Witness Name: Ed Humpherson
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UK COVID-19 INQUIRY

WITNESS STATEMENT OF ED HUMPHERSON

I, Ed Humpherson, Director General for Regulation, will say as follows:

The Office for Statistics Regulation role, function, and responsibilities

1. I am the Director General for Regulation at the Office for Statistics Regulation. The Office for Statistics Regulation (OSR) is the independent regulatory arm of the UK Statistics Authority (known as 'the Authority'). We provide independent regulation of all official statistics produced in the UK, including those in devolved administrations. Official statistics are an essential public asset produced by governments and public bodies, and these bodies will be named in the Statistics and Registration Service Act 2007 or secondary legislation such as the Official Statistics Order.
2. Our vision is that statistics should serve the public good. For the public to have confidence in government statistics, it is not enough that statistics are produced well – they must also be communicated appropriately. If statistics are used poorly in communications, including in public health communications, there is a risk that the public becomes mistrustful and frustrated.
3. OSR's core aim is to uphold the principles of the Code of Practice for Statistics (Exhibit EH/01-INQ000092790) which are trustworthiness, quality and value. We work to promote, monitor and safeguard the production and publication of official statistics. We do this in accordance with the statutory requirements of the Statistics and Registration Service Act 2007. Our main regulatory tools are assessments and compliance checks of sets of statistics against the Code, systemic reviews on cross-cutting statistical issues, and casework. Casework is where we identify and investigate issues relating to the production and/or use of official statistics.

The Code of Practice

4. The Code sets the standards that producers of official statistics should follow. It provides a framework to ensure that statistics are trustworthy, good quality, and are valuable. The Code is based on a number of key principles - for example, those producing statistics must demonstrate their integrity and professionalism; and statistics must be equally available to all and not be released partially or to selected audiences.
5. OSR sets this statutory Code, assesses compliance with the Code, and awards the National Statistics designation to official statistics that comply with the highest standards of the Code. Experimental statistics are a subset of official statistics going through development and evaluation which may have a wider degree of uncertainty. The status of experimental statistics is useful as it allows producers of statistics to involve users in the assessment of suitability and quality at an early stage.
6. In March 2020, OSR published guidance to statistics producers regarding changes to statistical outputs during the pandemic (Exhibit EH/02-INQ000092791). This outlined OSR's proposal to introduce and carry out rapid reviews or 'mini assessments' to confirm National Statistics designation for rapidly produced supplementary or complementary statistics (where the parent statistical series was already designated as National Statistics), and a similar process to provide endorsement (rather than designation) of any completely new statistics.
7. In chronological order, from January 2020 to March 2022, OSR carried out rapid reviews on:
    a. ONS Opinions and Lifestyle Survey COVID-19 questions (Exhibit EH/03-INQ000092792)
    b. Coronavirus, the UK economy and society, faster indicators (Exhibit EH/04-INQ000092793)
    c. COVID-19 surveillance and registered deaths data (Exhibit EH/05-INQ000092794)
    d. Coronavirus (COVID-19) attendance in education and early years settings (Exhibit EH/06-INQ000092795)
    e. Coronavirus (COVID-19) infection survey (Exhibit EH/07-INQ000092796)
    f. DfT Transport Statistics during the COVID-19 pandemic (Exhibit EH/08-INQ000092797)
    g. Interim indicators from the People and Nature Survey (Exhibit EH/09-INQ000092798)
    h. Monthly Indicators from the National Survey for Wales (Exhibit EH/10-INQ000092799)

