Witness: Ben Dyson

Statement No: 3

Exhibits: BD3/1 – BD3/428

Dated: 11 April 2025

UK COVID-19 INQUIRY

DEPARTMENT OF HEALTH AND SOCIAL CARE
THIRD WITNESS STATEMENT OF BEN DYSON
CORPORATE STATEMENT MODULE 7

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1. I, Ben Dyson, Director of the Better Care Fund and Hospital Discharge, at the Department of Health and Social Care, 39 Victoria Street, London SW1H 0EU, will say as follows:

INTRODUCTION

2. I make this statement in response to a request from the UK COVID-19 Public Inquiry (the Inquiry) dated 29 August 2024 made under Rule 9 of the Inquiry Rules 2006 (the Request) asking for a corporate statement on behalf of the Department of Health and Social Care (the Department/DHSC) providing an overview of the structure of the Department and the role it played in the matters covered by Module 7 (testing, tracing and self-isolation) in the COVID-19 pandemic between 30 January 2020 and 28 June 2022.

3. As this is a corporate statement on behalf of the Department, it necessarily covers matters that are not within my personal knowledge or recollection. This statement is to the best of my knowledge and belief accurate and complete at the time of signing, in line with

responding, as far as possible, within the Inquiry's deadlines. Notwithstanding this, it is the case that the Department continues to prepare for its involvement in the Inquiry. As part of these preparations, it is possible that additional material will be discovered. In this eventuality the additional material will of course be provided to the Inquiry, and a supplementary statement will be made if necessary.

4. This corporate statement is the third of 4 witness statements that form the Department's corporate response to Module 7. It builds on the information outlined in my First Statement (Statement A), which sets out key decision makers, external stakeholders and the role of the Department in relation to testing, tracing and self-isolation during the relevant period. My Second Statement (Statement B) sets out information on questions relating to testing and my Fourth Statement (Statement D) provides an overview of equality considerations, relevant communications campaigns to raise awareness and/or encourage compliance and engagement with policy, and lessons learned. For areas outside of my responsibility, I have relied upon departmental records and briefings, and my understanding of the overall approach to the pandemic.

5. This statement focuses on questions relating to contact tracing and self-isolation, although, where relevant, reference will be made to aspects of testing, with reference given to where further information is provided in Statements A, B and D. It also covers information on tiering policy and borders policy requested by the Inquiry.

6. The statement has been structured into 6 sections that address the Inquiry's questions:

    a. **Section 1** provides an overview of contact tracing policy, focusing on the Department's role in the development of national systems and key decisions during the COVID-19 pandemic. Contact tracing, a long-standing public health measure, was used to identify individuals at risk of infection and to provide public health advice aimed at reducing the spread of COVID-19. This section also describes the establishment of a national contact tracing service as part of NHS Test and Trace (NHS T&T) using a combination of online services, central teams of contact tracers and Public Health England (PHE) in partnership with local authorities. Finally, it covers the development and usage of the NHS COVID-19 app.

    b. **Section 2** provides an overview of self-isolation policy during COVID-19. This section outlines how self-isolation, a key public health measure, evolved during

the pandemic in response to the virus, clinical developments, and emerging evidence. It highlights the initial use of isolation protocols informed by pre-pandemic practices for high-consequence infectious diseases (HCIDs) and explains how self-isolation rules were shaped by clinical advice from the 4 Chief Medical Officers (CMOs) and scientific bodies such as the Scientific Advisory Group for Emergencies (SAGE). The section includes a summary of the legal duties introduced in relation to self-isolation for positive cases and their close contacts, and the arrangements for their enforcement.

c. **Section 3** provides an overview of policy on financial and practical support measures for self-isolation, introduced to assist individuals who had to self-isolate, including the Test and Trace Support Payment (TTSP) scheme and the Local Authority Practical Support Fund. It summarises evidence on adherence to self-isolation for positive cases and their close contacts.

d. **Section 4** provides an overview of the development of the Tier regulations from the summer of 2020, as well as additional information on the development of local alert levels, the Winter Plan for 2020 to 2021 and the second and third national lockdowns.

e. **Section 5** provides an overview of borders policy, focusing on the Department's role in the development of testing policies, guidance and key decisions relating to individuals entering England from outside the UK. This section also outlines the establishment of the Managed Quarantine Service in early 2021, introduced as part of enhanced border measures in response to the emergence of COVID-19 variants.

f. **Section 6** provides an overview of regulations and enforcement. This section outlines the Department's involvement in the development of regulations and rules, which were subject to enforcement by other authorities. Early pandemic regulations were initially prepared by officials in the Ministry of Housing, Communities and Local Government (MHCLG), with the Secretary of State for Health and Social Care providing final approval. Responsibility for drafting submissions and advice later transitioned to the Department for subsequent legislation.

7. Policy on contact tracing and self-isolation in Scotland, Wales and Northern Ireland is a devolved matter. The statement sets out where the 4 nations of the UK chose to follow a common approach, but the Department directs the Inquiry to the relevant devolved administrations for further information about the specific policies in Scotland, Wales and Northern Ireland.

SECTION 1: CONTACT TRACING

8. Tracing contacts of positive COVID-19 cases, so that they could be advised to self-isolate or take other appropriate public health action, formed an important part of the wider set of measures designed to contain or limit transmission of COVID-19. This section describes the purpose of contact tracing, how it was used before and during the pandemic and the Department's role in the development of contact tracing during the pandemic.

9. This section describes the establishment, as part of NHS T&T, of a national contact tracing service, designed to manage contact tracing through a combination of public health experts to manage complex cases (Tier 1), health professional staff to interview positive cases (Tier 2), trained call handler staff to help trace contacts of positive cases (Tier 3) and web-based technology. It describes the development of local tracing partnerships to strengthen local authority involvement in contact tracing, working alongside regional health protection teams and national contact tracers. It also covers the development of the NHS COVID-19 App as a technological solution to extend the reach and speed of contact tracing.

Purpose of Contact Tracing

10. Contact tracing is a long-standing public health measure used to identify individuals at risk of having been infected with – and manage the spread of – a pathogen. This includes both forward and backward contact tracing, with forward tracing forming the primary approach during the pandemic.

11. The purpose of contact tracing is to identify people with a potential infection and take appropriate public health action to reduce risk of transmission to others, often by asking or instructing them to self-isolate for a specified period. Often used alongside other public health measures, it is a widely accepted form of infection prevention control, used for

many decades to identify potential chains of transmission and help reduce the spread of infectious diseases.

12. In the early days of a potential outbreak, when the number of cases is likely to be low, the focus of contact tracing and self-isolation is to prevent or delay any sustained community transmission. This is the point at which contact tracing and self-isolation have the greatest potential to have a significant impact on the course of a pandemic.

13. There are broadly 2 types of contract tracing: backward contact tracing and forward contact tracing, both of which were used over the course of the pandemic **(BD3/1 - INQ000527989)**. Backward contact tracing seeks to identify the source of infection by looking at the activities and interactions of a confirmed case in the period during which they were likely to have become infected, enabling public health teams to take appropriate follow-up action to help limit onward transmission, for instance by asking people who have may been exposed to the virus at the same time to get tested.

14. Most of the contact tracing discussed in this statement is forward contact tracing. During the pandemic, this involved tracing contacts of people thought to have been in close contact with someone who had tested positive for COVID-19 in the period when that person was likely to have been infectious. Given their heightened risk of having been infected, those close contacts were typically asked or instructed to self-isolate for a specified period to help prevent onward transmission. The contact tracing process was also used to reinforce the importance of positive cases and other members of their household completing the self-isolation period, which began at the point the positive case first developed symptoms (or, if they did not have symptoms, the date of their test), and to help ensure those needing to self-isolate knew how to access relevant support.

15. A more detailed background to contact tracing is available in Chapter 7 of the Technical Report, which has been drawn on to provide context in this section of the statement. The Technical Report covers technical aspects primarily of interest to future scientific leads in clinical and public health, for example future CMOs, Government Chief Scientific Advisers (GCSAs), National Medical Directors and UK public health leaders facing a new pandemic or major epidemic **(BD3/2 - INQ000203933)**.

Relationship between Testing and Contact Tracing

16. As set out in Statement B, testing for COVID-19 and other diseases can have multiple benefits, including enabling accurate clinical diagnosis to support treatment for patients, identifying positive cases so that they can self-isolate (or, if symptomatic, continue self-isolating), enabling people with symptoms to stop self-isolating if they test negative to prevent disproportionate economic and social burden, providing additional protections in high-risk settings, helping manage local outbreaks, and supporting research and surveillance. Most of these benefits do not rely or rely only partly on contact tracing.

17. A further benefit of testing, however, is that identifying positive cases also makes it possible to identify at least some close contacts who are – by virtue of that close contact with a positive case – at heightened risk of having been infected and advise or instruct them to self-isolate or take other precautions to help limit onward transmission.

18. Although the value of testing is only partially linked to contact tracing, the effectiveness of contact tracing is, therefore, intrinsically linked to the availability, uptake and speed of testing. The sooner an infected individual takes a test and the sooner it is processed and reported, the sooner it is possible to trace their contacts and give them appropriate public health advice. Statement B includes information on the relationship between the growth of testing capacity, expanded eligibility for testing and increased use of contact tracing as testing enabled more positive cases to be identified.

19. As well as its critical dependence on availability, uptake and speed of testing, the effectiveness of contact tracing also relies on the speed of the tracing process. For conventional (non-app-based) forms of contact tracing, this encompasses both the speed with which one reaches the person who has tested positive and asks them to share information about their recent contacts and the speed with which one then reaches those contacts and gives them appropriate public health advice. One of the advantages of app-based forms of contact tracing is that, once someone has reported a positive test result on the app, the tracing process is almost instantaneous.

20. The effectiveness of contact tracing also relies critically on behavioural factors: how reliably, accurately and promptly people take a test if they have symptoms (or if asked to do as part of an asymptomatic testing scheme); whether they report the results of that test if it is self-administered (as was the case in the COVID-19 pandemic for lateral flow device (LFD) tests); how far people are able to remember and how far they are willing to

share details about their recent contacts; how far people identified as contacts respond positively to attempts to contact them and follow the advice or instructions given to them; and how far people use contact tracing apps (where available) and act on the notifications given to them by the app. Statement D discusses in more detail the challenges involved in influencing these behaviours and the action taken by the Department during the COVID-19 pandemic to help influence positive behaviours.

Contact Tracing Prior to the Pandemic

21. As with other areas where the Department took on new responsibilities during the pandemic, the Department did not have responsibility for contact tracing before COVID-19. At the start of the pandemic, contact tracing was the responsibility of PHE and conducted by its health protection teams. These regional teams were staffed by public health professionals, including consultants in communicable disease control and health protection nurses.

22. Health protection teams were an important part of the public health response. Later parts of this section describe how health protection teams, working alongside local authorities, continued to undertake some contact tracing as part of the overall NHS T&T service, for instance in high-risk settings or as part of managing local outbreaks, working alongside and in partnership with the central teams established by NHS T&T.

23. For further information on pandemic preparedness, including personnel and their expertise and pre-existing technology, the Department refers the Inquiry to the UK Health Security Agency (UKHSA).

Middle East Respiratory Syndrome Coronavirus (MERS)

24. PHE carried out extensive contact tracing as part of its response to the Middle East respiratory syndrome coronavirus (MERS-CoV) infections in 2012 and 2013. From the initial infection in September 2012, there were no further infections identified in hospital staff, other patients or relatives. In February 2013, contact tracing for a cluster of MERS cases in the UK identified 20 household contacts, 6 of whom developed symptoms following exposure and one of whom was hospitalised, and a further non-household contact who did not require medical attendance for her illness and fully recovered after 9 days **(BD/3 - INQ000187820).**

25. In 2015, when a MERS-CoV outbreak occurred in South Korea, the Department confirmed that the NHS would isolate, test, diagnose and treat any suspected or confirmed MERS patient in line with their presenting clinical needs. To prepare clinicians for a possible case of MERS-CoV, PHE published and maintained guidance on infection control and an algorithm to assist in the diagnosis and management of MERS-CoV cases **(BD3/4 - INQ000022727; BD3/5 - INQ000113294)**.

26. In response to the 2015 MERS-CoV outbreak in South Korea, the CMO wrote to both PHE and NHS England (NHSE) to confirm they had systems in place to respond **(BD3/5-INQ000113294)**. Additionally, the health departments and public health agencies of the devolved administrations confirmed that, as in England, established guidance and infection control arrangements were in progress. Departmental officials met with PHE on 17 June 2015 to discuss the issues identified by the World Health Organization (WHO) International Health Regulations (IHR) Emergency Committee, to consider their relevance to the UK, and review overall preparedness arrangements.

27. On 23 August 2018, PHE confirmed a fifth case of MERS-CoV in England **(BD3/6 - INQ000565471)**. The individual had recently travelled from the Middle East to the UK. The case was identified by an emergency department at an NHS trust **(BD3/7 - INQ000565472)**. The patient was isolated and transferred to an airborne HCID treatment centre. PHE declared a national incident and worked with the relevant NHS trust. Over 70 individuals were contacted as part of contact tracing processes, including the patient's family, passengers on the plane in close proximity and healthcare workers who had treated the patient.

Exercise Alice

28. As referred to in paragraph 15 of the Department's Module 1 Closing Statement dated 2 August 2023 and paragraphs 171 and 172 of Section 5 of the Department's Corporate Statement for Module 5, in response to concerns raised by the CMO, the Department commissioned pandemic preparedness exercises on planning and resilience to respond to a large-scale outbreak of MERS-CoV.

29. PHE carried out Exercise Alice on 15 February 2016, supported by the Department and NHSE. The exercise was an opportunity to explore the policies, response and issues

associated with an outbreak in England. Observers were invited from all 3 devolved administrations, GO-Science and the Cabinet Office **(BD3/5 - INQ000113294)**.

30. One objective of the exercise was to "*explore the capability for contact tracing and quarantining of possible MERS-CoV cases*". Following the exercise, it was agreed that PHE and the Department would take forward several actions relating to contact tracing and quarantining **(BD3/5 - INQ000113294)**:

    a. The Department was to produce an options plan using extant evidence and cost benefits for quarantine versus self-isolation for a range of contact types including symptomatic, asymptomatic and high-risk groups.

    b. PHE was to develop a plan for the process of community sampling in a MERS-CoV outbreak.

    c. PHE was to develop a live tool or system to collect data from MERS-CoV contacts.

    d. PHE was to research, review and identify good practice for definitions for close/high risk contacts and recommend a definition for MERS-CoV.

    e. PHE was to prepare a frequently asked questions (FAQ) document for MERS-CoV close/high risk contacts.

31. The outcomes of the exercise informed cross-government work to increase resilience to a future HCID outbreak. Work undertaken since Exercise Alice included (but was not limited to) development of PHE guidance around MERS-CoV infection control, the development of planning documents on the use of surge and triage systems, and a plan for community sampling during an outbreak of MERS-CoV **(BD3/8 – INQ000223224)**.

32. An email from the Director of Health Protection and Emergency Response to the Deputy Director of Health Security in the Department on 15 February 2016 requested a high-level paper that set out options for developing a plan on self-isolation/quarantine **(BD3/9 - INQ000565469)**. The email laid out several issues to consider, which were considered during the COVID-19 pandemic. These included:

    a. the viability of different facilities appropriate for quarantine of contacts (for example hotels and detention centres)

b. care for dependants of high-risk contacts and protection of employment/income for those required to isolate/quarantine

c. the legislative framework

d. minimum standards for social distancing within quarantine/isolation facilities, including issues of multiple occupancy houses and how to provide food and other essential support

33. PHE completed the actions described in paragraph 30 **(BD3/10 - INQ000057654)**:

a. PHE published version 5 of the plan for processing community sampling in a MERS-CoV outbreak '*Epidemiological protocols for comprehensive assessment of Early Middle East Respiratory Syndrome coronavirus cases and their close contacts in the United Kingdom*' in November 2013 **(BD3/11 - INQ000593003)**.

b. PHE developed the FF100 system for the purpose of collecting data on contacts of MERS cases and this was used in the response to an imported case of MERS in 2018.

c. The definitions for close/elevated risk contacts are set out in the document '*Investigation and public health management of possible cases of MERS-CoV: algorithm*', which was designed to be read in conjunction with '*MERS-CoV algorithm: public health investigation and management of close contacts of confirmed cases*'. Together these set out the definitions of close contacts and the protocols for their identification and management **(BD3/12 - INQ000023132; BD3/13 - INQ000023041)**.

d. The FAQ document prepared for contacts was not published but was provided directly to identified contacts during an incident response.

34. In 2016, as part of a Risk Deep Dive into Major Infectious Disease Outbreaks, the Departmental Board discussed plans for both pandemic flu and emerging infectious disease outbreaks. The plans in place to mitigate risks of a pandemic flu outbreak included case identification and contact tracing to establish the epidemiological basis for modelling and response, as well as routine syndromic surveillance for flu via primary care,

NHS 111 and emergency departments and sentinel surveillance of around 3,500 GP practices **(BD3/14 - INQ000022738)**.

35. In 2019, PHE updated the Monkeypox (now known as Mpox and referred to in this statement as such) Contact Tracing Management Protocol after 2 cases of Mpox were confirmed in England in 2018. The protocol involved active and passive surveillance (depending on the risk of exposure to infected individuals), data collection, data management, data analysis and dissemination guidance, in addition to how to manage symptomatic contacts **(BD3/15 - INQ000565489; BD3/16 - INQ000593005)**.

36. On 11 December 2019 (prior to the UK exiting the EU on 31 January 2020), Departmental officials attended an EU Health Security Committee (HSC) plenary meeting at which EU member states raised concerns about difficulties in receiving data from airlines for contact tracing **(BD3/17 - INQ000565475; BD3/18 - INQ000565487); BD3/19 - INQ000565476; BD3/20 – INQ000565477; BD3/21 - INQ000565478; BD3/22 - INQ000565479; BD3/23 – INQ000565480; BD3/24 - INQ000565481; BD3/25 - INQ000565482; BD3/26 - INQ000565483; BD3/27 – INQ000565484; BD3/28 - INQ000565485; BD3/29 - INQ000565486)**. The European Commission finalised an assessment of the legal framework regulating the sharing of personal data between transport and public health sectors in the context of contact tracing activities, in consultation with the Working Group on Preparedness, and circulated the resulting discussion paper to the HSC. At the recommendation of the Working Group on Preparedness, the Chair proposed to set up an ad-hoc working group on contact tracing to work on the sharing of personal data between transport and public health sectors in the context of contact tracing activities **(BD3/18 - INQ000565487)**.

Early Pandemic Response to Tracing Contacts

37. At the start of the COVID-19 pandemic, the Department's only involvement in contact tracing was in its capacity as the sponsoring body of PHE. While the Department's Emergency Preparedness and Health Protection Directorate engaged closely with PHE as the lead for operational management of the response and received updates on suspected and confirmed cases and contact tracing measures being taken, it did not have a direct decision-making role. As the situation in Wuhan escalated and the first cases were confirmed outside of China and then in the UK, the Department became increasingly

involved in plans for containing the situation in the UK and in engaging more closely in how the situation was managed.

38. The Department's stages of responding to COVID-19 are set out in paragraphs 126 to 128 of Statement A. Early measures to contain the virus included tracing passengers who had arrived from Wuhan, implementing port health measures including communications with newly arrived passengers from Wuhan and then other destinations (as outlined in Statement D), and repatriating UK nationals from China and isolating them. This process is covered in more detail in Section 5 of this statement.

39. On 21 January 2020, the Department asked for an update on public health plans in the scenario that a positive case was brought into the country via a commercial flight **(BD3/30 - INQ000527866; BD3/31 - INQ000527870; BD3/32 - INQ000106897)**. The PHE Incident Management Team provided advice to the Department, which included outlining plans that involved contacting passengers and cabin crew in the area of the plane where a positive case had been seated.

40. At this stage, contact tracing was considered likely to be more effective in the early stages of the pandemic, when the focus was on preventing wider community transmission. For example, the paper written by Departmental officials 'UK Escalation Triggers and Response Options', which was discussed and agreed at the Cabinet Office Briefing Room (COBR) meeting held on 24 January 2020, noted that contact tracing (and testing) would no longer be effective and should cease where there was sustained community transmission.

41. On 28 January 2020, the Department's Director of Emergency Preparedness and Health Protection shared a First Case Protocol with the Cabinet Office, No.10 and other cross-government colleagues that outlined the steps and organisations involved in the management of the first COVID-19 case. This included a PHE health protection team initiating the contact tracing process by collecting contact tracing information from the positive case. The health protection team would speak with the positive case to identify anyone with whom they had had close contact during the period in which they were potentially infectious **(BD3/33 - INQ000106072; BD3/34 - INQ000106073)**.

