versions of those documents contained in other mailboxes.

[62] With the exception of NR, who is sadly now deceased.

Appendix 7: Extracts from pages 122-123 of the Goldacre Review

"National TREs [Trusted Research Environments] are a substantial piece of work with an extremely high return on investment. This work is currently in the planning stage within NHS Digital. This must be a high status and well-resourced project delivering a core piece of NHS infrastructure, not a small side project. Delivering a national TRE for the GP Data for Planning and Research data collection will do all the groundwork necessary to create a strong, performant, general purpose TRE, as the GP data poses a larger computational and data management challenge than any of the other smaller national datasets."

TRE 7. Include GP data and certain commonly used national datasets from the start

The first iteration of a national TRE should contain the key, commonly used national datasets including GP data, HES/SUS, and prescribing data. GP data is by far the most challenging dataset to support; the others represent a marginal increase in work. This data alone will represent unprecedented depth and breadth of NHS data, supporting a broad array of innovative outputs. NHS service analysts have not previously been able to work systematically with GP data. This alone represents a phenomenal opportunity. Early outputs are likely to include: work evaluating variation in service activity and clinical outcomes between different organisations and regions; monitoring the resumption of clinical activity following the COVID-19 pandemic; identifying opportunities to improve the quality, safety and efficiency of prescribing; understanding and predicting demand based on detailed data about local patients; and so on. When linked to HES and ONS death certificate data at national scale this resource becomes even more productive, as analysts can create a clear picture of the full patient journey through services. Combined with RAP working methods, to ensure work is systematic and reproducible, this will be a new dawn for NHS data science."