i. NHS England's statistics on daily Covid-19 deaths in hospitals (Exhibit EH/11-INQ000092800)
j. NHS Test and Trace statistics (England) (Exhibit EH/12-INQ000092801)
k. Coronavirus Job Retention Scheme and Self-Employment Income Support Scheme statistics (Exhibit EH/13-INQ000092802)
l. Telephone-operated crime survey for England and Wales (Exhibit EH/14-INQ000092803)
m. COVID-19 Infection Survey Statistics (Exhibit EH/15-INQ000092804)
n. Statistics from the Scottish Victimisation Telephone Survey (Exhibit EH/16-INQ000092805)
o. Statistics on COVID-19 vaccinations published by NHS England (Exhibit EH/17-INQ000092806)
p. NHS Test and Trace (England) and NHS COVID-19 app statistics (Exhibit EH/18-INQ000092807)
q. Monthly Adult Social Care statistics for England (Exhibit EH/19-INQ000092808)
r. Weekly COVID-19 and Winter Statistical Report (Exhibit EH/20-INQ000092809)

Intelligent Transparency

8. Intelligent transparency is a concept which is fundamental in supporting public trust in statistics. It is about supporting an open and accessible approach to communicating numbers, and is achieved by following three core principles:
    a. equality of access (data and statistics quoted publicly are made available to all).
    b. enhancing understanding (data and statistics enhance understanding of societal and economic issues).
    c. analytical leadership (decisions about the publication of statistics and data are independent of political and policy processes).
9. Intelligent transparency cuts across all our regulatory work, including our casework. Intelligent transparency was highlighted as a key theme in several reports we wrote during the pandemic, such as our State of the Statistical System 2021/22 report (Exhibit EH/21-INQ000092811), two reports on lessons learned for health and social care statistics from the COVID-19 pandemic (Exhibit EH/22-INQ000092810/Exhibit EH/23-INQ000092812), and our Annual Casework Report 2021/22 (Exhibit EH/24-INQ000092813). Intelligent transparency was often an issue in our casework relating to COVID-19 and I advocated for the transparent use of figures supporting

government decisions about the pandemic in several oral and written evidence submissions to Parliaments across the UK, as referred to in paragraph 11.

10. Our expectations for transparency apply regardless of how data are categorised. For many who see numbers used by governments, the distinction between official statistics and other data, such as management information or research, may seem artificial. We therefore adopt the principle that any data which are quoted publicly, or which are of significant public interest, should be released and communicated in line with the intelligent transparency principles.

Parliamentary engagement

11. I engaged through both oral and written evidence for Select Committee inquiries relating to data and statistics concerning Covid-19 in the UK Parliament, Scottish Parliament, and Welsh Parliament from January 2020 to end of May 2022.
    a. Public Administration and Constitutional Affairs Committee (PACAC)
        i. PACAC wrote on 14 April 2020 asking for clarity on Covid-19 cases and mortality (Exhibit EH/25-INQ000226515) and I responded on 22 April (Exhibit EH/26-INQ000226516). Ian Diamond and I gave evidence to the Committee on 13 May 2020 (Exhibit EH/27-INQ000226517), and I followed up in writing on 18 May 2020 (Exhibit EH/28-INQ000226518).
        ii. I provided oral evidence on 22 September 2020 for the inquiry *data transparency and accountability: Covid-19* alongside Ian Diamond (Exhibit EH/29-INQ000226519). The Authority provided written evidence on 9 February 2021 (Exhibit EH/30-INQ000226520).
        iii. For their inquiry on *Covid-19 Vaccine Certification* I submitted written evidence on 28 April 2021 (Exhibit EH/31-INQ000226521).
        iv. PACAC wrote directly on 12 January 2021 regarding vaccination data (Exhibit EH/32-INQ000226522) to which I responded on 20 January 2021 (Exhibit EH/33-INQ000226523).
        v. On 21 January 2022 I provided written evidence to the inquiry *coronavirus act 2020: two years on* (Exhibit EH/34-INQ000226524).
    b. Digital, Culture, Media and Sport sub-committee on online harms and disinformation
        i. I provided written evidence for their inquiry of the same name on 24 April 2020 (Exhibit EH/35-INQ000226525).
    c. Treasury Committee

i. I provided written evidence to their inquiry on *jobs, growth, and productivity after coronavirus* on 17 May 2021 (Exhibit EH/36-INQ000226526).