42. On 30 January 2020, the 4 UK CMOs raised the risk level from low to moderate in light of increasing number of cases in China **(BD3/35 - INQ000106080).**

Scaling Up Contact Tracing in February and March 2020

43. During the early stages of the pandemic, PHE used established procedures for detecting and isolating the first cases of COVID-19 and for rapid tracing, monitoring and self-isolation of their close contacts, with the aim of preventing the disease taking hold in this country for as long as was reasonably possible. Local authorities had limited involvement in contact tracing at the beginning of the outbreak and the Department initially encouraged local authorities to focus on working with PHE to support investigation and containment.

44. While initially the cases that were subject to contact tracing were mainly those travelling from Wuhan, this changed quickly. Between 31 January 2020, when the first 2 documented cases of COVID-19 in the UK were reported, and early March 2020, the number of confirmed cases grew to just over 100. At this time, contact tracing was carried out through existing PHE infrastructure, but this became more challenging as the number of positive cases increased.

45. On 31 January 2020, the Department received a paper from PHE, asking for agreement on proposed recommendations for contact tracing for confirmed cases and severely ill suspected cases. Recommendations for the management of contact tracing were based on experiences from other epidemic-prone coronaviruses (such as severe acute respiratory syndrome coronavirus 1 (SARS) and MERS) and included actions such as active follow-up and self-isolation for 14 days in high-risk situations, such as household contacts. For aircraft exposure, PHE recommended that there should be contact tracing for people who had been within a 2-seat radius of the positive case (based on MERS guidance) **(BD3/36 - INQ000527877)**. The Deputy Chief Medical Officer (DCMO) Professor Jonathan Van-Tam agreed with the recommendations on behalf of the Department on the same day and they were shared with health protection teams that day to operationalise **(BD3/37 - INQ000527878; BD3/36 - INQ000527877)**.

46. In mid-February 2020, PHE notified the Department that it had set up a dedicated contact tracing cell within its incident management structures to provide greater coordination to local health protection teams and scale up capacity **(BD3/38 - INQ000527887)**.

47. As cases increased during February 2020, discussion progressively turned to the length of the period for which contact tracing would be useful in helping to contain or delay the virus. On 10 February 2020, the Secretary of State met with officials from the Department and PHE to discuss the trigger point at which contact tracing would no longer be effective

if community transmission became widespread **(BD3/39 - INQ000527883; BD3/40 - INQ000527882)**. On 11 February 2020, SAGE asked PHE to work with the SPI-M Operational sub-group (SPI-M-O) to develop criteria for the point contact tracing would become redundant **(BD3/41 - INQ000075784)**.

48. On 14 February 2020, PHE provided the Department with a paper on contact tracing which set out concerns that current capacity for contact tracing was not sufficient to control higher rates of infection in the UK **(BD3/42 - INQ000527884; BD3/43 - INQ000527885)**. The paper recommended capacity was bolstered, but it also recommended a set of triggers at which point contact tracing would no longer provide the same benefits and so should be discontinued.

49. On 18 February 2020, SAGE met and agreed that early warning surveillance systems needed to feed into trigger points for decisions on when the current monitoring and contact tracing approach would no longer be working. It was agreed that PHE would present a paper at the next SAGE meeting, informed by SPI-M, proposing trigger points for when the approach to monitoring and contact tracing should be reviewed, revised or stopped **(BD3/44 - INQ000106114)**. On 20 February 2020, SAGE discussed the paper and agreed that the proposed triggers were sensible **(BD3/45 - INQ000087502)**.

50. The triggers for the point at which PHE recommended discontinuing contact tracing are outlined in the following paper **(BD3/46 - INQ000087180)**. PHE recommended that when person to person spread was epidemiologically demonstrated to be dominated by second and subsequent generational cases, or there were more than 8,000 cases per day as a proxy, then contact tracing measures should cease.

Widespread Community Transmission

51. By early March 2020, it was clear that it would not be possible to slow the spread of the virus through containment. On 2 March 2020, the CMO updated COBR that efforts to establish the source of the infection for the last 2 positive UK cases had been unsuccessful. His update also noted that there was sustained community transmission in both France and Germany **(BD3/47 - INQ000056217)**.

52. On 3 March 2020, the government published its pandemic response plan known as the 'Coronavirus Action Plan', which is described in paragraphs 126 to 128 of Statement A **(BD3/48 - INQ000057508)**. The Action Plan, based on early evidence from PHE,

described the phases of response and circumstances that would trigger moving to a different level. The plan noted that intensive contact tracing would not be an effective large-scale preventative measure as the disease became more established in the community and resources would be more valuably used elsewhere.

53. On 3 March 2020, the Secretary of State received a submission from Departmental officials which recommended, based on the clinical evidence, that COVID-19 should be made a notifiable disease under the Health Protection (Notification) Regulations 2010/659. This meant that doctors would be required to notify local authorities if they suspected a patient had COVID-19. Local authorities would in turn notify PHE **(BD3/49 - INQ000106146; BD3/50 - INQ000106147)**. The submission recommended that the usual 30-day consultation period was waived. The Secretary of State agreed to implement the recommendation on the same day **(BD3/51 - INQ000106148)** and the Health Protection (Notification) (Amendment) Regulations 2020 came into effect on 5 March 2020.

54. On 4 March 2020, the Secretary of State met with the DCMO and Departmental and PHE officials. PHE's Medical Director and Director of Health Protection advised that evidence was emerging of the start of community transmission in the UK **(BD3/52 - INQ000049512)**. Community transmission (outbreaks of local transmission of the virus) was seen as a key trigger marking the escalation of the pandemic in the UK, and the point at which efforts to contain the virus would no longer be effective.

55. On 12 March 2020, COBR met to discuss a package of interventions to lessen the peak of infection and protect the most vulnerable. The recommended option from SAGE was for symptomatic individuals to self-isolate for 7 days. Section 2 of this statement contains a more detailed explanation of the development of self-isolation rules.

56. Later that day, the government announced that it was moving to the Delay phase of the government's Action Plan. All symptomatic individuals were asked to self-isolate at home for 7 days **(BD3/53 - INQ000106195)**. The UK CMOs raised the risk to the UK from moderate to high.

57. As part of the previously agreed escalation triggers **(BD3/54 - INQ000310088)**, and in line with the Coronavirus Action Plan, community contact tracing ended at this point, with the exception of contact tracing in high-risk settings such as care homes to protect the most vulnerable.

58. PHE's Incident Management Team sent guidance to health protection teams outlining the impact of the move to the Delay phase of the Action Plan and setting out how this would be practically managed. In effect, this meant moving from individual case management to a focus on management of outbreaks in high-risk settings **(BD3/55 - INQ000527901; BD3/56 - INQ000527902; BD3/57 - INQ000527903)**.

59. On 23 March 2020, the Prime Minister announced the first national lockdown and widespread contact tracing did not resume until 28 May 2020 with the establishment of NHS T&T **(BD3/58 - INQ000107094)**.

NHS Test and Trace (NHS T&T)

60. During April and May 2020, the government sought to identify a range of non-pharmaceutical interventions (NPIs) which, in combination, would enable lockdown restrictions to be removed whilst protecting the NHS and ensuring that the rate of reproduction of the virus (the 'R number') did not rise to a level that caused exponential growth and necessitated repeated lockdown measures. This included maintaining social distancing and making workplaces COVID-secure. It also included a major expansion in testing capacity (as set out in Statement B) to identify people who had COVID-19 and ensure they avoided contact with other people, as well as greater use of contact tracing to identify people at heightened risk of having COVID-19 and ask them to self-isolate to limit the risk of onward transmission. This required a rapid scaling up of contact tracing capacity.

61. In April and May 2020, SPI-M-O modelled potential scenarios for numbers of positive cases and the average number of contacts per positive case to provide estimates of the number of staff that might be needed to undertake contact tracing once the lockdown period ended **(BD3/59 - INQ000223519; BD3/60 - INQ000593037; BD3/61 - INQ000593039)**. On 24 April 2020, the Second Permanent Secretary shared a note with Cabinet Office and No.10 colleagues that looked at the drivers of contact tracing volumes based on SAGE modelling **(BD3/62 - INQ000565513)**. The Department worked with NHS Professionals to recruit around 3,000 health professionals as clinical caseworkers, who would interview positive cases, and with commercial companies to recruit around 15,000 call handlers **(BD3/63 - INQ000565516)**.

62. From April 2020, and particularly in May 2020, it became clear that key elements of the government's approach to managing transmission, following the exit from lockdown, would benefit from a more integrated and strategic approach. This is covered in more detail in paragraph 131 of Statement A. As set out above in paragraphs 17 and 18, although COVID-19 testing had several benefits that existed independently of contact tracing, contact tracing, by contrast, relied critically on the availability, uptake and speed of testing. There were, therefore, clear benefits in bringing together policy and operational responsibility for testing, contact tracing and self-isolation. At a COVID-19 Operations Committee (COVID-O) meeting on 26 May 2020, the Chair of NHS T&T explained that the programme was an important part of the strategy to reduce restrictions in the absence of a vaccine. The Chair also explained that the programme was underpinned by the importance of self-isolation (this is expanded upon in Section 2), the speed of the end-to-end testing and contact tracing process, and support for vulnerable groups to help reduce barriers to self-isolation (expanded upon in Section 3). Behavioural changes were critical to this **(BD3/64 - INQ000083699)**.

63. The need for additional contact tracing capacity to manage the projected volume of tracing that would be needed once lockdown measures were ended, alongside the benefits of combining policy and operational responsibility for testing and contact tracing, contributed to the decision to create NHS T&T in May 2020, as described in paragraphs 131 to 139 of Statement A **(BD3/58 - INQ000107094)**.

64. On 1 May 2020, at a Health Ministerial Implementation Group meeting chaired by the Secretary of State, he noted that a 'test, track and trace' programme (as the NHS T&T programme was initially referred to) would be key to keeping the R number low.

65. On 28 May 2020, the Prime Minister announced a phased easing of restrictions, supported by the new NHS T&T programme **(BD3/65 - INQ000551632)**.

66. On 27 May 2020, new guidance was issued **(BD3/58 - INQ000107094)**, under which close non-household contacts of individuals with a positive test result were advised to self-isolate until 14 days after the date of their most recent contact with the positive case **(BD3/66 - INQ000565519)**. This was based on increased understanding of how the disease spread and that there was an inbuilt lag of up to 14 days between contact with someone with the virus and the onset of infection **(BD3/67 - INQ000249693)**. The close contact was not advised to get tested unless they developed COVID-19 symptoms and

members of their household did not have to self-isolate unless they or the close contact developed symptoms of COVID-19.

67. The NHS T&T service launched on 28 May 2020. The service was overseen by a unit in the Department led by Baroness Dido Harding and brought together a range of services run by the Department, PHE, NHSE and other partner organisations into an integrated end-to-end service. This helped ensure alignment of policies and operational processes for testing, contact tracing and self-isolation, with the aim of designing and running services in ways that best met user needs and contributed as effectively as possible to limiting the rate of transmission of COVID-19 and supporting economic and social recovery.

68. NHS T&T established a national system of contact tracing alongside the development of a contact tracing app as set out in paragraphs 108 to 132 below. The service sought to contact everyone for whom it received notification of a positive test result, provided the notification included relevant contact details, to ask them for information about other household members and about non-household contacts with whom they had been in close contact **(BD3/66 - INQ000565519)**. The service then sought to contact those household and non-household contacts as quickly as possible to provide appropriate public health advice, typically to self-isolate (or, in the case of household contacts, to continue self-isolating) and share other public health advice as appropriate.

69. Close contacts were defined as someone who had been close to someone who tested positive for COVID-19 any time from 2 days before they developed their symptoms or, if they were asymptomatic, from 2 days before the date their positive test was taken and for up to 10 days afterwards (as this was the estimated period in which a positive case could be infectious to others). Guidance outlined that a contact could be:

    a. anyone who lived in the same household as another person who had COVID-19 symptoms or had tested positive for COVID-19

    b. anyone who had any of the following types of contact with someone who had tested positive for COVID-19:

        i. face-to-face contact including being coughed on or having a face-to-face conversation within 1 metre

ii. having been within 1 metre for 1 minute or longer without face-to-face contact

iii. having been within 2 metres of someone for more than 15 minutes (either as a one-off contact or added up together over one day)

c. someone who had travelled in the same vehicle or plane as a person who had tested positive for COVID-19 **(BD3/68 - INQ000565517)**

70. This tracing service was designed and overseen by public health experts based in PHE and involved both the process of contacting people who had tested positive ('positive cases') to enable them to share information about their recent contacts and the follow-up process of reaching those contacts to provide relevant public health advice. In both cases, this included – as appropriate – helping people understand how to access additional health advice if they needed it and how to access support for self-isolation. Both processes were automated as far as possible, initially using a PHE web-based system called the 'Contact Tracing and Advisory Service' (which was entirely distinct from the NHS COVID-19 app introduced in September 2020) **(BD3/69 - INQ000565512)**, but also involved the following 3 'tiers' of staff **(BD3/70 - INQ000593031)**:

a. Tier 1: public health experts who managed complex cases referred to them by Tier 2, a partnership between PHE's regional health protection teams and field service teams, working in partnership with local authorities

b. Tier 2: a team of professional staff, recruited by NHS Professionals, who were available to interview people who had tested positive, if those positive cases chose not to share information through the web-based tracing system or preferred for any other reason to speak to a contact tracer – initially a team of 7,500 returning clinicians

c. Tier 3: call handling staff provided by contracted commercial providers, who were trained to follow protocols for telephoning contacts of positive cases, if those contacts did not respond to initial attempts to contact them by text or email, to explain the need to self-isolate and how to access available support

71. The scale of the task was underpinned by a SAGE recommendation from a meeting on 1 May 2020 that at least 80% of contacts for a positive case needed to be traced to be effective **(BD3/71 - INQ000498548)**. This contrasted with previous epidemics, such as

SARS or MERS, which had less rapidly rising case numbers and therefore less need for large-scale contact tracing. SAGE also recommended that, for a joined-up system to be effective, contacts of individuals testing positive for COVID-19 should be contacted within 48 hours of identification of the person who had tested positive (sometimes, as in SAGE's advice, referred to as the "index case" in the context of contact tracing).

72. In the first week of the NHS T&T contact tracing operation, 28 May to 3 June 2020, 8,117 people who tested positive for COVID-19 had their case transferred to the contact tracing system, of whom 5,407 (67%) were successfully reached and asked to provide details of recent contacts; 31,794 contacts were identified and, of these, 26,985 (85%) were successfully reached and advised to self-isolate **(BD3/72 - INQ000565522; BD3/73 - INQ000593041)**. Where positive cases or contacts were not successfully reached, this was generally because there were insufficient or incorrect contact details or because they did not respond to attempts to contact them. NHS T&T published regular statistics that included the number of positive cases requiring contact tracing, how many had been reached, not reached or had no contact details provided and how many cases were managed by health protection teams **(BD3/74 - INQ000565528)**. Regular dashboards were produced internally weekly and sometimes daily to support the process of continuous quality improvement **(BD3/75 - INQ000593045; BD3/76 - INQ000593046)**.

73. On 30 July 2020, 8 weeks after the establishment of NHS T&T, the Department published a policy paper, 'Breaking chains of COVID-19 transmission to help people return to more normal lives: developing the NHS Test and Trace service' **(BD3/77 - INQ000527961)**. By that point, the NHS T&T service had worked with over 33,000 newly diagnosed people to identify their recent contacts and successfully reached over 184,000 contacts and advised them to self-isolate, using the 27,000 dedicated contact tracing staff working under the leadership of PHE, local public health experts and online contact tracing services. Over 30,000 people had provided feedback on the overall NHS T&T service and 87% were satisfied or very satisfied with the service.

74. One of the priority objectives set out in the 30 July 2020 policy paper was to increase the number of contacts that the service reached and advised to self-isolate. The paper indicated that increasing the number of people entering the Test and Trace journey (that is, the number of people reporting their symptoms and ordering a test) would have the single biggest impact in achieving that goal.

75. The paper also committed to shortening the length of the overall user journey so that the great majority of contacts could self-isolate before they were likely to be infectious to other people, through a combination of:

    a. speeding up the process of reporting symptoms and booking tests

    b. increasing the number of contacts successfully identified, including using QR code technology to help people keep an accurate log of the places they had visited, encouraging people to start compiling information about recent contacts at the point they ordered at test, and introducing an inbound calling route (on top of the web-based system and outbound calls by Tier 2 contact tracers) to make it easier for people who had tested positive to share information

    c. increasing the number of contacts successfully reached, including working with local authorities to pilot new outreach approaches for people who did not respond when contacted by NHS T&T (see next section on 'Collaboration with local authorities')

76. The policy paper also set out plans to extend use of 'backward' contact tracing by systematically collecting wider information on where people testing positive for COVID-19 had been and any contact they had had with infectious individuals in the 7 days prior to onset of symptoms, enabling the NHS T&T service to identify common links and possible chains of transmission linked to specific settings or events.

77. Finally, the policy paper set out plans for the next phase in developing the NHS COVID-19 app, as set out in paragraphs 108 to 124 below.

78. As outlined above in paragraph 72, NHS T&T regularly published statistics. These statistics were used to help drive action at the national and local level, both through service improvements discussed in paragraphs 81 to 86 and local engagement in paragraphs 90 to 104.

79. On 10 December 2020, the Department published a Test and Trace Business Plan. At the time of publication, over 2 million people had been contacted by NHS T&T and told to self-isolate. The business plan described the expansion of local contact tracing to create a more integrated local and national tracing model, together with the further development of the NHS COVID-19 app to supplement that standard tracing model and extend the reach of contact tracing. The business plan cited externally reviewed model-based

estimates, suggesting that in October 2020, testing, tracing and self-isolation (upon symptom onset or following contact by NHS T&T) had reduced the R number by around 0.3-0.6 compared to a scenario where only social distancing was used. The aim of the commitments set out in the document was to increase the R reduction to around 0.5-0.7.

80. The business plan set out a range of commitments, of which those most relevant to contact tracing were **(BD3/78 - INQ000059228)**:

    a. scaling up local contact tracing

    b. expanding and improving the contact tracing system with the aim of, by the end of January 2021, successfully reaching 90% of positive cases (those people with a notified positive test result) and 85% of the contacts they named, compared with rates of 85% of positive cases and 78% of contacts (where contact details were available) in the most recent performance week at time of publication

    c. reaching contacts faster, with around 80% notified within 72 hours of the positive case first booking a test (for in-person tests)

    d. using contact tracing data in combination with NHS COVID-19 app data, local 'soft' intelligence and wastewater analysis to identify and respond to clusters and outbreaks as close to real time as possible

    e. increasing adoption and use of the NHS COVID-19 app

Service Improvements

81. Following the setup of NHS T&T, there was a sustained ongoing focus on service improvements. This included work on improving the proportion of positive cases and their contacts successfully reached as well as reducing the time between someone ordering a test and, if they tested positive, their contacts being successfully reached.

82. In the 4 weeks ending 30 September 2020, the top 2 reasons for not successfully reaching people were 'maximum call attempts' and 'contact refuses cooperation'. On some days, there were also significant numbers of people not reached because the telephone number given was invalid (**BD3/79 - INQ000593060)**.

83. On 16 October 2020, COVID-O met to discuss contact tracing and service improvements, including a target proposed at a COVID-O meeting a few days before that, by December 2020, the NHS T&T should be reaching at least 90% of positive cases and 85% of contacts **(BD3/80 - INQ000090161; BD3/81 - INQ000090099)**. At this point in time, staffing levels were as follows:

    a. 1,000 members of PHE regional protection teams in Tier 1

    b. 5,000 healthcare professionals in Tier 2

    c. 10,000 contact centre agents in Tier 3

84. The Committee also discussed the importance of improving compliance with self-isolation to improve the impact of contact tracing and the measures to address this, including the Test and Trace Support Payment scheme (covered in more detail in Section 4 below).

85. In October 2020, NHS T&T developed a Service Improvement Plan to continue to improve contact tracing capabilities **(BD3/82 - INQ000565551; BD3/83 - INQ000593061)**. The plan was shared with COVID-O and had 6 workstreams:

    a. Stabilise Current Service

    b. Improve Call Centre Service

    c. End-to-End Improvement

    d. Local Partnerships Roll-Out

    e. Enhanced Contact Tracing

    f. Isolation Support and Compliance

86. By mid-December 2020, changes from the improvement plan started in mid-October 2020 had resulted in **(BD3/84 - INQ000565571)**:

    a. the proportion of positive cases successfully reached rising from 81.9% to 86.6%

    b. the proportion of positive cases reached within 24 hours rising from 58.2% to 74.9%

c. the proportion of contacts successfully reached rising from 60.1% to 92.7%

d. the proportion of contacts reached within 24 hours rising from 63.3% to 97.3%

De-duplication of Contact Tracing for Households

87. On 16 November 2020, ministers received a submission on the de-duplication of contact tracing in households **(BD3/85 - INQ000565558; BD3/86 - INQ000593064)**. Contact tracing policy up to that point was that positive cases and their contacts were contacted individually to notify them to self-isolate and advise them of financial support. Positive cases often listed members of their households as contacts, including children, which meant multiple contact tracing calls to the same households. This was leading to negative feedback. The submission recommended that when a positive case provided details of their recent contacts, then these conditions would apply:

    a. If their household contacts included children under 18 for whom they were a parent or guardian, they would be informed that it was their responsibility to ensure those children self-isolated.

    b. For other adults in the household where the positive case had told those adults to self-isolate or would do so in the next 24 hours, no follow up calls would be made. Each household contact would still get an email/SMS or, where no method of digital communication was available, a physical letter to ensure that the legal duty to notify was met.

88. The Secretary of State agreed with the submission and the new policy went live operationally shortly afterwards **(BD3/87 - INQ000565559)**.

Increasing Capacity to Meet Demand from Community Testing

89. As outlined in paragraphs 180 to 199 of Statement B, the introduction of community testing in the winter of 2020 meant projected increases in demand for contact tracing from around 20,000 to 40,000 cases per day **(BD3/84 - INQ000565571)**. A number of service improvement initiatives across December 2020 and January 2021 were predicted to increase contact tracing capacity by 13,000 to 15,000 cases per day to meet this demand. Initiatives included:

a. removal of household duplication (as covered above in paragraphs 87 to 88) – grouping citizens within a household

b. improvements to supplier productivity and performance management

c. multi skilling agents – creation of a flexible workforce with the ability to deploy against the highest volumes

d. enhanced call centre technologies to improve efficiency

e. improvements to the digital self-service journey, including resolving stability issues

f. streamlining Tier 3 call scripts to improve efficiency

90. Alongside these service improvements, a further 4,000 Tier 3 contact tracing agents were introduced **(BD3/84 - INQ000565571)**. Following the change in the self-isolation period for contacts from 14 to 10 days introduced on 14 December 2020 (as covered below in paragraphs 238-239), there was also a reduction in the number of follow-up calls made to contacts. This was in line with a trial conducted by the on the frequency of follow-up calls and compliance with self-isolation.

Collaboration with Local Authorities

91. The balance between centralised, regional and local approaches to contract tracing continued to be a consideration as the service developed. When COVID-19 case numbers were small, contact tracing was conducted within existing public health structures and systems and followed existing guidance and protocols for managing high consequence infectious diseases. However, as case numbers increased, the existing contact tracing workforce, resources and systems were not able to handle this increase in demand.

92. The government decided that setting up a largely central contact tracing service, overseen by NHS T&T, alongside the continuing role of health protection teams and local authorities in tracing contacts in complex or high-risk settings and major local outbreaks, was the most effective and reliable way of standing up contact tracing capacity at the scale and pace needed in May 2020.

93. In September 2020, the Department finalised a retrospective business case for NHS T&T and its associated expenditure in 2020-21, confirming the basis for the chosen option of having established NHS T&T. The business case explained that the Department had judged that other potential options did not meet the criteria of demonstrably reducing COVID-19 transmission, feasibility, value for money and economic impact (that is, reducing the need for national restrictions on daily life). This included an option to deliver testing and tracing locally, coordinated by NHS trusts and local authorities. The business case noted that this option was not considered value for money because of a high risk of duplicated effort, in addition to lower economies of scale compared with the national scheme. It also considered that local variation in service quality would mean an insufficiently high impact on transmission across the UK **(BD3/88 - INQ000595349)**.

94. Following its launch, NHS T&T seconded representatives from local government to its Executive Committee and set up several channels to engage with local government, including exploring how best to involve local authorities in the further development of contact tracing.

Local Outbreak Management Plans and the Contain Framework

95. In June 2020, the government allocated £300 million to local authorities in England to develop local outbreak management plans to implement measures to identify and contain COVID-19 outbreaks **(BD3/89 - INQ000546919)**. This funding was initially under the Test and Trace Support Service Grant, subsequently renamed the Contain Outbreak Management Fund. As part of this, all upper tier local authorities (UTLAs), given their statutory responsibilities for public health, published local outbreak management plans. Given the devolved responsibilities for testing and tracing in Scotland, Wales and Northern Ireland, the Contain Outbreak Management Fund applied only to local authorities in England.

96. Development of local outbreak management plans was led by directors of public health, on behalf of UTLAs. The plans were regularly reviewed in collaboration with the local NHS, employers, voluntary organisations and other community partners, linking into the work of local resilience forums, integrated care systems, combined authorities and directly elected Mayors as appropriate. All 152 UTLAs published local outbreak management plans **(BD3/77 - INQ000527961)**.

97. In July 2020, the government published the COVID-19 contain framework (also covered in paragraphs 182 to 184 of Statement B in relation to testing), the blueprint for how NHS T&T would work in partnership with local authorities, the NHS, local business, community partners and the wider public to take action against outbreaks **(BD3/90 - INQ000053606; BD3/91 - INQ000075721)**. Ministers were accountable nationally, as set out in the Prime Minister's statement on 3 July 2020, for setting this framework and for oversight and intervention where necessary **(BD3/92 - INQ000234406)**.

98. The Contain team in NHS T&T, together with Joint Biosecurity Council (JBC) and PHE colleagues, engaged with local authorities through regional partnership teams to ensure their views were part of decisions about testing, contact tracing and other interventions to help prevent, manage, and contain local outbreaks.

99. The Contain team met regularly with a range of local leaders to share information and intelligence through several platforms which they either hosted or attended. The Local Government Association hosted the Local Outbreak Advisory Board which was attended by nominated local councillors, and SOLACE hosted the Chief Executives Sounding Board which was attended by chief executives representing each region of the country.

100. The Contain team also convened a regular webinar to which the chief executives of all UTLAs and lower tier local authorities (LTLAs) (district councils) were invited. This provided an opportunity for chief executives to raise any concerns and share learning with a wide group of their peers.

Local Tracing Partnerships

101. On 10 August 2020, local tracing partnerships were announced **(BD3/93 - INQ000593051)**. These partnerships involved local staff on the ground working with a dedicated team of contact tracers from NHS T&T. If the dedicated NHS T&T team was unable to make contact within 24 hours with a local resident who had tested positive for COVID-19, the case was referred to the local contact tracing service.

102. The number of Tier 3 contact tracers was reduced from 18,000 to 12,000, and some national staff worked in teams linked to local authorities. This reduction in the size of the Tier 3 tracing team was designed to provide better value for money whilst maintaining resilience in the service so that capacity could be ramped up if needed **(BD3/94 - INQ000593050)**.

103. Calderdale was one of the first local tracing partnerships to be set up in July 2020 and illustrates how local contact tracing could help reach additional cases. In September 2021, Calderdale local contact tracing service received details of 213 local residents who had tested positive and who could not be reached by the national tracing service within 24 hours **(BD3/95 - INQ000565591)**. Of the 213, 86% were contacted by local contact tracers and invited to share details of their recent contacts, 9% could not be reached, 4% refused to provide details and one person had died **(BD3/96 - INQ000565550)**. The local team then passed back to NHS T&T the details of these people's contacts so that they could be contacted and advised to self-isolate. Local partnerships eventually expanded to 300 local tracing partnerships schemes. More information on the different partnerships can be found in these case studies: **(BD3/97 - INQ000593103)**.

104. The Technical Report mentioned above at paragraph 15 refers to an evaluation of local tracing partnerships, which is exhibited here. The evaluation explains that the introduction of the local authority teams had a small positive impact, but the effectiveness and timeliness of local contact tracing varied. The evaluation was not conducted by the Department, but by the MRC Biostatistics Unit at the University of Cambridge and Public Health England, and so the Department refers the Inquiry to the source for the further information they seek on the study's remit and sources used **(BD/98 - INQ000543905).**

Contact Tracing in High Risk and Complex Settings

105. Under protocols established by PHE, Tier 2 contact tracers referred more complex cases to Tier 1 tracing teams made up of public health experts in health protection teams and field service teams, working in partnership with local authorities. This included positive cases who worked in, lived in or had recently visited healthcare settings, care homes, prisons, homeless hostels or schools, where it could be difficult to establish the levels of contact or where there was a risk of vulnerable people having been exposed to COVID-19, as well as contact tracing for elite sports. Tier 1 teams also received notifications of any settings that required further investigation, for example where there was a cluster of positive cases and worked directly with those settings to carry out risk assessments and reduce risks. They contacted positive cases to obtain additional information about the setting and who they were in close contact with, to inform decisions on how best to limit the onward spread of the virus **(BD3/99 - INQ000593030)**.

106. On 27 November 2020, the Department for Education (DfE) published the Contingency Framework **(BD3/100 - INQ000565564)** guidance on measures that education and childcare settings should introduce to manage COVID-19 risk in these settings. This was shared with the Department for comments and clearance on 16 August 2020 **(BD3/101 - INQ000565607)** and was agreed by COVID-O on 24 November 2020 **(BD3/102 - INQ000565562; (BD/103 - INQ000090951); BD3/104 - INQ000565563)**.

107. The Contingency Framework set out the principles for managing local outbreaks of COVID-19 in education and childcare settings. It included information on measures that settings should be prepared for, including testing, contact tracing and self-isolation. The guidance advised education and childcare settings to review their plans for managing COVID-19, outlining how they would operate if any of the measures described within the contingency framework needed to be introduced. This guidance was updated throughout the pandemic to reflect the latest public health advice with the last update being on 24 February 2022 following the government's publication of the 'Living with COVID-19' guidance on 21 February 2022.

NHS COVID-19 App

108. Whilst I have provided as much information as possible below in relation to the development of the NHS Covid-19 app, I direct the Inquiry to UKHSA for further information, including on the impact and efficacy of the app and how its impact was assessed and monitored, as well as the 'pingdemic', as it took over responsibility for the app from October 2021 until decommissioning it in April 2023. App-specific data, such as exposure notifications, usage statistics, and epidemiological outputs, were collected, stored and analysed initially by NHSX and then by UKHSA. The Department does not hold the necessary data to address technical or operational questions about the app's efficacy or impact.

109. The contact tracing app initially developed by NHSX was designed to supplement traditional forms of contact tracing and extend the reach of contact tracing to include people not known to the person testing positive **(BD3/105 - INQ000237570)**.

110. In early March 2020, NHS Digital was tasked to develop a method of identifying vulnerable people who might need to self-isolate to reduce their chances of exposure to

COVID-19 **(BD3/106 - INQ000564674)**. The aim of the proposed app, as set out at the first meeting of the COVID-19 Contact Tracing Board, was to:

a. make personal recommendations to people on their recommended degree of self-isolation based on who they had been near

b. generate data for use by NHS planners and epidemiologists **(BD3/107 - INQ000564685; BD3/108 - INQ000564686)**

111. There were 2 versions of the app: the initial version developed by VMware Pivotal Labs ("VMware"), with support from Zühlke Engineering because NHSX did not have in-house development capacity, which was piloted on the Isle of Wight in May 2020, and the Google/Apple version that was rolled out in September 2020.

112. The initial app developed by NHSX was a centralised model (that is, the data was held centrally by the government as the 'owner' of the app) whereas the Google/Apple app was decentralised (that is, the data was held on the user's phone).

113. Development of the initial app by VMware took place between March 2020 and June 2020. The Department decided to switch to the Google/Apple version of the app, following a recommendation from the NHSX CEO Matthew Gould based on extensive testing between the 2 versions. Testing of the Google/Amazon version had been continuing whilst the initial version was being trialled.

114. The Isle of Wight was chosen to conduct a pilot of the initial app, because it has a single NHS trust that covers all NHS services on the island and its circumscribed geography as an island with a sizeable population made it an ideal place to introduce the app and wider testing service in the pilot period. The app was initially made available to council and NHS workers before being rolled out to the entire population on the island shortly afterwards. An evaluation report of the pilot was published in April 2021: 'NHS COVID-19 app: Isle of Wight pilot evaluation report' **(BD3/109 - INQ000533166)**. The pilot highlighted problems with the use of the app on incompatible and older operating systems, which precipitated the move to the Google/Apple version.

Second Version

115. On 18 June 2020, the government announced the next phase of development in building the NHS COVID-19 app, bringing together the work undertaken by NHSX with the

Google/Apple framework to create an app that would enable anyone with a smartphone to engage with every aspect of the NHS Test and Trace service, from ordering a test through to accessing the right guidance and advice.

116. The app was designed to allow citizens to:

    a. identify symptoms, seamlessly order a test and, if they needed to self-isolate, feel supported during the period of self-isolation

    b. scan the unique QR codes of venues they had visited to aid in contacting and tracing individuals to prevent the spread of the virus

    c. quickly identify when they had been exposed to people who had COVID-19 or locations that may have been the source of multiple infections

117. The app was built using the Google/Apple application programming interface (API) and a Quick Response (QR) code system, both of which were based on a decentralised model designed to ensure the highest standards of data privacy and data security **(BD3/110 - INQ000593043)**.

118. The app used Bluetooth processing algorithms to log nearby app users, measuring both their degree of proximity and the duration of that proximity. Where a user recorded a positive COVID-19 test result, the app used those logs to alert other app users who were most likely to have been exposed to SARS-CoV-2 during the period in which the person testing positive was likely to have been infectious. Those other app users then received an alert advising them to self-isolate for a specified period and a timer to count down the self-isolation period **(BD3/111 - INQ000593033)**.

119. In the policy paper published on 30 July 2020, NHS T&T indicated that it would shortly release an initial version of the app to a selected group of users and gather rapid feedback on user experience **(BD3/77 - INQ000527961)**. Testing of the app by NHS volunteer responders, and selected residents of the Isle of Wight and the London Borough of Newham began in mid-August 2020 **(BD3/112 - INQ000593052)**.

120. The policy paper of 30 July 2020 explained that NHS T&T would then further develop and roll out the app, based on user experience and testing to create more targeted advice and support for users. To promote mass adoption, it would work with the public, business and public services to reach as high a proportion as possible of smartphone users, with a

strong focus on building trust and coverage in communities that were at greater risk from COVID-19 and/or less likely to engage with the standard NHS T&T service.

121. The NHS COVID-19 app was launched on 24 September 2020 **(BD3/105 - INQ000237570)**, supported by a major campaign to encourage downloads of the app with an advertisement on primetime TV with the strapline: *'Protect your loved ones. Get the app'*.

122. The app was downloaded on 21 million unique mobile devices and used by at least 20 million citizens at its peak in late 2020. The total download figures are given below in paragraph 133 **(BD3/113 - INQ000565628)**.

123. The NHS COVID-19 app continued to run after the widespread lifting of restrictions announced in the 'Living with COVID-19' plan in February 2022 (detailed below in paragraphs 145 to 148). This was so it could act as a contingency measure in the event of a new variant requiring a quickly scalable response. In June 2022 it still had approximately 11 million users who could still check symptoms, log test results, and receive warn and inform contact notifications with health advice **(BD3/114 - INQ000593101; BD3/115 - INQ000593102)**.

124. The NHS COVID-19 app was decommissioned on 27 April 2023 **(BD3/116 - INQ000593104)**.

Impact of the NHS COVID-19 App

125. Analysis published in Nature in May 2021 estimated that the NHS COVID-19 app prevented around 600,000 cases of COVID-19 between September 2020 and January 2021 alone and that, for every 1% increase in app users, the number of coronavirus cases in the population could be reduced by 2.3% **(BD3/117 - INQ000562944)**. Further research published in February 2023 in Nature by scientists at the University of Oxford and University of Warwick estimated that the app prevented around 1 million cases and 44,000 hospitalisations and saved 9,600 lives during its first year alone **(BD3/118 - INQ000561521)**.

126. Analysis from the University of Oxford's Pathogen Dynamics Group at the Big Data Institute showed that, in the first 3 weeks of July 2021, the app averted up to 2,000 cases per day and reduced the spread of COVID-19 by around 4.3% each week.

Engagement with Devolved Administrations

127. Interoperability with the devolved administrations was discussed at an early stage. Wales chose to join with England in adopting the NHS COVID-19 app while Scotland chose to develop its own contact tracing app. Northern Ireland joined with the Republic of Ireland in adopting a test and trace application. The NHS COVID-19 app was interoperable with the Northern Irish StopCOVIDNI app because it was also based on the Google/Apple system and became interoperable with the Protect Scotland app in November 2020.

Costs

128. As of June 2020, the total cost of the NHS COVID-19 app pilot stood at £10.8 million **(BD3/119 – INQ000593057)**. Figures widely quoted in the media were based on the contracts published on platforms such as Contracts Finder rather than government publications confirming the actual cost.

129. While the Department has provided as much information as possible in relation to the costings of the NHS COVID-19 App, the Department directs the inquiry to UKHSA for further information on costs.

Privacy

130. At every stage of development of the COVID-19 App, consideration was given to privacy concerns. This included:

    a. the establishment of an Ethics Advisory Board, chaired by Professor Sir Jonathan Montgomery of University College London, when developing the initial app to provide independent and constructive challenge to the development and rollout of a contact tracing application **(BD3/120 - INQ000564700; BD3/121 - INQ000564701)**

    b. an ICO 'Opinion' produced on the Google/Apple proposal on 17 April 2020 **(BD3/122 - INQ000571266)**

    c. the Information Commissioner's Office (ICO) 1 May 2020 paper, 'COVID-19 Contact tracing: data protection expectations on app development' (provided as part of a submission to the Joint Committee on Human Rights)

131. Consideration was also given to those who did not want to or could not use the NHS COVID-19 App. Because of the privacy and anonymity built into the app, the NHS T&T service did not know whether someone with a reported positive test result was an app user: app users and non-app users were treated in an identical way by the NHS T&T service, with the service in either case contacting anyone for whom they received a positive test result notification and asking them to share information about their recent contacts. In this way, the app supplemented but did not in any way replace standard contact tracing systems. Inequalities were considered throughout the development of the NHS COVID-19 App and addressed where possible, for example the option to choose to use the app in a number of languages. Paragraphs 136 to 151 of Statement D provide further information about how inequalities were identified and mitigated in the development of the app.

132. The Inquiry has asked what was meant by the reference, *"NHSX developing back-end for data to flow and onto App"* in the Department's COVID-19 battleplan **(BD3/123 - INQ000106280)**. The 'backend' of the initial NHS COVID-19 app (the centralised version) was what saved and managed data (as, for example, with any website: the 'frontend' is what the user of a website sees, whilst the 'backend' stores data about the user, like their profile) and the reference in the battleplan is simply to that aspect of the app being developed in late March 2020.

Usage

133. There were 30,431,376 app downloads between 13 August 2020 and 2 March 2022 **(BD3/113 - INQ000565628)**.

134. The Department is not able to provide any demographic data for those who downloaded the app. Because of privacy protections, users were not asked to provide any demographic data and so the Department does not hold information on who was using the app and for how long.

Role of Contact Tracing in the Roadmap Out of Lockdown

135. In September 2020, a variant detected in Kent (later called the Alpha variant – B.1.1.7) emerged, which was far more transmissible than previous detected strains of COVID-19. Due to rising case and hospital rates, a second national lockdown was announced on 31

October 2020 and began on 5 November 2020. The national lockdown ended on 26 November 2020, to be replaced by local restrictions based on a system of 'tiers' across England, as covered in more detail in Section 4. On 4 January 2021, the Prime Minister announced the third national lockdown. On 22 February 2021, the 'Roadmap out of Lockdown' was published.

136. The Roadmap Out of Lockdown set out how the government intended to cautiously ease lockdown restrictions in England, supported by the increased protection offered by COVID-19 vaccines, which had started to be administered in December 2020. The roadmap followed 4 steps, beginning with the reopening of schools, followed by the easing of outdoor social and business restrictions, the reopening of indoor venues, and finally the removal of most legal restrictions **(BD3/124 - INQ000234765**). Continued use of testing, contact tracing and self-isolation was designed to support this gradual easing of social and economic restrictions by helping to control the rate of reproduction of the virus.

137. Ongoing use of testing and contact tracing was also designed to play a key role in identifying and responding to local outbreaks and variants of concern, as outlined in the 'managing local outbreaks, enduring transmission, and variants' paper for a COVID-O meeting on 9 March 2021 **(BD3/125 - INQ000119942; BD3/126 - INQ000565587)**. To tackle the threat posed by new variants, an updated contain framework **(BD3/127 - INQ000593082)** was released in mid-March 2021. In parallel, local authorities were asked to revisit their local outbreak management plans **(BD3/128 - INQ000565586)** and consider the challenges of the next period, including enduring transmission and variants of concern. NHS T&T national and regional teams continued to work with local areas in outbreaks relating to settings of national significance.

138. As part of this wider strategy for outbreak management, NHS T&T strengthened the approach to contact tracing by partnering with local authorities, based on successful 'Local-0' pilots in 26 areas. The approach was designed to reach 90% of all COVID-19 cases through quicker contact tracing at a local level **(BD3/129 - INQ000565598; BD3/130 - INQ000593089)**. NHS T&T also rolled out a new JBC analytical tool to support early identification and prioritisation of clusters **(BD3/128 - INQ000565586)**.

139. NHS T&T also introduced new systems to provide 'surge' contact tracing in response to local outbreaks or new variants of concern. Work on responding to new variants had shown the value of having dedicated contact tracing cells, as part of national contact

tracing teams, that could be deployed to support local authorities in responding to specific outbreaks or variants. NHS T&T introduced call-off contracts to allow it to support local authorities with additional surge capacity at less than 24 hours' notice. It also made plans to expand surge capacity in COVID-19 regional partnership teams, which acted as a bridge between local authorities and national teams, working collaboratively with local areas to support outbreak management and, where necessary, escalating issues and risks to national level **(BD3/125 - INQ000119942)**.