d. Welsh Parliament's Health, Social Care and Sport Committee
   i. I provided written evidence on the *impact of the Covid-19 outbreak, and its management, on health and social care in Wales*, on 9 December 2020 (Exhibit EH/37-INQ000226527).

e. Science and Technology Committee
   i. I provided oral evidence for the inquiry *UK science, research and technology capability and influence in global disease outbreaks* on 2 March 2022 (Exhibit EH/38- INQ000226528) and followed up in writing on 8 April 2022 (Exhibit EH/39-INQ000226529).

f. Scottish Parliament's COVID-19 Recovery Committee
   i. On 26 May 2022 I gave evidence to the Committee for their inquiry on *communication of public health information* (Exhibit EH/40-INQ000226530).

Regulating data and statistics during the pandemic

Engagement with Governments across the UK

12. To fulfil our statutory role, we engage with producers of government statistics on a regular basis. During the Covid19 pandemic, the main purpose of our engagement with producers was to understand the impact of the pandemic on statistical production and to inform our response to casework.
13. In our discussions with producers of government statistics, we saw a commitment to continuously improve the statistical information provided to the public. Following our discussions, improvements were made to provide greater clarity on several issues, including:
    a. clarification of what the daily figures published by the Department of Health and Social Care (DHSC) did and did not include (those who have died in hospitals and who have tested positive for COVID-19)
    b. improvements to the supporting information available on the Public Health England (PHE) dashboard (now the UK Health Security Agency (UKHSA) dashboard), including clearer explanations of sources and coverage
    c. better explanations in the Office for National Statistics (ONS) weekly deaths statistics about how COVID-19 related deaths impacted the figures
    d. clarification of how ONS and DHSC deaths figures related to each other

e. cessation of the publication of a "patients recovered" figure by PHE because of data quality limitations
f. improvements to published statistics on the NHS Test and Trace service in England, such as the addition of new information on rapid asymptomatic testing and overseas arrivals, and better explanations of data limitations.

14. We liaised with producers of government health statistics on a frequent and informal basis. We engaged regularly with PHE (now part of UKHSA), DHSC, NHS England, the Scottish Government, Public Health Scotland (PHS), the Northern Ireland Statistics and Research Agency (NISRA), the Department of Health in Northern Ireland and the Welsh Government. Our regulators held weekly meetings with Heads of Profession for Statistics, Chief Analysts and lead statisticians within departments and organisations responsible for producing health statistics. We had regular meetings with the four nations groups established during the pandemic (for example on death statistics), and frequently engaged with the Cabinet Office on casework issues (for example with the Deputy Director of the COVID-19 Press Data Team regarding improvements to data used in daily press conferences). Finally, as and when required, I carried out engagement at a senior level, for example with Directors of Analysis, Permanent Secretaries and the National Statistician. The topics covered by our engagement were wide-ranging, from statistics on infections, hospitalisations and deaths, to data informing decisions about public health measures, such as local lockdowns, self-isolation and international travel restrictions.

Lessons learned reports

15. As mentioned at paragraph 9, in October 2021 we published a report on the lessons learned for health and social care statistics during the pandemic. We published a follow-up report on this topic in November 2022.
16. Our reports emphasised that there was huge public appetite for data and statistics, both to support individuals to reach informed decisions and to hold their governments to account. The reports also noted that we had seen a remarkable response from producers of government statistics to meet the increased demand for data and statistics. Producers worked quickly and collaboratively, in many cases overcoming challenges which would previously have seemed insurmountable. They demonstrated a clear commitment to transparency through their efforts to inform and engage the public. As a result, there was unprecedented public engagement with health and social care data, for example through dashboards and other tools.