140. Tackling areas of enduring transmission was identified as a challenge that might require additional support for local authorities. This was because failure to tackle enduring transmission would increase inequalities in more vulnerable communities and because areas with high rates of prevalence were more susceptible to variants emerging. On 4 March 2021, this was discussed at COVID-O **(BD3/131 - INQ000092380)**. On 7 May 2021, SAGE published a paper, considered at its meeting on 22 April 2021, 'Risk factors associated with places of enduring prevalence and potential approaches to monitor changes in this local prevalence' **(BD3/132 - INQ000593087; BD3/133 - INQ000189700)**. COVID-O discussed enduring transmission again on 28 April 2021. Pilots were run in local authorities with behavioural experts, and monitored by a group of Departmental, MHCLG and His Majesty's Treasury (HMT) officials, to evaluate a series of highly targeted new approaches to tackle enduring transmission.

141. As set out more fully in Section 3 below, the government announced on 6 July 2021 that, as part of Step 4 of its COVID-19 Roadmap and as a result of the success of the UK's vaccine programme, people who were fully vaccinated or aged under 18 would, from 16 August 2021, no longer have to self-isolate **(BD3/134 - INQ000565606)**. This significantly altered the nature of contact tracing, because in most cases contacts no longer needed to be instructed to self-isolate. It did not, however, remove the rationale for contact tracing because:

    a. it was still considered important to contact positive cases, regardless of age or vaccination status, to help ensure that they completed the self-isolation period and to check whether they needed support to do this, to determine who they might have been in contact with and to establish how and where they might have been infected

    b. adult contacts who were not fully vaccinated (and not exempt on any other grounds) were still under a legal duty to self-isolate and it was not possible to

establish whether they met the relevant exemptions until after they had been traced

c. for those contacts who were fully vaccinated or exempt on other grounds, the contact tracing service was able to reinforce the importance of taking a PCR test and self-isolating if the result was positive, as well as following other precautions to help limit the spread of COVID-19 (such as wearing a face mask in enclosed spaces) and reduce risk to vulnerable people

142. Both the standard tracing processes used by NHS T&T and the NHS COVID-19 app were adapted to reflect this revised public health guidance for fully vaccinated contacts and those aged under 18. Sometimes it took longer to update the app to reflect new policy because of the time needed to 're-programme', test and release an update. The government's 'COVID-19 Response: Autumn and Winter Plan 2021' confirmed that contact tracing would continue through the autumn and winter of 2021 **(BD3/135 - INQ000065168)**.

143. Local authorities continued to play a key role in contact tracing, with over 300 local tracing partnerships by then in operation. Some local authorities also adopted the 'Local - 4' approach, under which local tracing partnerships took responsibility for contacting positive cases as soon as a 4-hour window for 'self-completion' (that is, the positive case sharing their details via the online tracing system) had elapsed, as opposed to taking responsibility only for those positive cases whom national tracing teams had not been able to reach within 24 hours.

144. Some local authorities experienced capacity issues with local tracing due to high case rates. NHS T&T worked with those local authorities to help prioritise cases by postcode area, give them more flexibility in deciding which cases came to them first and providing tools to help set local capacity limits **(BD3/91 - INQ000075721)**. This was a further example of how national and local tracing teams were able to work in partnership to make effective use of their combined capacity and resources.

Living with COVID

145. By 16 February 2022, 91% of the population over 12 years old had received a first dose of a COVID-19 vaccine, 85% had received a second dose and 66% had received a

booster. SAGE future scenarios predicted a longer-term stable position would be reached.

146. The government's 'Living with Covid Plan' published on 22 February 2022 set out how, following the Omicron variant in December 2021 (which had driven prevalence of the virus to an unprecedented high), adherence to Plan B, wider behaviour changes and large-scale testing had slowed growth in transmission sufficiently to buy time for the extended booster campaign. The plan set out how, based on the success of the vaccine programme and the future outlook for the course of the pandemic, the government's objective in the next phase of the response was to manage COVID-19 like other respiratory illnesses, while minimising mortality and retaining the ability to respond if a new variant emerged with more dangerous properties than the Omicron variant, or during periods of waning immunity, that could put the NHS under unsustainable pressure. To meet this objective, the government removed most remaining domestic restrictions, including removing the legal requirement to self-isolate following a positive test and the legal requirement for unvaccinated adult contacts to self-isolate. These changes meant that routine contact tracing was no longer needed **(BD3/136 - INQ000565617)**.

147. For these reasons, routine contact tracing ended on 24 February 2022. Guidance instead set out precautions that contacts could take to reduce risk to themselves and other people – and those testing positive for COVID-19 were encouraged to inform their close contacts so that they could follow that guidance.

148. As outlined above in paragraphs 108 to 134, the NHS COVID-19 app was adapted to reflect these changes in policy and continued in a modified form until it was closed on 27 April 2023.

SECTION 2: SELF-ISOLATION AND QUARANTINE

149. Self-isolation was a significant component of the government's response to the COVID-19 pandemic, as one of the most effective ways of limiting COVID-19 transmission was for people to avoid close contact with others if they had symptoms of COVID-19, if they had tested positive for COVID-19 or if, by virtue of close recent contact with a positive case or inbound travel from certain countries outside the UK, they were at heightened risk of having been infected with COVID-19. This section of the statement describes how the Department was involved in decisions around self-isolation and quarantine in

England. It describes changes in self-isolation and quarantine rules throughout the pandemic, and engagement with stakeholders and the devolved administrations. Section 3 covers support for those self-isolating.

150. Self-isolation policies were informed by expert public health advice, supported by scientific research. Ministers agreed to changes in self-isolation policy based on clinical advice from the 4 UK CMOs as covered in paragraphs 176 to 206. This was in turn underpinned by advice and modelling from scientific advisory groups, such as SAGE.

151. Although self-isolation policy was devolved in Scotland, Wales and Northern Ireland, the 4 UK countries generally applied the same policies on the self-isolation periods for people with COVID-19 symptoms, those who tested positive and contacts of positive cases. From August 2021 onwards, there were some differences in the guidance for fully vaccinated contacts of positive cases, as set out in paragraph 256 below.

152. The terms "isolation", "self-isolation" and "quarantine" can all be used to describe arrangements whereby people who are at risk of infecting others remain in a given place, typically their home or a designated facility, to avoid contact with other people. While the terms are sometimes used interchangeably, the term "quarantine" is generally used to describe the process of isolating individuals in a particular facility. For example, as described later in this section, at the start of the COVID-19 pandemic, people who were returning from at-risk areas (such as Wuhan) were required to isolate or "quarantine" in particular facilities. For instance, inbound travellers were isolated at Arrowe Park following flights from Wuhan in January 2020 and after being evacuated from the Diamond Princess cruise ship in February 2020. Later in the pandemic, the Managed Quarantine Service arranged for people to isolate in designated hotel facilities if they had travelled from a red-list country.

153. The government and the NHS T&T service generally used the term "quarantine" to refer to isolating someone in a designated facility and the term "self-isolation" to describe the situation in which an individual was asked or instructed to stay at home for a specified period to avoid contact with people outside their household, whilst also – as far as possible – avoiding close contact with other people within their household. This statement uses those terms in the same way.

154. The 3 main scenarios in which self-isolation was advised or instructed were where:

a. an individual or a member of their household had symptoms of COVID-19

b. an individual or another member of their household tested positive for COVID-19, including situations where they had taken a test without having had symptoms ('asymptomatic testing') and were therefore unlikely to have been self-isolating up to that point

c. an individual had had close recent contact with someone outside their household who had tested positive for COVID-19

155. As this section describes, the conditions in which individuals isolated or quarantined changed over the course of the pandemic, with guidance and regulations updated to respond to a range of factors, including developments in clinical understanding of the virus, people's behavioural responses, the development of vaccines, advances in testing technology, and government decisions on how best to protect lives whilst simultaneously promoting economic and social recovery. Testing capacity also had an important bearing on self-isolation, both in enabling people with COVID-19 symptoms (and other members of their household) to stop self-isolating if they had a negative test result and, when combined with tracing capacity, in enabling close contacts to be asked or instructed to self-isolate (if they were not already doing so). This section also describes these interdependencies.

156. For certain periods of the pandemic, self-isolation was mandatory for people with a positive COVID-19 test result and their contacts, where they received a notification to self-isolate from NHS T&T, PHE or a local authority (but not including notifications from the NHS COVID-19 app).

157. The Health Protection (Coronavirus) Regulations 2020, which came into force on 10 February 2020, enabled the imposition of proportionate restrictions to isolate people who were believed to be infected with COVID-19 to reduce or remove the risk of them infecting others.

158. From 28 September 2020 when the Health Protection (Coronavirus, Restrictions) (Self-Isolation) (England) Regulations 2020 came until force until 24 February 2022, there was a legal duty for individuals to self-isolate, with some limited exemptions, if they were notified to do so following a positive COVID-19 test result. From 28 September 2020 close contacts of positive cases were also legally required to self-isolate, with some limited

exemptions, if notified of the requirement to do so. From 16 August 2021, close contacts who were fully vaccinated, aged under 18 or subject to other exemptions were no longer legally required to self-isolate; for other close contacts, the legal requirement to self-isolate continued until 24 February 2022. This section explains these policies in more detail.

Purpose of Isolation and Quarantine

159. Isolation, in a clinical context, refers to the practice of separating individuals who are either infected or suspected of being infected with a contagious disease from those who are not infected. It is a critical measure in managing the spread of infectious diseases, particularly HCIDs, by breaking transmission chains and protecting vulnerable populations.

Isolation Policies Prior to the Pandemic

160. Prior to the COVID-19 pandemic, responsibility for managing HCID outbreaks lay primarily with PHE **(BD3/137 - INQ000090352)**. As outlined in Section 1, the Department commissioned pandemic preparedness exercises to improve planning and resilience response to a large-scale outbreak of MERS-CoV. Following Exercise Alice, which was carried out by PHE on 15 February 2016, supported by the Department and NHSE, PHE produced a high-level paper, setting out options for self-isolation/quarantine **(BD3/5 - INQ000113294).**

161. Prior to the pandemic, NHSE had 2 specialist High-Level Isolation Units and 5 specialist airborne HCID centres to isolate suspected cases of HCIDs. HCIDs are rare in the UK but, when they occur, they are often caused by travel to areas where recent disease outbreaks have occurred. Examples of this include Mpox and Ebola.

162. NHSE prepared health isolation facilities and managed quarantine hotels in anticipation of those required to isolate in 2018 during the Ebola outbreak in the Democratic Republic of Congo. The UK hospital isolation facilities available in 2019 **(BD3/138 - INQ000593004)** were:

    a. High Level Isolation Units: specialised facilities at the Royal Free Hospital in London and Royal Victoria Infirmary in Newcastle, designed for HCIDs, with 2 commissioned beds each

b. Surge Facilities: additional isolation capabilities available within Sheffield Teaching Hospitals, Liverpool Teaching Hospitals, the Royal Free Hospital and the Royal Victoria Infirmary, which were activated when high-level units reached capacity

Isolation Policy Early in the Pandemic

163. From the very early stages of the COVID-19 pandemic, there were plans to isolate those who might have come into contact with the virus. In January 2020, Arrowe Park Hospital in the Wirral was identified by Stephen Groves, National Head of EPRR, as a quarantine facility for British nationals evacuated from China **(BD3/139 - INQ000527875)**.

164. PHE published guidance classifying the novel coronavirus as a HCID on 16 January 2020 based on consideration of the UK HCID definition **(BD3/140 - INQ000565597)**. On 13 March 2020, UK public health agencies declassified COVID-19 as a HCID, following advice from the Advisory Committee on Dangerous Pathogens **(BD3/141 - INQ000565504; BD3/142 - INQ000115534)**, meaning that individuals with COVID-19 infections or suspected infections were no longer managed only by HCID treatment centres **(BD3/143 - INQ000106267)**.

165. On 22 January 2020, before the first cases were formally identified in the UK and when knowledge about the virus was still very limited, SAGE held a precautionary meeting. SAGE agreed that, while incubation periods for the virus had not yet been clarified, it was reasonable to advise that individuals returning from Wuhan were no longer at risk if they did not show symptoms within 14 days. This was based on lessons learned from MERS and SARS **(BD3/144 - INQ000106049)**.

166. On 7 February 2020, the Foreign and Commonwealth Office (FCO) updated travel advice on GOV.UK on travel to and from China, to include guidance to self-isolate. The new guidance advised that anyone returning to the UK from Wuhan in the preceding 14 days was to stay indoors and avoid contact with other people for 14 days from the date of their return. They were also advised to call NHS 111, even if they did not have symptoms **(BD3/145 - INQ000527874)**.

167. Repatriation flights from Wuhan began on 31 January 2020, with individuals quarantining for 14 days at a designated facility. 83 UK nationals and 27 non-UK nationals returned to

the UK as part of the repatriation flight from Wuhan. None of the individuals in quarantine at Arrowe Park at this time had symptoms **(BD3/146 - INQ000527876)**.

168. The Department's Operational Response Centre (ORC) worked closely with NHSE to coordinate the reception of the repatriated individuals. This included working with the Ministry of Defence (MoD) to coordinate airfields for the flight to land in the UK as well as the coordination of patient transport between the airfield and the supported isolation location. Individuals were allowed to travel on the plane back to the UK on the condition that they would enter into voluntary self-isolation provided by the government **(BD3/147 - INQ000106074; BD3/148 - INQ000106075)**.

169. On 28 January 2020, the Department's Director of Emergency Preparedness and Health Protection shared a First Case Protocol with the Cabinet Office, No.10 and other cross-government colleagues that outlined the steps and organisations involved in the management of the first COVID-19 case. Following a clinical and public health assessment, a decision would be made on whether to move the patient to a HCID **(BD3/33 - INQ000106072; BD3/34 - INQ000106073)**. The decision would depend on the risk to wider public health, the patient's clinical condition and local capacity. If the patient was not admitted to a HCID, NHSE and PHE would establish a support plan for the patient's care at home.

170. The first 2 cases of COVID-19 were announced in the UK on 31 January 2020 **(BD3/149 - INQ000106083)**. The patients were transferred to a HCID unit **(BD3/150 - INQ000565497)**.

171. On 7 February 2020, PHE's self-isolation guidance was expanded to departure from countries other than China, with returning travellers asked to self-isolate if they developed symptoms **(BD3/151 - INQ000527880)**.

172. On 10 February 2020, the Secretary of State made regulations (the Health Protection (Coronavirus) Regulations 2020) which enabled the Department or a registered public health consultant to impose requirements for individuals to be detained in a designated facility if there were reasonable grounds to believe they might have COVID-19 or they had travelled to England from a designated "infected area" outside the UK. ORC was the lead team in the Department responsible for the development and implementation of this legislation.

173. In February 2020, the Arrowe Park facility was used for the quarantine of 30 British nationals and 2 Irish citizens who were evacuated from a cruise ship in Japan **(BD3/152 - INQ000049449)**.

174. On both 11 and 18 February 2020, SAGE met and reiterated the advice that the 14-day self-isolation period stood **(BD3/41 - INQ000075784; BD3/44 - INQ000106114)**, agreeing that, based on current data, this seemed reasonable. On 18 February 2020, SAGE noted that it was difficult to reach definitive conclusions, given the small number of cases.

175. As of 26 February 2020, following the significant surge in cases in Italy from mid to late February 2020, people entering the UK from locked down regions in Italy were asked to self-isolate for 14 days if they had symptoms **(BD3/153 - INQ000593008)**.

Enforcing Isolation Early in the Pandemic

176. As outlined above, early isolation included the repatriation of UK nationals to isolation facilities and the early quarantining of first cases in HCID units. Initially it was the Public Health (Control of Disease) Act 1984 (the 1984 Act) which provided the legislative framework for quarantine.

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

178. The first 83 UK nationals and 27 non-UK nationals repatriated on 31 January 2020 were asked to sign an agreement that they would enter into voluntary self-isolation for 14 days. If an individual did not agree to self-isolate, the relevant local authority could apply for a Part 2A order to quarantine them. In practice, local authorities did not need to invoke these measures, as there was full compliance.

179. On 10 February 2020 the Health Protection (Coronavirus) Regulations 2020 were made by the Secretary of State and came into force on the same day. They enabled the Secretary of State or a registered public health consultant to impose a requirement to

detain a person for screening or isolation purposes where they had reasonable grounds to believe the person was, or might be, infected with COVID-19 and might infect others. The regulations also enabled a police constable, where proportionate, to detain an individual under certain circumstances and enforce restrictions. The regulations were made under the powers set out in sections 45B, 45C, 45F and 45P of the 1984 Act and developed by the Operational Response Centre in response to repatriations from Wuhan. They were revoked and superseded by the Coronavirus Act 2020 which gained Royal Assent on 25 March 2020.

Changes in Self-Isolation Policy

180. Throughout February 2020, the situation escalated globally, with the first lockdowns due to community transmission announced in Italy, and with cases in the UK rising from the first identified case on 29 January 2020 to 23 cases by 29 February 2020 **(BD3/154 - INQ000527892; BD3/155 - INQ000527893)**. With increased risk of community transmission, the government extended policy on self-isolation beyond those coming into the country from high-risk areas.

181. Throughout March 2020, with the situation changing rapidly, there was a period of intense policy review and work continued to understand the benefits and impacts of a range of NPIs to inform ministerial decision-making. As community transmission started to increase exponentially and emerging data was assessed, the Department's public health guidance was updated to reflect increased risk and/or new evidence.

182. A series of policy proposals in late February and early March 2020 were informed by and developed alongside a series of SAGE papers on the potential impact of 6 different NPIs, including household self-isolation for symptomatic cases. This advice was based on modelling scenarios from SPI-M-O, as well as SPI-B advice on behavioural considerations for each of the interventions. Note that these modelling scenarios were not forecasts or predictions, but indicative scenarios exploring the potential impact under a reasonable worst-case scenario and specific assumptions on adherence to and effectiveness of the policies. As such, and given the level of uncertainty in relation to these underpinning assumptions, the advice provided only broad insights rather than precise results.

183. On 24 February 2020, SPI-M-O met to discuss a paper from Imperial College that modelled 4 NPIs. These included self-isolation of symptomatic cases for 7 days and whole household self-isolation for 14 days, where a member of the household was symptomatic **(BD3/156 - INQ000527888; BD3/157 - INQ000527889; BD3/158 - INQ000383614)**.

184. SAGE considered the Imperial College paper on 25 February 2020, as part of a wider discussion on potential measures to reduce spread **(BD3/159 - INQ000087503; BD3/160 - INQ000527891)**. Following the meeting, the Government Office for Science (GO-Science), the secretariat for SAGE, commissioned SPI-M to develop a table summarising the potential effectiveness of NPIs, incorporating both SPI-M-O and SPI-B input **(BD3/161 - INQ000593007)**. On 26 February 2020, after a call between the Civil Contingencies Secretariat (CCS), GO-Science staff, the DCMO (Professor Sir Jonathan Van-Tam) and Departmental officials, CCS shared a draft of the SPI-M-O input table for the NPI table and asked the Department to scope potential impacts **(BD3/162 - INQ000565501; BD3/163 - INQ000593011)**. SPI-M-O discussed the NPI table at a meeting later that day **(BD3/164 - INQ000593009; BD3/165 - INQ000593010; BD3/166 - INQ000593012; BD3/167 - INQ000593013)**. On 27 February 2020, SAGE discussed a combined SPI-M-O/SPI-B NPI table (**BD3/168 - INQ000087326; BD3/169 - INQ000106129)**.

185. Further iterations of the SAGE paper on potential impact of interventions were produced and discussed at a number of SAGE meetings. On 3 March 2020, SAGE discussed an updated version of the paper (**BD3/170 - INQ000119719; BD3/171 - INQ000087584)** and provided advice on NPIs to COBR(O) in advance of its meeting on 4 March 2020 **(BD3/172 - INQ000593015; BD3/173 - INQ000279894)**, with a view to further discussing the optimal combination of interventions, point of enactment and duration of implementation at a subsequent SAGE meeting planned for 5 March 2020. At the COBR(O) meeting on 4 March, the CMO provided his view on the impact of NPIs on the health and care system.