Interventions

17. However, during the first year of the pandemic we often had to intervene, both publicly and privately, when data about COVID-19 did not meet expectations around accessibility or transparency. Whilst we continued to intervene on transparency issues between October 2021 and October 2022, our most recent lessons learned report highlights that we found that producers were quick to respond.
18. We investigated a total of 347 cases between April 2020 and March 2022 that related to health data or deaths during the pandemic. We intervened when figures quoted by ministers or government officials were not publicly accessible or when poor use and presentation of data risked undermining public trust. We found that a lack of transparency often resulted in confusion about where numbers came from or accusations that governments cherry pick or manipulate data. There is now a better understanding of the need for intelligent transparency in governments across the UK.
19. The remainder of my statement summarises five key issues that we identified through our regulatory work, drawing on casework examples that relate most directly to the inquiry's request. These issues are:
    a. Supporting the public to understand technical information and data sources in an accessible way
    b. Issues with use and presentation of data or statistics by governments
    c. The use of unpublished data or statistics by governments
    d. Transparency of data or statistics used to support government press conferences
    e. Comparability of health data and statistics across the UK

Supporting the public to understand technical information and data sources in an accessible way

20. One of the most significant challenges facing the producers of government statistics was communicating sometimes quite technical information in an accessible, understandable way.
21. In our report '*Lessons learned for health and social care statistics from the COVID-19 pandemic: 2022 update'* we found that, because of the increased public appetite for data and statistics about COVID-19, producers had a greater appreciation for the need to communicate with, and meet the needs of, a range of different users. During the pandemic, this included members of the public who were accessing statistics for general interest, to make decisions about their lives or to enhance their understanding of an issue of high public interest. This was often a big change for

producers, many of whom were used to communicating with more specialist audiences (usually other parts of government or experts, such as academics). Following the principles of intelligent transparency (specifically equality of access and enhancing understanding) helped producers to support public understanding of technical information.

22. For example, in April 2020 I wrote to the Permanent Secretary for the Department of Health in Northern Ireland (Exhibit EH/41-INQ000092814). Responsibility for daily reporting of surveillance data in Northern Ireland had changed from the Public Health Authority to Department of Health in April with the release of a COVID-19 Statistics dashboard. This dashboard was suspended two days later on the grounds that a figure in it was incorrect, with limited explanation of the nature of the error. In place of the dashboard, less complete daily statistics were released by the Department of Health through daily news releases on the departmental website and through Twitter announcements. I reiterated the importance of the COVID-19 figures given the huge public interest. I also reiterated the general principles that statistics producers should be guided by. This included that:
    a. Daily surveillance statistics should have been released in a transparent, easily accessible, and orderly way. A news release on the departmental website and Twitter were not sufficient.
    b. There were gaps in the data, and daily time series were lost since the statistics were issued through the Department of Health news releases. These gaps and losses needed to be addressed.
    c. Data and statistics should have been accompanied with clear information on data sources, definitions, and explanations. Users should have been provided with appropriate context and explanation, particularly where different statistics from different data sources were produced and used in relation to COVID-19.
    d. Communication to users of the statistics should have been improved so people knew in advance about any changes, and where and when they could find the changed statistics.
23. In May 2020, the ONS published the first statistics on COVID-19 infections in the community in England from the Covid Infection Survey (CIS). This was a positive example of how producers of government statistics worked to understand their users and communicate technical information in an accessible way. During 2020, the CIS expanded to become a UK-wide survey and provided a regular, timely insight into the prevalence of COVID-19 in the general population. To better understand who was using the statistics and how to meet their needs, the ONS established a strategic development hub responsible for user engagement on the CIS. This team developed

an engagement strategy, which aimed to identify and understand the needs of current and potential CIS users through a broad range of engagement activities. These activities included the establishment of a user group, regular technical seminars with government stakeholders, the use of web analytics, and ensuring that each interaction with users provided value, for example by offering one-to-one conversations with individuals who contacted the ONS about the CIS.

24. As a result of its engagement activities, the ONS identified that the users of the CIS were extremely varied, including members of the public, government officials, academics, and journalists. This meant that a range of products were required, each targeted to different audiences. For example, for general users and the media, the weekly CIS bulletin and the ONS's COVID-19 Insights tool provided a high level overview of the latest results. For more expert users, the ONS published a range of technical outputs, including a methods report, quality information and technical articles about bespoke analyses. The ONS made the underlying data available to support users to carry out their own analysis. The ONS also made use of blogs to communicate important technical detail in an accessible way and to clarify issues if there was confusion about the statistics among the public. And finally, the ONS used both its organisational and personal staff Twitter accounts to share information with users of the CIS, as well as discussing the survey on the ONS podcast, Statistically Speaking.
25. In June 2020, we published a blog to explain the R, or reproduction, number (Exhibit EH/42-INQ000092815). It was clear that there was an increasing public interest in the reproduction number and that more could be done to explain what estimates of the R number meant. We commended the cooperation taking place between the four nations which led to a consistent approach to calculating, publishing, and presenting uncertainty around the R number. However, we advised that governments could improve the public communication of the R number by adopting clearer language and terminology, providing clear accessible supporting material, and being clear about assumptions made in the calculation.
26. It was clear that dashboards were a hugely popular way of communicating statistics to the public during the pandemic, with extraordinary levels of engagement across the UK. These dashboards provided daily updates to the public on key statistics, including COVID-19 deaths. Understanding information on COVID-19 deaths was a challenge in the early stages of the pandemic because multiple figures were published by different organisations. Each figure used different sources, definitions, and methodologies. The purpose of each figure and what it sought to measure was not always clear. To improve public understanding, in August 2020 we published a

blog providing information on the available daily and weekly COVID-19 deaths statistics (Exhibit EH/43-INQ000092816). We then published another blog in January 2021 explaining what the different deaths statistics that were quoted in the media meant and which statistics were most helpful in understanding whether COVID-19 was a cause of death (Exhibit EH/44-INQ000092817).

27. In May 2021, I wrote to DHSC, NHS England, PHE and the ONS about vaccination statistics (Exhibit EH/45-INQ000092818). Further work was needed to support the public's understanding of the vaccine rollout – for example, by improving the clarity and accessibility of the presentation and commentary. I commented on the need to ensure that producers across organisations worked together to fill gaps in the available data on vaccinations. To ensure greater public access to the information, the UK government's COVID-19 dashboard was updated to include the number of vaccinations administered and the proportion of the population who had been vaccinated. This enabled users to drill down to find information about their local area.
28. In November 2021, I wrote to the UKHSA regarding its COVID-19 vaccine surveillance statistics which presented infection rates by vaccination status (Exhibit EH/46-INQ000092819). While UKHSA published the statistics with good intentions of supporting transparency, the data were being misused to argue that vaccines were ineffective. We also found that people had to work quite hard to find official figures and that understanding the data was not easy for everyone due to the technical nature of the reports in which they were published. We published a blog to support interpretation of the UKHSA statistics, highlighting what the data were and were not measuring (Exhibit EH/47-INQ000092820). We discussed the implications of the choices that producers make when analysing data. I welcomed changes to the presentation of UKHSA's analysis, which made important caveats clearer, and an accompanying blog published by UKHSA to guide appropriate interpretation of the statistics. In April 2022, following the implementation of the UK Government's Living with COVID-19 plan, which ended free universal testing in England, we supported the UKHSA's decision to remove infection rates by vaccination status from its reports. This decision was taken due to increased uncertainties in the data resulting from the testing policy change.

Issues with use and presentation of data or statistics by government

29. To support appropriate interpretation of data and analysis, we expect producers of government data to include information about:

a. How the data have been produced and collected (e.g., are the data sourced from administrative or survey data).
b. The definitions used within the data and any impact on how the statistics can be interpreted (e.g., are financial data in real or cash terms).
c. Any notable strengths and limitations of the data.