186. On 4 March 2020, COBR met and discussed the NPIs covered in the paper including **(BD3/174 - INQ000056218; BD3/175 - INQ000056158)**:

    a. self-isolation of symptomatic cases for 7 days

    b. whole household self-isolation for 14 days where an individual in that household was symptomatic

187. On 4 March 2020, the CCS commissioned departments to set out the impacts, challenges and cross-government interdependencies for their sectors based on the interventions outlined in the paper. DHSC sent its return on 5 March 2020 highlighting a range of issues to consider across the proposed NPIs, including but not limited to financial impact, compliance and the stigma placed on certain groups in society **(BD3/176 - INQ000212693; BD3/177 - INQ000593016)**. At a meeting on 6 March 2020 **(BD3/178 - INQ000052373)**, the CCS commissioned the Department to:

a. set out for each of the 3 potential interventions ((i) self-isolation; (ii) household isolation; and (iii) social distancing for the elderly and susceptible) what each would require of the public in practice to facilitate assessment of impacts, covering in precise terms what people would be asked to do under each measure (e.g. stay at home; go to or not go to work; receive visitors; attend gatherings; visit the supermarket etc), informed by clinical assumptions made about what types of 'social contact' might lead to transmission

b. list and test the critical social interactions for over 65s with external experts, for example Age Concern

c. set out for the different options the scope of the measure (elderly cohorts and definition of susceptible/vulnerable groups)

d. finalise a comprehensive version of the behavioural and social intervention table setting out all of the assumptions made about compliance and effects of each measure and its variations (alongside PHE and GO Science)

e. confirm mortality numbers net of expected average mortality

f. liaise with departments (alongside SAGE), including HMT and BEIS, to ensure assumptions informing the Reasonable Worst Case Scenario staff absence figure of 20% held under each of the measures and different combinations of the measures (and if not, what alternative figures might be)

g. set out (alongside all departments), for each of the 3 potential interventions (or their variants) (a) its assessment of the policy and public service delivery impacts (b) mitigations for these, their effect and how they would be delivered.

188. The Department submitted a paper to the Cabinet Office on 6 March 2020, setting out detailed proposals for the 3 interventions **(BD3/179 - INQ000106157; BD3/180- INQ000106158)**. A follow up officials meeting convened by CCS took place on 8 March 2020.

Introduction of Seven-day Self-Isolation for Symptomatic People

189. On 9 March 2020, COBR discussed the updated Commonly Recognised Information Picture **(BD3/181 - INQ000106166)** on interventions moving to the Delay phase including 3 stages of intervention:

    a. self-isolation of symptomatic individuals

    b. whole household self-isolation where one individual was symptomatic

    c. social distancing measures to safeguard older and vulnerable individuals

190. The CMO advised that scientific advice supported early implementation of self-isolation for symptomatic individuals **(BD3/182 - INQ000056219)**. The Committee agreed to discuss again on 12 March 2020.

191. On 12 March 2020, officials briefed the Secretary of State on proposals for NPIs and the preparations underway to operationalise them, ahead of the COBR(M) meeting due to take place later that day **(BD/183- INQ000106197).** Based on advice from CMO, SAGE, and COBR(O), the briefing paper recommended implementing individual isolation in no more than 10 days, and household isolation and protective isolation within 1 to 3 weeks. It also outlined suggested methods of operationalising NPIs.

192. Following further discussions across government on NPIs, COBR discussed a package of recommended interventions at a meeting on 12 March 2020 **(BD3/184 - INQ000056221; BD3/185 - INQ000056209)**. The discussion was held in the context of an estimated 5,000-10,000 cases in the UK, which were considered likely to increase exponentially. The 4 recommended options were as follows:

    a. Individuals stay at home for 7 days from the point of displaying mild symptoms – to delay the peak.

b. All household members stay at home for 14 days from the point that any member of the household displays symptoms – to delay the peak.

c. The most vulnerable individuals stay at home for a period of 13-16 weeks – to reduce deaths and delay the peak.

d. Significant reduction of social contact by the over 70s and at-risk groups – to reduce deaths and delay the peak.

193. Discussions centred on when it was most appropriate to implement different interventions. Scientific advice was to implement option a (individuals stay at home for 7 days from the point of displaying mild symptoms – to delay the peak) immediately. This could then be followed by implementing option b (all household members stay at home for 14 days from the point that any member of the household displays symptoms – to delay the peak) and option c (the most vulnerable individuals stay at home for a period of 13-16 weeks – to reduce deaths and delay the peak) in the following weeks.

194. The Committee agreed with the proposal that anyone with symptoms compatible with COVID-19 should stay at home for at least 7 days. The Committee agreed that the other intervention measures should be held under active review, with option b being discussed at a COBR meeting the following week **(BD3/186 - INQ000056210**), and that timing of introduction should be guided by scientific advice. The Prime Minister announced this at the COVID-19 press conference on the same day **(BD3/53 - INQ000106195)**, which also outlined that the government was moving to the Delay phase of its COVID-19 response.

Introduction of 14-day 'Stay at Home' Policy for Household Contacts of Symptomatic People

195. Following the 12 March 2020 meeting, the Department provided further advice on actions that should be taken by people living in the same household as an individual with COVID-19 symptoms. This included advising household contacts to stay at home for 14 days, as confirmed in a statement by the Prime Minister on 16 March 2020 **(BD3/187 - INQ000086753;BD3/188 - INQ000106206; BD3/189 - INQ000106207; BD3/190 - INQ000106208 BD3/191 - INQ000106204; BD3/192 - INQ000106205; BD3/193 - INQ000106211; BD3/194 - INQ000106212; BD3/195 - INQ000106213; BD3/196 - INQ000106214; BD3/197 - INQ000106215; BD3/198 - INQ000106216; BD3/199 - INQ000106217;BD3/200 - INQ000106218; BD3/201 - INQ000106219; BD3/202 - INQ000106220; BD3/203 - INQ000106221; BD3/204 - INQ000106222)**.

196. On 16 March 2020, the CMO and GCSA gave a situation update to COBR, which indicated that the UK was now at the cusp of a fast swing up the infection curve. The Committee discussed and agreed the recommended introduction of whole household self-isolation for 14 days, where any member of the household was symptomatic, from the day that individual became symptomatic. Any other member of the household who went on to become infected in that period would need to self-isolate for 7 days from the point of developing symptoms (so might have to self-isolate for longer than 14 days).

197. The aim of this was to limit further transmission of COVID-19 to others in the community by ensuring that those who had been exposed to the virus were self-isolating for long enough for symptoms to develop, given they might have become infected at a much later date than the originally infected individual.

198. The Prime Minister announced this new policy at the No.10 press conference on the evening of 16 March 2020 **(BD3/186 - INQ000056210; BD3/205 - INQ000230992; BD3/187 - INQ000086753)**.

Introduction of the First Lockdown

199. On 23 March 2020, the UK entered its first national lockdown. Individuals were told to stay at home, other than for very limited purposes, to stop COVID-19 spreading between households.

200. These instructions were given legal force through the Health Protection (Coronavirus, Restrictions) (England) Regulations 2020, which came into effect on 26 March 2020 **(BD3/206 - INQ000565506)**.

201. Individuals were allowed to leave their residences only for specific purposes, including:

a. shopping for basic necessities

b. one form of exercise per day, such as walking, running, or cycling

c. medical needs or providing care to a vulnerable person

d. travelling to and from work when this was absolutely necessary and could not be done from home

Self-Isolation Developments Alongside Increasing Testing Capacity

202. As testing capacity progressively expanded between March and May 2020 and new groups became eligible for testing, as described in Statement B, this had significant implications for self-isolation. It meant that someone who had COVID-19 symptoms or was living in the same household as someone with symptoms could stop self-isolating if they – or the other member of the household (whoever had those symptoms) – tested negative. This had major economic and social benefits, as it meant that they had to self-isolate only during the period while they were awaiting the test result (if negative). Where an individual (or the other member of their household who was symptomatic) tested positive, the self-isolation period continued.

203. As set out in Statement B, testing eligibility was initially targeted at key health and care workers, then extended to other key workers and – from 18 May 2020 – extended to all individuals with symptoms of COVID-19 **(BD3/207 - INQ000527945)**, progressively expanding the group of people able to stop self-isolating if they or other symptomatic members of their household tested negative.

204. As of 18 May 2020, the advice for people with COVID-19 symptoms was **(BD3/208 - INQ000527943; BD3/209 - INQ000527944)**:

    a. Self-isolate for at least 7 days – and other household members for 14 days

    b. Order a COVID-19 test immediately:

        i. If your test is positive, you and other household members complete your self-isolation period

        ii. If it is negative, you no longer need to self-isolate

    c. Share your contacts, so that NHS T&T can alert close contacts and ask them to self-isolate for up to 14 days

205. Where someone without symptoms had a positive test result, guidance was to self-isolate until 7 days after the date of the test and for other household members to self-isolate until 14 days after the date of the test.

Changes to Self-Isolation Period for Symptomatic or Positive Individuals

206. As more clinical data about COVID-19 was accumulated, advice on self-isolation changed. On 17 July 2020, given evidence of the virus having the potential for transmission beyond 7 days after symptoms started, the 4 UK CMOs recommended it would be advisable to increase the self-isolation period for symptomatic individuals and those with a positive test result from 7 to 10 days **(BD3/210 - INQ000106537; BD3/211 - INQ000070122)**.

207. The Department provided a paper for a COVID-S meeting on 22 July 2020 where the change was agreed. Following discussions with the devolved administrations, the UK CMOs announced the change on 30 July 2020 **(BD3/212 - INQ000106546)**.

The Introduction of the Legal Requirement to Self-Isolate

Early Enforcement Policy

208. On 8 May 2020, ministers received a submission, requested by the Prime Minister, on voluntary and mandatory options for self-isolation for positive cases and their contacts (**BD3/213 - INQ000593034)**. The recommendation was to use a voluntary approach rather than making self-isolation a legal duty, because of concerns that a mandatory approach might deter people from reporting symptoms, ordering tests, sharing information about contacts and using the NHS COVID-19 app. This position was agreed by 28 May with No.10, but it was also agreed that a range of nudge options would be tested in different parts of the country and that a mandatory approach would be kept under review **(BD3/214 - INQ000593040; (BD/209 - INQ000527944).**

209. Throughout the summer of 2020, there were discussions on how best to encourage adherence to self-isolation guidance. On 30 June 2020, COVID-O met to discuss improving public cooperation with self-isolation guidance. Suggested proposals included financial incentives (covered in more detail below in Section 4), communications and trials of using the NHS T&T contact tracing service to engage with positive cases during their period of self-isolation. Mandatory self-isolation was included as an option in the paper presented, with two sub options:

    a. Proactive enforcement: this would have involved significant practical and legal challenges and was considered unlikely to be publicly acceptable.

b. Prosecuting only flagrant breaches, for example a social media viral post reported in mainstream media or by members of the public: this was considered faster and more straightforward to implement but largely of symbolic value to reinforce the importance of self-isolation.

210. The paper recommended pursuing other options in the first instance alongside gathering more information on the factors driving adherence or non-adherence to self-isolation and the likely behavioural response to a system of mandatory self-isolation.

211. The Department produced a paper on 3 July 2020 on support for those shielding and self-isolating. The paper discussed the option of introducing a legal duty to self-isolate, suggesting that making self-isolation mandatory would send a stronger message about the importance of compliance and open up a spectrum of potential enforcement options, ranging from light-touch compliance checks and prosecution of only flagrant breaches to more proactive enforcement. The paper highlighted that the positive impact on compliance of any measures would need to be carefully weighed against the risk of disincentivising people from coming forward for testing. The report included initial indications from No.10 polling, which suggested that introducing mandatory self-isolation (a £1,000 fine) would make 55% of people more likely to adhere to self-isolation **(BD3/215 - INQ000593047)**. A further submission shared with ministers on 21 July 2020 noted that it was likely HMT would press strongly to introduce a legal duty to self-isolate alongside any enhanced financial support to encourage greater adherence to self-isolation rules **(BD3/216 - INQ000592884)**.

212. On 27 August 2020, the Department considered advice shared from the Behavioural Insights Team, which suggested that:

a. a legal duty could be beneficial if it was aligned with other levers that made it easier and more attractive for people to self-isolate

b. the rules would need to be "firm but fair", which could mean limiting penalties to areas of higher prevalence

c. not enforcing rules when breached could result in total loss of compliance **(BD3/217 - INQ000593054)**

Introduction of Legal Duty to Self-isolate

213. On 17 September 2020, ministers received a submission on improving compliance with self-isolation in parallel to the development of a Cabinet Office paper to be discussed at a COVID-O meeting which was provided in draft in the submission **(BD3/218 - INQ000565542)**. The advice was to implement a legal duty to self-isolate along with a package of financial support (the latter covered in more detail in paragraphs 274 to 313 of Section 3).

214. On 21 September 2020, COVID-O discussed introducing a system of mandatory self-isolation. Although data on adherence to self-isolation for positive cases and their contacts was not available, data suggested that 20% of people with COVID-19 symptoms were not self-isolating. The Committee agreed with the proposal to introduce a legal obligation to self-isolate, penalties for employers who forced employees to leave self-isolation and an isolation support payment for low paid individuals to commence on 28 September 2020. On 25 September 2020, ministers received a signing submission that set out in detail the proposed content of the regulations and the next day the Secretary of State agreed **(BD3/219 - INQ000565545; BD3/220 - INQ000565546)**.

215. On 28 September 2020, regulations came into force that imposed a new legal duty for people to self-isolate if they were notified of a positive test result or were notified to do so by NHS T&T or local authorities and to provide details of where they would be staying for the duration of their self-isolation period, with provision for fines for breaches of these duties. Alongside this change, the government introduced a new system of financial support for those on lower incomes who lost income as a result of having to self-isolate, as set out in Section 3.

216. Prior to this new legal duty, existing legislation did allow for people to be detained or kept in isolation if they were believed to be infected with COVID-19 or if they were at risk of infecting others, but the rules on self-isolation for positive cases and their contacts were set out in guidance rather than statute. The new legislation introduced a direct legal obligation for people to self-isolate if they were instructed to do so following a positive test result or after being identified as a close contact of someone who had tested positive.

217. The legal duty did not apply to people who had symptoms of COVID-19 but had not yet taken a test, as there was no way of knowing who these individuals were, but guidance continued to advise symptomatic individuals and other members of their household to

self-isolate for 10 days or until they received a negative test result. Nor did the legal duty apply to people advised to self-isolate via the NHS COVID-19 app, as it was an intrinsic design feature of the app that its users did not share any personally identifying information.

Enforcing the Legal Requirement to Self-Isolate

218. On 28 September 2020, the Health Protection (Coronavirus, Restrictions) (Self-Isolation) (England) Regulations 2020 ("Self-Isolation Regulations") came into force. Failure to comply with the new legal duty to self-isolate could result in a Fixed Penalty Notice (FPN) ranging from £1,000 to £10,000. Where there were reports of suspected breaches, the police were authorised to engage, explain and encourage compliance and, where necessary, to enforce the rules. Following a report of suspected non-compliance and following checks by NHS T&T to confirm the individual was under the legal duty to self-isolate, NHS T&T was able to share personal information with the police on a case-to-case basis to support appropriate enforcement action.

219. NHS T&T developed a memorandum of understanding (MoU) with the National Police Chiefs' Council, on behalf of local police forces, governing exchange of information for the purposes of enforcing self-isolation requirements. The MoU came into effect on 14 October 2020 **(BD3/221 - INQ000595350)**.

220. On 20 October 2020 Lord Hunt gave assurances in a House of Lords debate that health data would not be shared under the agreed memorandum of understanding with the police.

Concerns Regarding the Enforcement of the Legal Requirement to Self-Isolate

221. In a meeting held with the Department on 27 November 2020, the police and Crown Prosecution Service (CPS) raised evidential concerns regarding the issue of identity in relation to enforcement of the self-isolation rules **(BD3/222 - INQ000565565)**.

222. These concerns arose from the fact that NHS T&T was not able to verify the identity of people who were notified of a legal duty to self-isolate. Individuals who had a positive COVID-19 test were not required to provide identification when taking a test, whilst the identity of their reported contacts relied on the individual providing accurate information to NHS T&T. This meant that it was not possible for the police to establish with certainty

that someone alleged to have breached self-isolation requirements was under a legal duty to self-isolate and had been notified of that legal requirement to self-isolate. In addition, the police were unable to know whether someone had breached the relevant self-isolation requirements unless admitted by the individual or witnessed by the police.

223. On 10 December 2020, a submission was sent to the Secretary of State setting out a proposal to help improve enforcement of self-isolation rules **(BD3/223 - INQ000203837)**. Subject to resolving legal and data privacy implications, the police would be informed whether individuals were positive cases or contacts. This information was considered essential by the police to enable a different approach to be taken for positive cases and contacts. The police could issue copies of a self-isolation notification from NHS T&T if individuals claimed they had not received it. Recordings of this action would provide evidence that the self-isolation notification had been received.

224. The approach set out in the submission of 10 December 2020 would provide sufficient evidence to allow some fixed penalty notices to be issued and a reasonable chance for prosecution in some cases but would not be fully effective in all situations. Further consideration was needed to identify solutions for enforcing self-isolation for household and non-household contacts. A wider range of methods for self-isolation notifications were also introduced, including by text, email, in writing, or in person, helping to reduce the likelihood of claims that the notification had not been received.

225. Ministers agreed with the suggested approach for the police to follow when enforcing self-isolation for positive cases. Ministers also asked that the Department seek to improve systems for establishing the identity of people testing positive for COVID-19 by asking those taking a test to provide their NHS number, an approach that was subsequently considered but not taken forward.

226. The Department also explored whether those taking a test could be asked to provide photo ID. This option was not pursued, given the likely negative impact it would have on uptake of testing and its incompatibility with arrangements for home testing.

227. On 25 January 2021, the Secretary of State received a further submission **(BD3/224 - INQ000203705)** setting out the continued concerns of the CPS and policing colleagues that they did not have enough information from NHS T&T to enable them to enforce the self-isolation regulations as they could not meet the evidential bar to issue FPNs and prosecute non-payment of FPNs in court.

228. The submission dated 25 January 2021 explained that the amendment to the regulations recommended in the earlier submission of 12 December 2020 would allow additional information to be shared, which the police and Home Office agreed would support the successful issuing of FPNs against those who were in breach of the regulations, maintain the integrity of the regulations and protect police, CPS and court resources by preventing erroneous FPNs being issued.

229. On 27 January 2021 a submission was sent to the Secretary of State recommending signing the amendment to the Self-Isolation Regulations. The submission was accompanied by an Equality Impact Assessment regarding the police enforcement of self-isolation regulations **(BD3/225 - INQ000110498**; **BD3/226 - INQ000110492)**. The Equality Impact Assessment stated that the amended approach was necessary as it would allow the police to effectively enforce the regulations, which should encourage people to take the rules more seriously and drive up compliance with self-isolation.

230. As set out in Statement D, the Department conducted Equality Impact Assessments throughout the pandemic. These assessments identified that, for some people, self-isolation was likely to have an impact in respect of loss of income, concern about job security, loneliness, prevalence of domestic abuse, difficulty accessing food and separation from families and friends. Population groups identified as most vulnerable to these potential impacts included: those living alone or in multiple occupancy houses; the homeless; new or single parents; those with caring responsibilities; those from black and minority ethnic backgrounds, people suffering domestic abuse or living in hostile home environments; those with English as a second language; and those with a learning disability, mental illness or dementia **(BD3/227 - INQ000565925**; **BD3/228 - INQ000565911)**.

231. The Department took these potential impacts into account in developing policy on self-isolation, both seeking to ensure that self-isolation for contacts of positive cases was limited to people at highest risk of having been infected (based on the estimated proximity and duration of contact with a positive case) and, as set out in further detail in Section 3, seeking to ensure that appropriate support was available where needed **(BD3/227 - INQ000565925)**.

232. On 28 January 2021, a Written Ministerial Statement was laid in the House of Lords explaining the amendments to the Self-Isolation Regulations and the reasons for them.

Reduced Self-Isolation Period for Contacts

233. On 16 November 2020, at the sixty-eighth SAGE meeting on COVID-19 **(BD3/229 - INQ000517334)**, SAGE considered the possible effects on transmission of reducing the 14-day self-isolation period for contacts of positive cases or replacing self-isolation requirements for contacts with systems of regular testing. The attendees considered modelling evidence from PHE, SPI-M and SAGE.

234. SAGE discussed the possibility that a shorter self-isolation period for contacts might be more effective in reducing transmission if it resulted in more people coming forward for testing and/or it improved adherence to self-isolation. However, there was a trade-off with increased transmission risk from those who were still infectious beyond the end of the self-isolation period if it was shortened. SAGE discussed that daily testing could potentially be an effective alternative to self-isolation for contacts as covered below in paragraph 242.

235. On 1 December 2020, the 4 UK CMOs recommended reducing the self-isolation period for contacts from 14 days to 10 days **(BD3/230 - INQ000234637; BD3/231 - INQ000071961)**. The UK CMOs recommended that this change should happen as soon as was reasonably practical, but that an announcement should be aligned across the 4 UK countries. The CMOs also recommended piloting a system of daily contact testing, as covered below from paragraph 240, whereby contacts would take a daily test for a period of either 5 or 7 days after being identified as a contact and would self-isolate only if one of those tests was positive.

236. On 2 December 2020, the Secretary of State agreed to the recommended reduction in the self-isolation period for contacts from 14 to 10 days **(BD3/232 - INQ000565566)**.

237. This change was designed both to mitigate the economic and social impacts of self-isolation and, by encouraging greater adherence to self-isolation rules, to seek to improve the impact of those rules in limiting transmission of COVID-19.

238. On 7 December 2020, the 4 UK CMOs made a further recommendation to align the way in which the self-isolation period was calculated across the 4 UK countries **(BD3/233 - INQ000593068)**. The recommended approach was for England to align with the system already used in Scotland, Wales and Northern Ireland, whereby the day on which symptoms developed, or the test date for asymptomatic cases, was counted as Day 0

rather than Day 1 of the self-isolation period. The Secretary of State agreed to this recommendation on 9 December 2020, and it was announced publicly on 11 December 2020. The updated regulations (The Health Protection (Coronavirus, Restrictions) (Self-Isolation and Linked Households) (England) Regulations 2020), incorporating both the new 10-day self-isolation period for contacts and this change in the calculation of the self-isolation period, came into effect on 14 December 2020 **(BD3/234 - INQ000234639)**.

239. The self-isolation period for people returning from countries that were not on the travel corridor list (as described in Section 5 of this statement) was also reduced from 14 to 10 days from 14 December 2020 **(BD3/235 - INQ000203967)**.

Daily Testing of Contacts of a Positive Case

240. Given the economic, educational and other societal costs associated with self-isolation, the Department sought to identify potential alternatives to self-isolation for contacts of positive cases. Taking a single test was not an adequate alternative to self-isolation, because the incubation period for COVID-19 could vary from around 2 days to 14 days, meaning there could be a relatively long period during which infection had occurred but could not yet be detected through a test. This was why contacts were required to complete the specified self-isolation period, even if they received a positive test result during this time.

241. In August 2020, the Department proposed conducting a pilot for testing contacts of COVID-19 cases **(BD3/236 - INQ000593053)**. 'Serial Contact Testing' pilots were subsequently carried out in various settings across the UK from 14 December 2020 to 12 January 2021. The pilots investigated the use of daily testing for contacts of confirmed COVID-19 cases using self-administered LFD tests **(BD3/237 - INQ000593099)**.

242. On 16 December 2020, SAGE discussed that daily testing could potentially be an effective alternative to self-isolation for contacts, that is, if contacts took a daily test for a specified period and self-isolated promptly if the result was positive **(BD3/229 - INQ000517334)**. Its relative effectiveness would, however, depend on multiple uncertain factors, including how far contacts would adhere to daily testing protocols compared with how far they would adhere to standard self-isolation requirements – and how far more rapid and systematic identification of positive cases (particularly asymptomatic cases)

would both improve adherence to self-isolation (once it was deemed necessary) and allow greater identification of secondary contacts who might have been infected.

243. An initial pilot of workplace daily contact testing was introduced in December 2020, in Liverpool **(BD/238 - INQ000488615).** In December 2020, modelling from the London School of Hygiene and Tropical Medicine considered by SAGE **(BD3/229 - INQ000517334)** suggested that daily contact testing, as an alternative to self-isolation, could be effective at averting transmission by contacts of a positive case **(BD3/239 - INQ000422237)**.

244. However, the spread of the Alpha variant from November 2020 onwards, with its higher transmissibility and secondary attack rate, potentially affected the balance between the risks and benefits of daily contact testing. Two random controlled independent research studies were therefore initiated to provide further evidence of the impact daily contact testing could have on public health. These allowed a comparison of onwards transmission between those participating in daily contact testing and those self-isolating. One of the trials involved the public and the other involved secondary schools and colleges **(BD3/240 - INQ000565604)**.

245. SPI-M-O released a statement on daily contact testing on 3 March 2021 **(BD3/241 - INQ000075004)**. Across all analyses, daily contact testing demonstrated potential to detect more asymptomatic contacts and help reduce the growth rate of the epidemic. In addition to the clinical trials, those organisations already participating in the workplace pilot were offered the opportunity to continue with daily contact testing **(BD3/242 - INQ000593092)**.

246. On 24 July 2021, daily contact testing for contacts who would otherwise need to self-isolate was rolled out to further critical sectors following clinical trial results. Daily testing enabled eligible workers to continue working for each day that they tested negative **(BD3/243 - INQ000593091)**.

247. In August 2021, the Workplace Daily Contact Testing scheme was extended to a number of sites providing essential public services to enable non-household contacts who would otherwise have had to self-isolate to attend work and undertake other essential activities **(BD3/91 - INQ000075721)**.

248. The need for further use of daily contact testing was largely superseded by the decision, from August 2021, to exempt contacts who were fully vaccinated or under the age of 18 from the requirement to self-isolate. Daily contact testing was, however, used briefly as an additional precaution for fully vaccinated contacts as part of the response to the Omicron variant in December 2021 **(BD3/244 - INQ000565614)**.

Exemption from Self-Isolation for Fully Vaccinated Contacts and Those Aged Under 18

249. Successful rollout of the COVID-19 vaccine from 8 December 2020, and the development of more effective treatment options for the seriously ill, led the government to develop a strategy to reduce the degree of reliance on NPIs to control the virus **(BD3/245 - INQ000253807)**.

250. On 22 February 2021, the government published the 'Roadmap out of Lockdown' **(BD3/124 - INQ000234765)**, which set out how national COVID-19 restrictions would be eased in stages, with reviews taking place on set dates.

251. By June 2021 a significant proportion of the population was vaccinated and Step 4 of the Roadmap, which involved the relaxation of most remaining restrictions, was expected to proceed after 21 June 2021. However, moving to each step was conditional on the 4 tests being satisfied. When these tests were not met for Step 4, a 4-week pause was announced on 14 June 2021 to allow more people to receive their first dose of a COVID-19 vaccine **(BD3/246 - INQ000234938)**.

252. On 6 July 2021, the Department announced that, from 16 August 2021, if the government decided to move to Step 4 of the Roadmap (which was confirmed on 12 July 2021 **(BD3/247 - INQ000234967)**, individuals who had received 2 COVID-19 vaccinations and those aged under 18 would no longer be required to self-isolate if they had been identified as a close contact of someone with COVID-19 **(BD3/248 - INQ000565600)**.

253. Ahead of these significant changes to the self-isolation rules in August 2021, the Department worked with other government departments to develop proposals for addressing concerns about the impact of self-isolation on people working in essential public services. The COVID-O Committee meeting on 19 July 2021 agreed to the proposal that, in very limited and specific circumstances, fully vaccinated non-household contacts could leave self-isolation to carry out critical roles where they had a reasonable excuse to do so **(BD3/249 - INQ000182294; BD3/250 - INQ000065404)**. This policy was

implemented to avoid significant harm in certain sectors; it was time-limited, targeted and subject to a number of risk mitigations. Individuals covered by this policy would have to take a PCR test on day 2, take daily LFD tests and limit their travel to and from their place of work. The list of sectors in scope was kept flexible so that additional sectors could be added where there was a clear need to do so **(BD3/251 - INQ000092093; BD3/252 - INQ000092225)**.

254. The UK moved to Step 4 of the Roadmap on 19 July 2021 **(BD3/247 - INQ000234967)**.

255. On 11 August 2021, the government confirmed that from 16 August 2021 fully vaccinated individuals and those aged under 18 would no longer be legally required to self-isolate if identified as a close contact of someone with COVID-19. They were instead advised to take a PCR test, wear a face covering indoors, and limit their contact with anyone classed as clinically vulnerable. If they tested positive, they would still be legally required to self-isolate irrespective of vaccination status or age **(BD3/253 - INQ000049232)**. Exemptions also applied to people who were not fully vaccinated because they had taken part in – or were taking part in – a clinical trial for a COVID-19 vaccine and to people who were medically unable to receive a vaccination.

256. There were some differences in the approach taken for fully vaccinated contacts in the devolved administrations. In Scotland, fully vaccinated contacts were advised to self-isolate, take a PCR test and then end their self-isolation if the PCR test result was negative. In Wales and Northern Ireland, fully vaccinated contacts were advised to get a PCR test on day 2 and day 8 **(BD3/254 - INQ000593036)**.

257. On 14 September 2021 the Secretary of State gave an oral statement in the House of Commons on autumn and winter planning **(BD3/255 - INQ000257045)**, and the government published the Autumn and Winter Plan **(BD3/135 - INQ000065168)**. A key element of this plan was the continued exemption from self-isolation for fully vaccinated contacts and those aged under 18, which had been introduced to reduce disruption while maintaining public health safety.

Omicron Variant

258. On 30 November 2021, new rules came into force as part of the response to the threat posed by the Omicron variant **(BD3/256 - INQ000565612)**. These included:

a. All international arrivals were required to take a PCR test by the end of the second day after arrival and to self-isolate until they received a negative test result.

b. All contacts of suspected Omicron cases were required to self-isolate, regardless of their age or vaccination status.

259. On 12 December 2021, the Department announced that from 14 December fully vaccinated contacts of a COVID-19 case, whether or not it was a suspected Omicron case, would be advised to take a daily LFD test for 7 days and self-isolate immediately if any of these tests was positive. This superseded the requirement for all contacts of suspected Omicron cases to self-isolate. Unvaccinated adults had to continue to self-isolate for 10 days if they were a contact of someone with COVID-19 **(BD3/244 - INQ000565614; BD3/257 - INQ000257192)**.

Final Changes to Self-Isolation Period and the Ending of Self-Isolation Regulations

260. As outlined above, the success of the COVID-19 vaccine programme and the availability of new testing technologies like LFDs supported a gradual lifting of restrictions, enabling the public to participate more fully with everyday life and to take a stronger personal role in deciding how to manage risk.

261. The emergence of the Omicron variant necessitated the implementation of Plan B of the 'COVID-19 Response: Autumn and Winter Plan', which meant stronger measures to combat the high prevalence of the virus. Plan B's measures included a vaccine booster campaign that improved vaccine protection against severe disease and contributed to hospital rates remaining lower than in previous waves.

262. On 22 December 2021, new guidance enabled the 10-day self-isolation period for people who had tested positive for COVID-19 to be reduced to 7 days in most cases **(BD3/258 - INQ000257220)**. People who received a negative LFD test result on day 6 and day 7 of their self-isolation period, with tests taken 24 hours apart, no longer had to self-isolate for the full 10 days and self-isolation ended after day 7. Those who left self-isolation on or after day 7 were strongly advised to limit close contact with other people in crowded or poorly ventilated spaces, work from home and minimise contact with anyone who is at higher risk of severe illness if infected with COVID-19. There was no change to the

guidance for unvaccinated contacts of positive COVID-19 cases, who were required to self-isolate for 10 full days after their date of exposure to the virus.

263. UKHSA's analysis suggested that a 7-day isolation period alongside 2 negative LFD test results had nearly the same protective effect as a 10-day isolation period without LFD testing for people with COVID-19. This approach was supported by the latest evidence on the length of time for which positive cases could transmit the virus. This approach was designed to support essential public services and supply chains over the winter whilst continuing to limit the spread of the virus. Studies also demonstrated that LFD tests were just as sensitive at detecting the Omicron variant as they were for the Delta variant **(BD3/258 - INQ000257220)**.

264. On 17 January 2022, self-isolation advice changed so that people self-isolating were able to end self-isolation after 5 full days provided they had 2 negative LFD tests taken on consecutive days (day 5 and day 6) **(BD3/259 - INQ000565616)**.

265. On 21 February 2022, the government published the 'Living with COVID' strategy, which involved removing remaining legal restrictions on the public while taking ongoing measures to protect the vulnerable. The strategy set out plans to monitor COVID-19 and be prepared to respond to resurgences and new variants of concern. It explained that continued vaccination, improvements in vaccination technology and repeated exposure to COVID-19 would lead to greater protection from the virus and that, once COVID-19 had become 'endemic' (that is, when a more steady and more predictable state had been reached), it should be possible to respond to it in a similar way to other existing respiratory illnesses.

266. In line with the strategy, all legal restrictions, including the legal requirement for positive cases and unvaccinated adult contacts to self-isolate, ended on 24 February 2022. Until 1 April 2022, the government advised people who tested positive to stay home and avoid contact with other people for at least 5 full days and then continue to follow the guidance until they had received 2 negative test results on consecutive days **(BD3/260 - INQ000576647**.

267. From 1 April 2022, the government no longer provided free universal symptomatic testing to all population groups **(BD3/261 - INQ000565618)**. Symptomatic testing continued in high-risk settings and for those who were vulnerable, and some asymptomatic testing also continued in some circumstances. Guidance published by UKHSA on 1 April 2022

(which remains in force today) advises that people with symptoms of a respiratory infection, such as COVID-19, should try to stay at home and avoid contact with other people if they have a high temperature or do not feel well enough to go to work or carry out normal activities. The guidance says that it is particularly important to avoid close contact with anyone who is at higher risk of becoming seriously unwell if infected with COVID-19 and other respiratory infections. It advises people to try to work from home, if they can, and to talk to their employer about other options if they are unable to work from home.

Adherence to Self-Isolation

268. Throughout the pandemic, the government kept under review the factors influencing public adherence to guidance and regulations on self-isolation, including communications to help people understand the guidance and rules and to understand the importance of self-isolation and its benefits for society (discussed in Statement D). The other most critical factors influencing some people's willingness and ability to self-isolate – and, in turn, their willingness to come forward for testing in the first place – were the potential financial or employment impacts of not being able to work if they had to stay at home. Adherence to self-isolation could also be affected by practical issues, such as access to food or medicines or the need to provide informal care for other people. Section 3 discusses the government's evolving policies for helping address those financial and practical support needs, with the aim of helping improve both adherence to self-isolation and take-up of testing.

269. Data collected by the Office for National Statistics from February 2021 to August 2021 showed self-reported levels of adherence to self-isolation requirements for those required to self-isolate as a result of testing positive for COVID-19 or being the contact of a positive case. Data collected from 1 February to 13 February 2021 **(BD3/262 - INQ000565626)** (the first release for positive cases) and from 1 March to 6 March 2021 **(BD3/263 - INQ000565627)** (the first release for contacts of positive cases) indicated that the majority of respondents – 86% for positive cases and 90% for contacts – reported being fully adherent to self-isolation requirements throughout their self-isolation period.

270. These were experimental statistics, based on a sample of respondents and with a risk that those who did not respond to the survey were less adherent than those who did. The statistics nonetheless suggested a relatively high level of adherence among positive

cases and their contacts – and significantly higher than reported levels of adherence for people who had symptoms of COVID-19.

SECTION 3: SUPPORT FOR SELF-ISOLATION

271. This section outlines the financial support measures introduced to assist individuals who lost income as a result of not being able to work while self-isolating, particularly the Test and Trace Support Payment (TTSP) scheme. It also sets out approaches to helping people access practical support while they were self-isolating, including the Local Authority Practical Support Fund. The section examines the rationale for these measures, the challenges faced in their implementation, and the evolving policy decisions and evaluations that shaped their development.

272. This section focuses on 3 main forms of support developed as part of the NHS T&T service:

    a. The Test and Trace Support Payment (TTSP) scheme, a financial support payment of £500 to people on low incomes who had been told to self-isolate (both those who had tested positive for COVID-19 and their contacts) and would lose income because they were unable to work from home. This was introduced on 28 September 2020, alongside the new legal duty to self-isolate for positive cases and their contacts

    b. The Local Authority Practical Support Fund to enable local authorities to go further in providing practical, social or emotional support for those who had to self-isolate

    c. The Medicines Delivery Scheme

273. Local authorities could also use the Contain Outbreak Management Fund from June 2020 to provide, among many other possible activities, additional non-financial support for self-isolation.

Financial Support

Statutory Sick Pay, Universal Credit and Coronavirus Job Retention Scheme

274. Throughout the COVID-19 pandemic, the financial support available to those who were unable to work because of COVID-19 included Statutory Sick Pay (SSP), Universal Credit and (announced on 20 March 2020 but applied from 1 March 2020) the Coronavirus Job Retention Scheme. For SSP, those eligible were entitled to £95.85 a week, claimable from the first day of isolation. From 4 March 2020, as part of the provisions in the Coronavirus Act 2020, SSP became payable on the first day of COVID-19 instead of after 4 days **(BD3/264 - INQ000502351)**. To be eligible, claimants had to:

    a. display symptoms or test positive for COVID-19

    b. live in the same household as someone displaying symptoms or who tested positive, or

    c. be a non-household contact of someone who tested positive, as identified by NHS T&T

275. Some of those on low incomes who were ineligible for SSP were eligible for support through other benefits, including Universal Credit (rules were relaxed for self-employed claimants) or New Style Employment and Support Allowance, and through the Coronavirus Job Retention Scheme (announced on 20 March 2020 and applied from 1 March 2020), through which employees received 80% of their current salary for hours not worked, up to £2,500.

Additional Financial Support for Self-Isolation

276. On 30 June 2020 at a COVID-O meeting, 5 potential measures were put forward to improve public adherence to guidance on self-isolation **(BD3/265 - INQ000088856)**:

    a. Increased marketing and communications with the objective of driving up awareness of the NHS T&T service (discussed in Statement D)

    b. A trial involving calls by contact tracers to people self-isolating

    c. A trial involving daily text messages to those self-isolating

d. Support for people who needed to self-isolate outside the home, including providing accommodation for those unable to self-isolate at home, support for homeless people, and improved guidance for holidaymakers

e. Provision of financial support

277. These measures were aimed at people who had tested positive for COVID-19, other members of their household and any non-household contacts also told to self-isolate, as opposed to people self-isolating because they had symptoms of COVID-19. For the latter group, the focus was on encouraging them to get a test as soon as possible, enabling them to stop self-isolating if the result was negative.

278. On 2 July 2020, the European Centre for Disease Prevention and Control (ECDC) reported a resurgence in reported cases of COVID-19 across the EU and UK, with EU/EEA countries and the UK reporting 15% of all cases, including 35% of all deaths. Community transmission was still being reported in most EU/EEA countries and the UK. Additionally, some countries were reporting a resurgence of observed cases or large localised outbreaks. The reasons behind this increase varied and so the information was interpreted with caution. At the time, it was thought the increase could reflect increasing testing rather than necessarily indicating increased rates of transmission, or it could reflect genuine increases in transmission associated with the easing of NPIs, large, localised outbreaks, or importation of cases **(BD3/266 - INQ000565526)**.

279. On 27 July 2020, at a COVID Taskforce meeting, the Prime Minister expressed concern over the continuing trend in COVID-19 cases across Europe and stressed the need to redouble efforts to prevent a significant increase in cases. He asked for a range of steps to be taken forward urgently, including for the Department, NHS T&T and HMT to work together to develop a targeted package of financial support for lockdown areas **(BD3/267 - INQ000565533)**.

280. On 23 August 2020, the Chancellor agreed that the payment level for a self-isolation financial support scheme in lockdown areas should be £13 per day **(BD3/268 - INQ000565536)**. As a condition of funding, it was agreed that the Department was to play a largely operational role, which would include:

a. addressing delivery or legal hurdles around making the payments available to those without recourse to public funds

b. working with the Department for Work and Pensions (DWP) and HM Revenue and Customs (HMRC) to ensure that they could operationalise all income related benefits

c. launching trials to test key operational and policy elements

d. working with HMT to agree robust, quantitative plans for evaluation of the scheme, to clear formal communications materials, and to explore how local authorities and NHS T&T could strengthen compliance checking as the scheme developed

e. delivering the scheme through local authorities, with agreement that they could make payments within a 48-hour timeframe

f. ensuring that the relevant Accounting Officer (AO) had made an AO Assessment of the scheme

g. engaging in further work to increase compliance via behavioural and process changes, including looking at enforcement options and possibly making the scheme mandatory if relevant

281. On 27 August 2020, the Department announced a new payment for people on low incomes in areas with high rates of COVID-19, who needed to self-isolate and could not work from home **(BD3/269 - INQ000565537)**. The payment was to be funded by the Department and paid via local authorities. The scheme, which in September 2020 was extended to all areas (not just those with high rates of COVID-19), was initially piloted in the 3 local authorities of Blackburn with Darwen, Pendle and Oldham (**BD3/270 - INQ000565539)**.

Pilot Financial Support Scheme

282. The pilot for a new payment scheme for people self-isolating in the highest risk areas started on 1 September 2020. The objective of the pilot was to help reduce the transmission of COVID-19 in 3 local authorities by incentivising people on low incomes to self-isolate when they tested positive or were identified as a contact, and to encourage more people to get tested. All costs for the trials were met from the £100 million funding for local authorities to support contain activities. The trial was to end in an area when it was no longer on the JBC watchlist, or after 3 months – whichever was sooner.

283. As part of the trial, eligible individuals could receive:

a. £130 for a person who tested positive for coronavirus and was required to stay at home and self-isolate for 10 days from when they first developed symptoms (or, if they were asymptomatic, 10 days from the date of the test)

b. £182 for a person living with someone who had tested positive for coronavirus (a household contact). Household contacts were required to stay at home and self-isolate for 14 days from when the person who tested positive first displayed symptoms (or, if the person who tested positive was asymptomatic, 14 days from the date of the test)

c. £13 per day (up to a maximum of £182) for anyone who had been in contact with a person who has tested positive for coronavirus and did not live with that person (a non-household contact). Non-household contacts were required to stay at home and self-isolate for a period ending 14 days after their most recent exposure to the person who had tested positive. The communication from NHS T&T set out how long this was for.