30. We also expect care to be taken to avoid selective use of statistics, or use of statistics without appropriate context, as this can lead to misuse which damages public trust. We expect that when data or statistics are communicated, the information that underpins that statement is publicly accessible, meeting our equality of access principle.
31. During the pandemic we intervened where the use or presentation of data did not meet these expectations.
32. In April 2020, the UK Government claimed to have met its target of delivering 100,000 coronavirus tests a day. The Government also announced that it would deliver 200,000 tests a day by the end of May 2020. There was widespread media coverage of the Government's progress and concerns were raised with us directly about these figures. The Authority's Chair, Sir David Norgrove, wrote to the Secretary of State for Health and Social Care to highlight the importance of clearly setting out the target and its context (Exhibit EH/48-INQ000092821). The Authority asked the Secretary of State to make it clear whether the target was intended to reflect testing capacity, tests that were administered, test results received, or the number of people tested. The letter acknowledged that data around COVID-19 were complex but urged the government to update the COVID-19 national testing strategy to show more clearly how targets were being defined, measured, and reported. The Secretary of State for Health and Social Care responded and explained how the target capacity to perform 200,000 tests a day by the end of May would be measured and reported. However, we considered that the figures were still far from complete and comprehensible. The Authority highlighted the following further concerns with the data in a second letter to the Secretary of State (Exhibit EH/49-INQ000092822):
    a. The headline figure for total tests combined tests carried out with tests posted out. This distinction was often omitted during the UK Government's daily press conference where the figure may have misleadingly been described as the number of tests carried out.
    b. It was not clear from the data how often multiple tests for a single patient occurred.
    c. The presentation gave an artificially low impression of the proportion of tests returning a positive diagnosis.

d. Generally, the testing figures were presented in a way that was difficult to understand.

33. The Secretary of State acknowledged these concerns in a further response and proposed a weekly release of data. He committed DHSC to working with other organisations and departments to present the best estimates of prevalence on an ongoing, coordinated basis.

34. In June 2020, concerns were raised with me regarding a claim by the Prime Minister that 90% of COVID-19 tests were turned around within 48 hours and that tests conducted at testing centres and mobile testing centres were all done within 24 hours. Data published on 2 July supported the first claim. The second claim was based on internal management information. We reiterated our expectations with DHSC that when management information is used publicly and prominently to inform Parliament, the media, and the public, it should be published in an accessible form, with appropriate explanations of context and sources (Exhibit EH/50-INQ000092823). Following this, a decision was made to publish data based on a strict definition of 24 hours and 48 hours, rather than publishing the management information that was used to make the second claim. This meant that the second claim was still not directly verifiable with reference to publicly available sources.

35. In September 2020, concerns were raised with me about a claim made by the First Minister of Scotland that around 40% of care homes in Scotland allowed and enabled indoor visiting. An FOI published on 5 November set out the source of this statement and made clear that the 40% figure was a loose approximation based on incomplete data. We advised the Scottish Government's Head of COVID-19 Analysis that the uncertainty in this data should have been more clearly reflected in the FOI response and the associated published material. We also stated that it should not have been necessary to wait for the information to be published as part of an FOI. It would have been more appropriate to share the data publicly through an ad-hoc release shortly after the statement was made. In a public letter, I noted that the Scottish Government had asked health boards for more information about care home safety (Exhibit EH/51-INQ000092824). I welcomed the commitment to make this data available as soon as possible with appropriate context and explanation to enable users to understand what the figures mean.

36. In November 2021, I dealt with concerns that failed or incomplete cases were not being taken into account in Public Health Scotland's (PHS) Test and Protect statistics. The statistics were being used to measure timeliness in contact tracing against the World Health Organisation's (WHO) target. The target stated that at least 80% of new cases should have their close contacts traced and in quarantine within

72 hours of case confirmation. I advised PHS that it was extremely important that the statistics set out in the COVID-19 Statistical Report were clearly presented as these were being used by Scottish ministers to assess how effectively the Scottish Government was managing the pandemic (Exhibit EH/52-INQ000092825). I did note that PHS had already been working on an update to the report and that, in the updated report, treatment of incomplete cases was clearer. However, PHS could have been clearer on the impact of its choices on the comparability with the WHO target – for example, on the inclusion or exclusion of incomplete cases.