284. Eligible individuals had to apply within 2 weeks of being notified by NHS T&T. As proof they were eligible for the scheme, they had to provide:

a. a notification from NHS T&T

b. a bank statement

c. proof of employment or, if they were self-employed, evidence of self-assessment returns, trading income and proof that their business delivered services which cannot be undertaken without social contact

285. Payment was made in full and as a single payment within 2 working days of the evidence being verified.

286. The scheme was open to people who:

a. lived in Blackburn with Darwen, Pendle or Oldham, as checked against the relevant local authority's system and corroborated by the applicant's bank statement

b. had received a notification from NHS T&T telling them to stay at home and self-isolate

c. had agreed to comply with the notification from NHS T&T and provided contact details to the local authority

d. were employed or self-employed

e. were unable to work from home and would lose income while self-isolating

f. were currently receiving at least one of the following benefits (entitlement to which was not affected by receipt of the support payment): Universal Credit, Working Tax Credits, income-related Employment and Support Allowance, income-based Jobseeker's Allowance, Income Support, Pension Credit or Housing Benefit

287. There was an iterative evaluation of the pilot, supported by local authorities, to help make ongoing improvements to the scheme and inform further rollout in areas of high COVID-19 incidence in England. The metrics for evaluation included the number of people who had been tested, been identified as contacts, complied with NHS T&T instructions, engaged with local authorities/support groups, or contravened the conditions of financial payment; operational challenges (including compliance and fraud risks); performance (using the metrics and qualitative feedback); how effectively vulnerable people had been reached; and changes in levels of transmission of the virus in these areas.

288. Local authorities were also asked to conduct post-payment assurance as a counter-fraud measure. This consisted of spot checks to ensure recipients were self-isolating at home for the length of time indicated by NHS T&T and were not leaving home (to work or for any other reason).

Test and Trace Support Payment (TTSP) Scheme

289. On 21 September 2020, the Secretary of State gave an oral statement to Parliament on the government response to the recent acceleration of COVID-19 including an isolation support payment and testing allocation.

290. The full TTSP scheme, which applied across England (not just in areas with high rates of COVID-19), was launched on 28 September 2020 and ran until 24 February 2022. Local

authorities worked quickly to set up the scheme, and the government expected it to be in place by 12 October 2020. Those who started to self-isolate from 28 September 2020 received backdated payments once the scheme was set up in their local authority. The scheme supported low-income workers on benefits who had been contacted by NHS T&T and told to self-isolate. Eligible individuals received a £500 support payment from their local authority, which used HMRC data to check eligibility. People applied for the payment through their local authority and could submit an application up to 42 days after the first day of their self-isolation period.

291. The eligibility criteria were the same as for the pilot scheme, as set out in paragraphs 281 to 287 above, but there was additional funding to enable local authorities to make discretionary payments (covered further in paragraphs 301 to 307 below) to applicants who were not in receipt of one of the 7 means-tested benefits but who they judged would suffer financial hardship as a result of self-isolation.

292. When the TTSP scheme was launched, people self-isolating because they had received an alert via the NHS COVID-19 app (which had been launched on 24 September 2020), were not eligible for the £500 support payment, because the anonymity of the app meant that they were not personally identifiable and because the notifications given by the app were not legally binding. From 10 December 2020, NHS T&T introduced new app functionality that gave app users the option of indicating that they wished to apply for the £500 payment and then receiving a notification that placed them under a legal duty to self-isolate and to apply for the payment.

293. The Department collected weekly data from local authorities on:

    a. the number of successful/unsuccessful applications

    b. the administrative costs of processing each payment

    c. the length of time it took to make a payment

    d. the proportion of payments made from the main TTSP scheme and from the discretionary scheme

294. As of 18 January 2021, over 70,000 payments had been made at a cost of £35 million **(BD3/271 - INQ000595351)**. On 16 December 2020, HMT and the Department agreed

that the scheme was to be extended for 2 months (to 31 March 2021) on the understanding that the eligibility criteria would be reviewed **(BD3/272 - INQ000565570)**.

295. At the request of Cabinet Office, the Department produced a paper dated 19 January 2021 for a COVID-O meeting on 'Removing Barriers to Self-Isolation and Improving Adherence', which included proposals on the TTSP scheme **(BD3/271 - INQ000119872; BD3/273 - INQ000565574)**. The paper noted that the TTSP eligibility criteria excluded some people who could face financial hardships associated with self-isolation requirements, for example people who earned slightly above the threshold and people who could not work because they were looking after a child who was a non-household contact, and that local authorities had introduced very different criteria to manage the discretionary fund. Improving compliance with self-isolation was discussed at a COVID-O- meeting on 22 January 2021 **(BD3/274 - INQ000054522)**.

296. In January 2021, COVID-O agreed a package of interventions that were announced in the Roadmap on 22 February 2021 to improve the support available **(BD3/274 - INQ000054522)**. The announcement included **(BD3/275 - INQ000234766; BD3/276 - INQ000593084)**:

    a. an extension of the TTSP scheme to include the parent or guardian of a child who had to self-isolate where other eligibility criteria were met

    b. a significant expansion of the discretionary fund available to local authorities (from £15 million for the first 4 months of the scheme to £20 million per month, resulting in an overall increase of £16.75 million per month) to pay £500 to those who were not eligible under the main scheme but might still experience financial hardship

    c. £3.2 million per month for 4 months to fund a new Medicines Delivery Service for those who required prescription medicines whilst self-isolating (described in more detail under practical support below)

    d. £12.9 million per month, over and above existing funding through the Contain Outbreak Management Fund, to support local authorities to deliver the practical and emotional support agreed in the new Framework

297. This funding was agreed until the end of June 2021, with a review point in May 2021 to consider the impact **(BD3/277 - INQ000565593)**.

298. The review in May 2021 estimated that only one third of those who were eligible were making use of the TTSP scheme. Feedback from local authorities and community groups suggested the following reasons:

    a. eligible individuals were unaware of the scheme

    b. eligible individuals were unsure as to whether they qualified

    c. the time waiting for payment

    d. £500 might not be sufficient to cover a loss of earnings

    e. longer term implications rather than immediate cashflow issues for those in insecure work

299. The Department held meetings with local authorities to reinforce the importance of communicating the revised eligibility criteria and the local eligibility criteria for discretionary payments. The review in May 2021 emphasised that the Department would continue working with local authorities to make sure they further promoted the extension of the scheme to parents and guardians where numbers were growing.

300. From 16 August 2021, when fully vaccinated contacts became exempt from self-isolation requirements as outlined in paragraph 255 above, eligibility for the TTSP scheme changed. Fully vaccinated adults and under 18s did not legally have to self-isolate if identified as a contact by NHS T&T so were no longer eligible for the scheme. Fully vaccinated adults who tested positive, together with contacts who did not meet the new exemption criteria, were still legally required to self-isolate and so were still eligible. The scheme continued to run in this modified form until February 2022.

The Discretionary Fund

301. As part of the TTSP scheme, there was additional funding for local authorities to make discretionary payments to other applicants who they judged would suffer financial hardship as a result of self-isolation but did not qualify for the TTSP scheme **(BD3/278 - INQ000593083)**.

302. A review of the scheme discussed at a COVID-O meeting in January 2021 highlighted that the scheme raised questions about a 'postcode lottery', with local authorities

introducing very different criteria to manage the discretionary fund **(BD3/279 - INQ000595352)**.

303. As set out above in paragraph 296, the government significantly expanded the discretionary fund available to local authorities from £15 million for the first 4 months of the scheme to £20 million per month, as part of a wider package of measures announced in the Roadmap on 22 February 2021 to improve financial and practical support for people self-isolating **(BD3/276 - INQ000593084)**.

304. This expansion of the discretionary scheme allowed local authorities to adapt and extend their local eligibility criteria and so provide more certainty over eligibility. At the May 2021 review point, however, initial research showed that 200 out of 309 local authority websites visited were identified as needing improvements **(BD3/277 - INQ000565593)**, with problems including poorly worded eligibility criteria for the discretionary scheme and few suggesting that there was wider eligibility for discretionary payments. As of May 2021, initial returns from local authorities showed that less than 20% of the discretionary funding for March and April 2021 had been spent, with only 14 local authorities spending over 50% **(BD3/277 - INQ000565593)**.

305. On 22 April 2021, NHS T&T contacted all local authorities asking for information on how the additional discretionary funding had been used, specifically:

    a. the criteria for the discretionary scheme prior to the additional funding, the changes made since and whether further changes were planned given falling prevalence of COVID-19

    b. details on how the new scheme had been publicised

    c. early evaluation of how additional funding had impacted the administrative burden

306. To address the findings above, the Department agreed several actions to undertake as part of a review of support arrangements in early May 2021 **(BD3/280 - INQ000595355)**. Building on the initial guidance, which set out the importance of local authorities communicating their local criteria for discretionary support, the Department held meetings with local authorities to reinforce this message. The Department also worked with the devolved administrations to share learnings across the 4 nations.

307. NHS T&T also introduced self-isolation pilots, run by local authorities. The Department encouraged local authorities to use the full flexibility available to them to adapt the TTSP scheme to their local circumstances and identify potentially better ways to provide financial support. More information on the self-isolation pilots is at paragraphs 321 to 334 below.

Adult Social Care Infection Fund

308. On 11 March 2020, the Budget 2020 was announced. This included over £5 billion of cashflow support and £1.6 billion of emergency grant funding for local authorities to help them respond to COVID-19 pressures across all their services. On 18 April 2020, the Secretary of State for Housing, Communities and Local Government announced an additional £1.6 billion, taking total local authority emergency grant funding to £3.2 billion **(BD3/281 - INQ000593021)**.

309. On 13 May 2020, after feedback from adult social care sector representatives that funding was not reaching the front line quickly enough, the Department created the Adult Social Care Infection Control Fund. This was a new £600 million ring-fenced fund to tackle the spread of COVID-19. In light of scientific evidence showing significant asymptomatic transmission of COVID-19 in care homes via both residents and staff, care homes were being asked to restrict permanent and agency staff to working in only one care home, wherever possible; and the funding was used to meet the additional costs of restricting staff to work in one care home and pay the wages of those self-isolating.

310. The Department launched the Adult Social Care Infection Control Fund alongside the COVID-19: Care Home Support Package on 15 May 2020. The Care Home Support Package set out the steps needed to keep people in care homes safe and the support available to care home providers to put this in place.

311. The grant determination letter for the Infection Control Fund stipulated that local authorities had to pass 75% of the funding straight to care homes within the local authority's area on a 'per beds' basis (based on the Care Quality Commission Care Directory). On 9 June 2020, the Department published guidance in response to questions received from local government and care providers, which included clarification that local authorities had to ensure that 75% of the grant was allocated to support a range of measures in respect of care homes and that one of these measures was ensuring that

staff who were self-isolating received their normal wages. Funding could also be used to provide accommodation for staff who chose to stay separately from their families to limit social interaction outside of work and make self-isolation easier if needed.

312. Local authorities had to submit 2 high-level returns specifying how the grant had been spent. This helped to provide assurance that local authorities and care providers spent the funding on appropriate measures, including supporting staff to self-isolate.

313. The initial Infection Control Fund was designed to provide funding for 4 months and ran until 30 September 2020. This was to ensure providers and councils used the funding to respond to immediate issues, but also because there was considerable uncertainty about how long the pandemic would last. The funding continued until March 2022, by which point the Department had provided over £2.2 billion in funding for infection prevention and control (IPC) and testing measures, including supporting those in adult social care settings to self-isolate where needed.

Practical Support

314. Throughout the COVID-19 pandemic, local authorities worked with a range of voluntary and community organisations and the NHS Volunteer Responder network to help people who were self-isolating to access practical and emotional support where needed (for example help with food deliveries, befriending services, support with essential tasks). However, there was considerable local variation in the extent, visibility, and timeliness of support available. The government also gave local authorities funding to arrange support for clinically extremely vulnerable (CEV) people through the shielding programme, as announced on 18 April 2020 **(BD3/282 - INQ000106361)** and 4 November 2020 **(BD3/283 - INQ000593062)**, and funding to enable home delivery of medicines to the most vulnerable people in the country, as announced on 13 April 2020 **(BD3/284 - INQ000106346)**.

315. In January 2021, the Department's paper 'Removing Barriers to Self-Isolation and Improving Adherence' sought to assess the level of support given to people self-isolating and identify how to improve adherence to self-isolation requirements **(BD3/271 - INQ000595351).** It proposed working with local authorities to provide a more consistent, visible and accessible framework of practical, social and emotional support for people

self-isolating, modelled on the shielding support framework and expanding the medicines delivery service to cover people self-isolating.

316. The Cabinet Office commission for this paper asked the Department to work with MHCLG to provide information on the provision of temporary accommodation to support self-isolation outside the home, with particular consideration as to how this could support people in multigenerational and high occupancy households and those living with the clinically vulnerable. MHCLG considered options for sourcing alternative accommodation for those self-isolating, including through local authorities and private sector partners, such as hotels and Airbnb. However, the significant delivery challenges and legal risks involved meant that it was unclear whether enough accommodation of the right type and quality, in the right areas, could be sourced to make this a viable offer for people self-isolating. As a result, ministers decided to focus on options with clearer public health benefits and fewer delivery and health risks **(BD3/285 - INQ000566279)**.

317. A COVID-O meeting on 22 January 2021 agreed the following recommendations from the paper **(BD3/274 - INQ000054522; BD3/286 - INQ000092295)**:

    a. to increase communications

    b. to progress non-financial support proposals (subject to submission of a business case)

    c. to explore the expansion of discretionary payments to local authorities

    d. to agree to the enforcement proposals in the paper, subject to a robust parliamentary handling plan to address MPs' likely concerns

The Local Authority Practical Support Framework

318. From March 2021, the Department provided additional funding to local authorities to enable them to go further in offering practical, social and emotional support, where needed, for people self-isolating. The initial overall level of funding was £12.9 million per month from March to June 2021. The Local Authority Practical Support Framework set out a range of types of support that could be funded, but the framework was designed to be flexible so that local authorities and voluntary sector partners could adapt support to reflect needs, demand, capacity and infrastructure in their local areas.

319. Local authorities could use the funding to provide support either directly themselves or via delivery partners including voluntary, charitable and social enterprise organisations. Local authorities were asked to make proactive contact through appropriate means to people flagged by NHS T&T as having specific support needs to offer help in accessing support. Local authorities were also asked to ensure that anyone required to self-isolate who sought help directly from their local authority was able to receive the same help in accessing support as someone referred via NHS T&T. The overall funding was increased to £15.6 million per month from July to September 2021 **(BD3/287 - INQ000565605)**. On 13 September 2021, the Secretary of State and the Chief Secretary to the Treasury agreed that the funding for practical support would be extended **(BD3/288 - INQ000593093)**.

Medicines Delivery Service

320. Following agreement at a COVID-O meeting in January 2021 and a submission to the Lord Bethell on 11 March 2021, the government allocated funding for a free medicines delivery service to support individuals who were self-isolating after testing positive for COVID-19 or being identified as a close contact. £3.2 million a month was allocated to fund this service **(BD3/289 - INQ000565588; BD3/290 - INQ000593078; BD3/291 - INQ000593077; BD3/276 - INQ000593084)**. The medicines delivery service launched on 16 March 2021. The service was for prescription medication only and was available during an individual's self-isolation period where no alternatives were available **(BD3/292 - INQ000565608)**. NHSE made arrangements with participating pharmacies and dispensing doctors to provide the service and the NHS Business Services Authority administered payments. The scheme ran until 5 March 2022 **(BD3/293 - INQ000565625)**.

Self-Isolation Pilots

321. In early March 2021, NHS T&T initiated a programme of pilot interventions for communities disproportionately impacted by COVID-19 and in areas of enduring transmission and variant of concern outbreaks to improve adherence to self-isolation requirements and engagement with the NHS T&T service **(BD3/294 - INQ000595354)**. The kick-off meeting for this programme took place on 9 March 2021 **(BD3/295 - INQ000593079; BD3/296 - INQ000593080; BD3/297 - INQ000593081)** with implementation beginning in the week commencing 15 March 2021.

322. The pilots involved initiatives designed and delivered by participating local authorities to reflect local needs and generate national learning. The aim was to improve the evidence base for successful interventions by encouraging, testing, evaluating and sharing innovative approaches.

323. The pilots were designed to test hypotheses for barriers to engagement with NHS T&T and compliance with self-isolation, including (but not limited to) personal finance, practical and emotional support, living arrangements, communication and motivation, speed of contact tracing, and enforcement.

324. The pilots were in addition to wider work to evaluate the impact of the funding made available for the Local Authority Practical Support Framework and the Medicines Delivery Service. The pilots also evaluated the impact of the enhanced funding (£20 million per month) made available to local authorities to extend eligibility for discretionary TTSP payments. The pilots received HMT approval on 6 April 2021.

325. The pilot funding was in addition to the significant investment in supporting local outbreak management through the Contain Outbreak Management Fund. Local authorities were expected to use the Contain Outbreak Management Fund before submitting a bid for pilot funding.

326. The Department made payments via a section 31 grant to the relevant local authorities. The grant determination letter set out a series of conditions linked to the funding.

327. The pilots running by May 2021 were:

    a. Yorkshire and the Humber – implementation of a community-owned approach to communicating the support that was available across all 18 local authorities within the region

    b. Blackburn and Darwen – an enhanced buddying system, social care support and non-uniformed enforcement

    c. Hackney and the City of London – an enhanced buddying system, social care support and non-uniformed enforcement

    d. Merton – a daily contact testing pharmacy pilot

e. Kingston – contact tracers were assigned to the local hospital to identify positive cases, contact their families and close contacts to advise them to self-isolate and offer them welfare and support, and offer follow-up support when people were discharged from hospital

328. The following pilots focused on the running of temporary accommodation:

a. Newham & Hackney & the City of London – offering temporary accommodation to residents over 18 living in the highest areas of deprivation, who were unable to isolate safely within the family home or house of multiple occupancy (HMO) residences. Residents could self-refer or be referred via housing, benefits or community charities. The pilots also included transport to/from hotels, food parcels/medicines, welfare calls, and support with mental health and wellbeing

b. Peterborough, Fenland & South Holland – increasing uptake of the £500 Test and Trace Support Payment, using a third sector organisation to administer payments; providing financial support through rent payments for those ineligible for Test and Trace Support Payments; topping up local test and trace grants to incentivise workers and employers to increase testing and deploy targeted LFD testing to work places and agency pick up points; increasing job security by providing additional resources to Gangmasters and Labour Abuse Authority (GLAA) officers (whose work includes investigating labour market offences and protecting vulnerable workers), who worked with agencies to ensure job security and ensure agency staff were working for licensed employers; providing COVID-19-safe transport for low paid workers; and providing COVID-19-safe accommodation for those self-isolating in shared accommodation **(BD3/298 - INQ000496250)**.

329. When approving the pilots, HMT also agreed in principle to piloting different forms of financial support, including payments for people with earnings of below £26,000 (in addition to those already eligible for payments by virtue of receiving relevant benefits) and replacing a percentage of lost earnings (rather than paying the fixed-rate £500). Two of the proposed 3 pilots received HMT approval as outlined below in paragraph 331.

330. NHS T&T slides for a Test and Trace Senior Officials Meeting (with attendees from members from NHS T&T, the Community Testing programme, the COVID-19 Taskforce and HMT) **(BD3/277 - INQ000565593)** on 7 May 2021 stated that the reasons why more

eligible individuals did not apply for TTSP payments might include concerns about the level of payment and concerns about job security if they took time away from work to self-isolate **(BD3/299 - INQ000565594; BD3/300 - INQ000593088)**. NHS T&T set out the following options for addressing these potential barriers and proposed piloting them over the 2-week period in which surge testing (increased testing and enhanced contact tracing) was being conducted in areas with variants of concern:

a. replacing the main TTSP scheme with an income threshold for eligibility for the £500 payment, rather than basing eligibility only on receipt of qualifying benefits **(BD3/277 - INQ000565573)**

b. replacing the £500 flat-rate payment with a commitment to pay up to 70% of lost earnings

c. making payments to all who tested positive via a PCR test during a 2-week surge testing period in areas with variants of concern

331. On 7 May 2021, HMT initially confirmed that 2 of the 3 proposed pilots were consistent with the prior approval from the Chief Secretary to the Treasury, with the Secretary of State approving funding for the pilots on 14 May 2021. The 2 pilots were carried out in Bolton and Blackburn, and involved:

a. a £500 payment to positive cases who were on means-tested benefits or earning less than £26,000 per year who would lose income because they had to self-isolate

b. replacement of 80% of lost earnings or a £500 payment (whichever was higher) for those earning less than £26,000 a year or who were on means-tested benefits and would lose income because they had to self-isolate. Total payments would be capped at £1,000 for the period of self-isolation **(BD3/301 - INQ000565595)**

332. These 2 pilots were consistent with 8 criteria previously agreed by the Chief Secretary to the Treasury **(BD3/302 - INQ000593085)**. These criteria included a maximum number of 5 pilots, with a spend of no more than £5 million per pilot and total spend on all self-isolation pilots of no more than £28 million, with a requirement for further HMT approval if DHSC needed to surpass these caps. There was also a requirement for strong monitoring and evaluation, with DHSC to share the results of the pilots with HMT by the

end of May 2021 to inform decisions on the future of isolation support after 30 June 2021. HMT ministers would then approve if any pilots would be taken forward into June 2021 or in national policy.