37. In December 2021, the Secretary of State for Health and Social Care delivered a statement to Parliament and said that "*The UK Health Security Agency estimates that the current number of daily infections are around 200,000*". At this time, the UK COVID-19 dashboard showed the number of cases was around 45,000. The public were familiar with these figures, which were regularly covered by the media and used in press conferences, and so there was a risk of confusion when the 200,000 figure was used. In fact, the two figures were not comparable and measured different things. The 200,000 figure was a modelled estimate of the number of Omicron infections in the population. This included an estimate of the number of people who had been infected but did not yet know they had been infected. The number presented in the dashboard, by contrast, was the number of positive cases reported through the testing programme. But, based solely on the statement, it was hard for people to know this distinction.
38. I should note that OSR does not have a formal role in auditing models or assessing whether a model or its predictions are good or bad. However, we will comment on the data that come from a model if we think the context has not been made clear.
39. In response to the risk of confusion, UKHSA published an explainer about the 200,000 figure. This included detail about underlying assumptions, data sources and limitations of the calculation. UKHSA also published a daily overview of Omicron cases, hospitalisations, and deaths. On 17 December I wrote to UKHSA (Exhibit EH/53-INQ000092826), welcoming the publication of data to support the statement made by the Secretary of State. I acknowledged the commitment UKHSA had shown to share data to support public understanding in such a fast-moving environment but reflected that the time taken between the use of the figure and the publication of the data was unsatisfactory. After the casework was concluded, UKHSA shared with us its reflection that issues like this could have distracted from the key public health message and could have risked delaying buy-in from the public if trust was undermined. UKHSA also identified that ad-hoc releases were a useful way to provide short explanations to support figures used by ministers. UKHSA now has

processes in place for rapidly producing ad-hoc releases, both for proactive and reactive releases.

The use of unpublished data or statistics by governments

40. I recognise that given the volume of data flowing around governments and the pace at which things changed during the pandemic, there would inevitably be instances when unpublished figures were quoted in the public domain. I also consider that it is right that Ministers have access to up-to-date information to inform their decisions.
41. However, it is important that, where possible, information is also shared with the media and the public, in a way that promotes transparency and clarity. The public should be able to scrutinise the figures which underpin public health communications.
42. We made several interventions during the pandemic to support the publication of data or statistics.
43. In May 2020 the Secretary of State for Health and Social Care used unpublished figures on the percentage of people with COVID-19 antibodies in London and across the UK. Following our approach, PHE published these data a day after the statement was made. I wrote to the Chief Executive of PHE reiterating my expectation that where unpublished data are used by ministers in significant public statements, they should promptly be made available to all (Exhibit EH/54-INQ000092827). I thanked PHE for publishing the data so quickly after our approach.
44. In June 2021, the Authority received concerns about a statement made by the Scottish Cabinet Secretary for Health during an interview about the number of children in hospital with COVID-19. At the time the statement was made the figure used was not publicly available and it was inaccurately presented. The Scottish Government worked quickly to publish additional data and information to support the statement. I wrote to the Chief Statistician for Scotland to encourage the inclusion of the primary reason for the hospital admission in the data (Exhibit EH/55-INQ000092828). This would clarify whether an admission was because of COVID-19 or for another reason. Whilst we considered that the use of unpublished data was a genuine mistake by the Cabinet Secretary, we re-iterated the importance of ensuring that ministers were appropriately briefed, and that any figures referred to in a public statement were made available publicly.
45. In January 2022, I wrote to the Chief Statistician for Wales regarding the use of unpublished data on critical care beds quoted by the First Minister for Wales in a press conference (Exhibit EH/56-INQ000092829). I reiterated our expectation that any data used publicly by governments should be published in an accessible form

with appropriate explanations. The Welsh Government were quick to recognise and respond to my concerns and published an ad-hoc release which contained the underlying data to support the statement that was made.

46. In early March 2022, I wrote to the UKHSA and the Cabinet Office regarding the use of unpublished data at a UK Government COVID-19 press conference and a subsequent UK Government statement that estimated the cost of the UKHSA test and trace programme (Exhibit EH/57-INQ000092830). The UKHSA worked very quickly to publish the data during our discussions and implemented a new process to rapidly publish ad-hoc releases should they be needed. The UKHSA and the Cabinet Office also agreed to work together to ensure that the necessary processes were in place to reduce the risk of this happening again.

Transparency of data or statistics that were used to support government daily press conferences

47. The daily press conferences by the UK's governments were a crucial mechanism for informing the public about the pandemic. These press conferences frequently featured the presentation of data and statistics.
48. Analysts in governments worked closely with communications colleagues to support the presentation of data. This support demonstrated the importance drawing on the skills of analytical experts. For example, in the early weeks of the pandemic, we considered that the presentation of data at No 10 press conferences could have been clearer. To improve the statistical rigour of the presentation of data, we liaised informally with the Cabinet Office and the ONS. Staff from the ONS and other Government analysts advised the Cabinet Office on the presentation of data, and this involvement of analysts resulted in marked improvements.
49. On 31 October 2020, the introduction of coronavirus restrictions was announced at a UK Government press conference. Several slides were presented on data about the COVID-19 pandemic. The data underpinning the decision to lock down were not published for several days after the press conference. This had the potential to confuse the public and undermine confidence in the data. I wrote to the Chief Medical Officer and Chief Scientific Advisor to highlight a statement we published on our website on 5 November 2020 (Exhibit EH/58-INQ00009231/ Exhibit EH/59-INQ000092832). I reinforced the principle that data should be published in a clear and accessible form with appropriate context and sources. In response, the Chief Scientific Advisor confirmed that openness and transparency of advice were principles to which he attached great importance. Following this intervention, Welsh

Government also announced plans to publish its briefing slides and data sources in a single place. We had also highlighted this issue as part of our submission to the Health, Social Care and Sport Committee's inquiry on the impact of the COVID-19 outbreak, and its management, on health and social care in Wales. In addition to specific changes to the presentation of data used at press conferences, our intervention provided a strong basis for further engagement on transparency issues.

Comparability of health data or statistics across the UK

50. As the pandemic progressed and more data were made available, it became increasingly important to users to understand the impacts of COVID-19 across the UK. In general, we expect that any comparison of the UK's four countries should clearly identify the sources used to make that comparison as well as any appropriate caveats. I wrote to producers of COVID-19 statistics stressing the importance of producers across the UK working together to coordinate statistics and ensure consistency (Exhibit EH/60-INQ000092833/EH/61-INQ000092834).
51. This desire to understand and compare data across the UK contributed to casework issues raised with us. The two main examples are:
    a. In July 2020, the First Minister of Scotland claimed at a press conference that the prevalence of coronavirus in Scotland was five times lower than it was in England. The sources used to underpin that claim were difficult to identify. We were able to confirm with the Scottish Government what sources were used for the claim and the decisions that were taken to create the comparison. However, this information was not publicly available. I advised that there were lessons to be learnt in this particular case, with different data sources quoted to the media and to us. Furthermore, it was important to recognise that a comparison of COVID-19 prevalence rates was not straightforward. In this case, we did not consider that the sources allowed for a quantified and un-caveated comparison of the kind that was made.
    b. In January 2022, I addressed concerns regarding the Deputy First Minister of Scotland who had claimed that only 1 in 40 Scots contracted COVID-19, compared with 1 in 25 in England, following a period of restrictions across Scotland. In the interview the Deputy First Minister was drawing on the most recent data available but was speaking in the broader context of the different policies in Scotland and England throughout the winter. However, I appreciated that those listening to the interview could have taken the

impression that he was referring to the period after Christmas when the new restrictions came into force.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed: Personal Data

Dated: 13 July 2023