333. On 14 June 2021, an email from Cabinet Office to HMT and the Department noted that the financial support pilot (income replacement) funding was awaiting HMT approval, but that one local authority was running it at risk already.

334. The UKHSA published an evaluation of these pilots 'COVID-19: evaluation of pilot projects to support self-isolation' **(BD3/303 - INQ000593105)**. This provided an overview of the background to the programme, described the approach to evaluation and the key evaluation findings. The publication reported that:

> *"A number of the pilots did find evidence of positive impacts, but in general it proved difficult to improve compliance with self-isolation or engagement with NHS Test and Trace as measured by testing rates or numbers of contacts shared. For many pilots, however, these outcomes were part of a broader set of aims related to building a sense of community and solidarity and reducing some of the negative effects of self-isolation. Unfortunately, the data was not available to assess the impact of the pilots on these outcomes but given the context within which the pilots were operating, the importance of these wider goals should not be underestimated."*

SECTION 4: SOCIAL DISTANCING REGULATIONS

335. The Inquiry has asked about the evolution of the Tier Regulations, the term by which the national regulations relating to social distancing came to be known. Tier regulations replaced the system of local lockdowns introduced following the end of the first national lockdown, introducing a more standardised approach to applying local restrictions to manage transmission and consistent criteria to match those restrictions to local risk levels. Both local lockdowns and the tier arrangements were designed to reduce social contact in the general population to lessen the transmission of the virus. This had some similarities with the use of self-isolation to help reduce transmission, but self-isolation policy applied to specific individuals who were either infected or had a heightened personal risk of having been infected, whereas local lockdowns and tier restrictions applied to the general population in the relevant local area.

First Tier Regulations

336. On 31 August 2020, Departmental officials provided the Secretary of State with a note on the COVID-19 Taskforce's draft compliance and enforcement paper and the possible design of a system of localised alert levels. They met with the Secretary of State on that date to discuss this proposal. On the same date, the Secretary of State wrote a note to the Prime Minister about risk-based rules on social contact in response to rising case numbers. This note informed the discussion between the Secretary of State and the Prime Minister on 1 September 2020, where the Prime Minister endorsed the Secretary of State's note on risk-based rules **(BD3/304 - INQ000233972; BD3/305 - INQ000234460)**.

337. Discussions continued throughout September 2020 on a strategy for a simpler, risk-based system that would provide greater consistency in how people were being asked to distance themselves from others to limit transmission of COVID-19.

338. On 7 September 2020, DHSC officials sent the Secretary of State a paper for a COVID-19 Strategy meeting **(BD3/306 - INQ000593055; BD3/307 - INQ000595351).** The paper stated that the system of targeted, local action to control outbreaks adopted in June 2020 had created a complex patchwork of bespoke requirements and guidance which could be perceived as inconsistent, were not readily understood by the public and were often hard to enforce. The paper proposed a simpler framework bringing together national and local approaches and using the decision-making processes already in place to consider local responses. This included a tiered approach to social distancing measures, supported by legislation, with the aim of improving compliance with – and enforceability of – those measures **(BD3/308 - INQ000565540; BD3/307 - INQ000595351).**

339. On 23 September 2020, No.10 commissioned the COVID-19 Taskforce for advice on the Local Alert Level policy **(BD3/309 - INQ000234510)**. The Cabinet Office provided advice to the Prime Minister on 25 September 2020, with a Departmental contribution, on the economic impact of the proposed restrictions for different tiers, based on Local Alert Levels, and the process for implementing them **(BD3/310 - INQ000593058; BD3/311 INQ000593059)**.

340. At the end of September and early October 2020, incidence was rising across the country in all age groups **(BD3/312 - INQ000070908)**. On 11 October 2020, COVID-O discussed and agreed the package of restrictions for Local Alert Level 'Very High' **(BD3/313 - INQ000234082; BD3/314 - INQ000234083; BD3/315 - INQ000234552)**. This

incorporated those elements in place for Local Alert Levels 'Medium' and 'High', but with the following additional measures that were designed to further reduce opportunities for people to mix:

a. no household mixing either indoors (as in Local Alert Level 'Medium') or in gardens or other private outdoor settings (with exceptions for support or childcare 'bubbles')

b. no wedding receptions: closure of 'wet led' pubs and bars, which relied entirely on the sale of drinks for their business

341. In addition, it was agreed that there would be scope to agree with local leaders a broader package from a menu of other closures and restrictions, depending on the epidemiology, demography, and economy of the area.

342. With concern continuing about the complexity of different restrictions being applied in different local areas, even after the introduction of the 'Rule of Six' in mid-September 2020, the first national 'tiered' approach was introduced from 14 October 2020. The 3 tiers corresponded to 3 COVID-19 alert levels: medium, high or very high **(BD3/316 - INQ000565547)**, with a standardised set of rules for each tier.

Further Developments on Local Alert Levels

343. The regulations required that the restrictions for all 3 Local Alert Levels or 'tiers' be reviewed at least every 28 days to consider their impact on individuals and on economic and social activities. There was also a requirement to review, at least every 14 days, whether each local authority area allocated to Local Alert Level 'High' should remain allocated to that level.

344. On 28 October 2020, the Secretary of State undertook a statutory review of the Local Alert Level regulations and decided that the restrictions remained necessary and proportionate and that no change was required. At this point it was felt that some areas should be escalated to the highest level, where evidence supported this **(BD3/317 - INQ000058651; BD3/318 - INQ000109906; BD3/319 - INQ000109907; BD3/320 - INQ000109909; BD3/321 - INQ000109910; BD3/322 - INQ000109911)**.

Second National Lockdown and Winter Plan

345. In response to a worsening epidemiological situation, the Prime Minister announced on 31 October 2020 that from 5 November 2020 people would once again be required to stay at home, which was the start of the second lockdown **(BD3/323 - INQ000234586)**.

346. On 10 November 2020, Department officials provided advice to the Secretary of State on the proposed approach for reinstating tiered restrictions following the end of national restrictions on 2 December 2020. This included a proposal to introduce a further tier ('Tier 4') for the areas of highest prevalence, a strengthened package of measures for Tiers 2 and 3 and a slight easement in restrictions for Tier 1 (the lowest tier) to encourage greater compliance with restrictions in the higher tiers **(BD3/324 - INQ000593063)**.

347. On 23 November 2020, the government announced its Winter Plan, which set out its approach to ending the national restrictions on 2 December 2020 and managing COVID-19 through the winter **(BD3/325 - INQ000565561)**. The Winter Plan stated that the new tiers would be applied to areas *"from 2 December, based on analysis of the most up-to-date information"*. Decisions would be based primarily on data on COVID-19 cases and pressure on local health services **(BD3/326 - INQ000106867)**.

348. The Health Protection (Coronavirus, Restrictions) (All Tiers) (England) Regulations 2020 (the 'Tiers Regulations') were published on 30 November 2020 and came into force on 2 December 2020, effectively ending the November 2020 lockdown. These regulations provided for revised tiers for England and for the implementation of 'Christmas bubbles'. Christmas bubbles, or 'linked Christmas households' as they were described in the regulations, were designed to provide additional flexibility for people to choose who they spent time with on 25 December, subject to following a set of rules to help minimise risk of spread of COVID-19 infection.

349. In December 2020, with an exponential rise in confirmed cases in some areas, evidence suggested that Tier 3 measures were not effectively curbing transmission in some parts of England, particularly in Kent, where case numbers had continued to increase. The Department proposed to the Secretary of State that Tier 4 should include a simple 'stay at home' message, along the lines of the March 2020 lockdown, and the closure of non-essential retail, providing that the data supported that decision **(BD3/327 - INQ000234650; BD3/328 - INQ000234667; BD3/329 - INQ000234668)**.

350. The December 2020 statutory review of the Tier Regulations happened in the context of a concerning epidemiological situation and a public appetite to de-escalate areas going into the festive period **(BD3/330 - INQ000234660; BD3/331 - INQ000110194; BD3/332 - INQ000110196; BD3/333 - INQ000110198; BD3/334 - INQ000110199; BD3/335 - INQ000234658; BD3/336 - INQ000110202; BD3/337 - INQ000110200; BD3/338 - INQ000059306; BD3/339 - INQ000234662; BD/340 - INQ000110193).**

Third Lockdown - January 2021

351. On 4 January 2021, the Prime Minister announced a national lockdown following a rapid rise in infections, hospital admissions and case rates across the country. This drastic jump in cases was attributed to the emerging 'Alpha' variant of COVID-19. On that date, there were 26,626 COVID-19 patients in hospital in England, an increase of over 30% in one week, and the April 2020 hospital admissions peak had been surpassed by 40%. Non-essential retail and services were closed down, reducing social contact to try and curb transmission of the new variant.

352. On the same day, the 4 UK CMOs advised that the COVID threat level should move from level 4 to level 5, indicating that if action was not taken NHS capacity might be overwhelmed within 21 days **(BD3/341 - INQ000234693)**.

353. From 5 January 2021, all educational establishments moved to remote learning, except for the children of key workers and vulnerable children. Early years settings were able to remain open and vulnerable children and children of critical workers were able to use registered childcare, childminders and other childcare activities.

SECTION 5: BORDERS

354. The international nature of the pandemic meant that, from the outset, there was a strong focus on how the risk posed by people entering the UK with potential infection could be mitigated. Given the importance of managing this risk, the response required cross-government collaboration, with the Department's role sometimes less central than, for example, the Home Office or the Cabinet Office.

355. Sections 1 and 2 of this statement describe policy concerning contact tracing and isolation in the early pandemic. Whilst isolation and tracing initially focused on those travelling from

Wuhan, as the evidence of wider transmission increased, a more cautious approach at the borders was implemented. Statement B sets out the role that testing played in managing risk of transmissions for those coming into the country in the early months of 2020.

356. This section provides more detail on measures taken in relation to those returning from Wuhan and the rapid extension of those measures to other inbound travellers. It covers the Department's involvement in the development of policy and guidance and key decisions in testing and other mitigations for those entering England from outside the UK, including the development of the Managed Quarantine Service (MQS). It also covers the Department's role in development and implementation of border policies with the emergence of new variants of concern, prior to responsibility for testing policy and the MQS moving to UKHSA.

Border Management for Health Issues Prior to the Pandemic

357. As outlined in Sir Christopher Wormald's First Witness Statement dated 25 November 2022, local authorities have the primary responsibility for responding to public health risks at borders. PHE (now UKHSA) provided advice and expertise as well as any other interventions required for new and emerging public health hazards.

Borders and the Devolved Administrations

358. Policy, guidance and decision-making on testing, isolation or other public health measures for individuals entering the UK are devolved matters for the devolved administrations.

359. DfT led a discussion forum amongst the 4 UK nations, but decision making lay with each of the 4 nations. The JBC provided a weekly public health risk assessment to help ensure decisions in each of the 4 nations were based on a common expert analysis.

360. As explained in Statement A, each of the devolved administrations has its own CMO and DCMOs. The UK CMOs meet regularly and there is collaboration and coordination between the CMOs across the UK Government and the devolved administrations, which supports coordinated scientific advice to the UK Government and the devolved administrations.

Early Quarantine and Self-Isolation Requirements for Those Entering England from Outside the UK

361. As outlined above in paragraphs 167 to 170 of Section 2, quarantine arrangements were introduced in January 2020 for people returning from Wuhan, whilst travellers from China and – from 7 February 2020 – other countries outside the UK were advised to self-isolate following inward travel.

362. On 10 January 2020, PHE published advice regarding travel to China **(BD3/145 - INQ000527874)**. On 21 January 2020, PHE and the CMO, in agreement with the New and Emerging Respiratory Virus Threats Advisory Group (NERVTAG), revised the risk to the UK from very low to low. This was due to observations of human transmissibility and increases in case numbers in China which could indicate the possibility of a minor number of imported cases leading to limited onward transmission **(BD3/342 - INQ000106898)**.

363. On 23 January 2020, the Secretary of State asked for a note outlining options to contact travellers from Wuhan to the UK over the last 14 days to provide advice on the WN-CoV symptoms to look out for and who to contact if they thought they had those symptoms **(BD3/343 - INQ000565491)**. Over a 14-day period, it was estimated that 2,000 people had arrived in the UK from Wuhan alone.

364. On 23 January 2020, Department officials advised a 'best efforts' approach. This proposed asking applicable airlines to email relevant customers with agreed public health information, with, if possible, a click-through link to NHS advice. The Department for Transport (DfT) had provided relevant contact details and the Department planned to begin this process the following morning (24 January 2020). There was an acknowledgement that some airlines might retain passenger details for only 48-72 hours and that this information could be incomplete (for example contain details of travel agents rather than individual passenger details) but this approach was the quickest as most airlines were likely to hold email addresses for travellers **(BD3/343 - INQ000565491)**.

365. On the same day (23 January 2020), the Secretary of State agreed to this approach but was clear that this was a first step and wanted to be able to say at some point that the Department had contacted everyone who had arrived from Wuhan **(BD3/344 - INQ000565492)**.

366. On 24 January 2020, COBR met for the first time to discuss COVID-19 with the Secretary of State as chair. PHE officials briefed COBR that PHE did not hold full contact details for all individuals inbound from Wuhan in the previous 14 days, for example where they had booked through a travel agent, and some returning UK residents, but others were visitors or transit passengers. However, working with the relevant airlines and Border Force, it was possible to send advice to everyone for whom an email address or postal address was available. The Committee's Chair (the Secretary of State) asked that PHE provide regular updates to the Committee on progress in tracing recent returnees and work with Border Force and DfT to ensure they received passenger contact information **(BD3/345 - INQ000056214; BD3/346 - INQ000565493**.

367. By 27 January 2020, the Secretary of State was updated that airlines had provided information on all passengers and that PHE was working with airlines to send a letter to passengers for whom contact details were available **(BD3/347 - INQ000565494)**. The letter advised them, if they had symptoms, to contact NHS 111 and remain indoors avoiding contact with others where possible. The Secretary of State's preference was that these passengers should be advised to self-isolate and that their passport numbers should be used for contact **(BD3/348 - INQ000565599)**.

368. On 28 January 2020, PHE published updated advice for individuals who had returned from Wuhan within the last 14 days. The guidance advised that they should stay indoors and avoid contact with other people (as with other flu viruses) and call NHS 111 to inform them of their recent travel to the city **(BD3/145 - INQ000527874)**.

369. On 27 January 2020, at a COVID-19 meeting, the Secretary of State discussed the process for evacuating the 200 British nationals who were then in Wuhan. The Secretary of State asked the Department to begin preparing immediately for their quarantine or self-isolation and provide advice on either option. Contact tracing was not needed for these individuals (**BD3/349 - INQ000565495)**, as once they arrived in the UK, they were immediately taken to a self-isolation facility.

Testing for Those Entering England from Outside the UK

370. As with other elements of border management during the pandemic, key responsibilities sat with other departments. The Department's role in relation to policy, guidance and key decisions in testing individuals entering England was primarily to provide health input into

a cross-government programme of work on international travel that was initially led by the Home Office and later by DfT. From early 2021, the Department also played a role in the implementation of measures relating to testing those entering the UK through the MQS covered in more detail in paragraphs 401 to 410.

371. Cross-government coordination and governance was overseen by the Cabinet Office Taskforce, with COVID-O a key decision-making body on border restriction measures. The Department provided advice to COVID-O on border restrictions, including testing. However, advice to COVID-O on border issues was primarily coordinated by and/or came from Home Office and DfT.

372. As set out in Sections 1 and 2 of this statement, policy relating to borders and managing the risk posed by those entering the country evolved in January and February 2020. At this time, there was limited knowledge about the virus and limited evidence on what steps might be effective. Although SAGE was able to provide advice based on knowledge of previous viruses (see paragraphs 24 to 36 above), this advice changed as the evidence base grew, which impacted on published guidance.

373. For most of 2020, the main measure taken to reduce risks arising from inbound international travel was to require people travelling from designated countries to self-isolate for a specified period on arrival in the country. From late 2020 onwards, as the availability of testing increased, testing started to be used as a way of reducing the self-isolation period following international travel.

Developing a Coordinated Border Approach

374. On 17 April 2020, the Cabinet Office commissioned a paper on the public health approach at the border to supplement the UK's COVID-19 response **(BD3/350 - INQ000565507)**. Leading on this coordinated approach, the Home Office developed a cross-government programme of work to develop and implement measures to be introduced at the border to reduce the risk of COVID-19 cases coming from abroad. Amongst other things, it was decided that urgent cross-departmental work was required to bring together a proper assessment of the options, which included: temperature checks, testing and tracing, mandatory quarantine, self-validation forms and carrier screening **(BD3/351 - INQ000565508)**.

375. The Department's involvement in the programme included reviewing and advising on the health impact of options for border controls. For example, on 19 April 2020 the Department provided input on papers co-ordinated by the Home Office relating to options for available measures to introduce at the border, enforcement and legislative options, and implementation of border measures **(BD3/352 - INQ000593027)**. These papers were considered by a Small Ministerial Group (SMG) on the Public Health Approach at the Borders on 22 April 2020 **(BD3/353 - INQ000053167; BD3/354 - INQ000565510; BD3/355 - INQ000593028; BD3/356 - INQ000565511; BD3/357 - INQ000593029)**.

376. During this period, the Department provided advice to the Home Secretary and other ministers on the legislative approach to self-isolation, effectiveness of border measures, and policy on self-isolation as detailed below.

Strengthening Isolation and Border Restrictions

Self-Isolation

377. As the epidemiological picture continued to cause concern within government over the early summer of 2020, the Department played a lead role in developing and extending guidance on self-isolation, quarantine and managing risk at the borders (some of which is outlined in Section 2 of this statement). In early June 2020, the Secretary of State agreed a submission on regulations on border measures for international arrivals **(BD3/358 - INQ000234372; BD3/359 - INQ000565520)**. This included a small number of exemptions to self-isolation and enforcement of self-isolation requirements.

378. On 8 June 2020, health protection regulations came into force in all parts of the UK, requiring people arriving in the UK from outside the Common Travel Area to self-isolate for 14 days and to complete a passenger locator form.

Travel Corridors

379. On 6 July 2020, DfT announced that from 10 July 2020 the government was ending the self-isolation requirement for people entering the country from a number of exempt countries and territories known as 'travel corridors'. The JBC, in consultation with PHE and the CMO, developed the approach to assessing the public health risk associated with inbound travel from specific countries and territories. This categorisation was informed by estimations of population infection, virus incident rates and trend data in incidence and

deaths. Data also considered transmission status, international epidemic intelligence, testing capacity and a consideration of the quality of the data **(BD3/360 - INQ000565529)**.

380. To implement the travel corridor policy, regulations were amended to:

    a. require people to submit information via the Passenger Locator Form regarding whether they had been in a non-exempt country in the 14 days preceding their arrival

    b. apply the requirement to self-isolate only to people who had been in a non-exempt country outside the Common Travel Area in the 14 days preceding their arrival

    c. set out the list of countries where travellers were exempt from self-isolation when arriving from those countries **(BD3/361 – INQ000565523)**

381. DfT led the implementation of this framework, with the JBC providing a public health risk assessment of countries (updated weekly), providing the expert analysis for which countries should be designated as travel corridors.

382. In early July 2020, DfT was confirmed as the lead department for borders **(BD3/362 - INQ000593048)**. DfT was primarily responsible for advising COVID-O on testing and other border measures, with the Department providing input where required.

Test to Release

383. From June 2020 onwards, the government began to consider whether some international arrivals (who were not exempt from self-isolation requirements) should be permitted to exit self-isolation early if they took a COVID-19 test with a negative result (known later as 'test to release') **(BD3/363 - INQ000565524**; **BD3/364 - INQ000593044)**.

384. On 23 June **(BD3/363 - INQ000565524)**, 29 July (**BD3/365 - INQ000593049)**, 19 August (**BD3/366 - INQ000565535)**, 28 August (**BD3/367 - INQ000565538)**, 15 September (**BD3/368 - INQ000565541)**, 16 October (**BD3/369 - INQ000565548)**, 29 October (**BD3/370 - INQ000565553)** and 18 November 2020 **(BD3/371 - INQ000593065)**, ministers received advice on 'test to release'. Under the resulting 'test to release' policy, people who had to self-isolate after travelling to England from overseas were given the option of taking a private COVID-19 test after 5 days of their self-isolation period and, if the result was negative, leaving self-isolation.

385. The government worked with the devolved administrations on proposed changes to ensure a common approach across the 4 nations **(BD3/363 - INQ000565524)**.

386. On 17 September 2020, COVID-O agreed to establish a Global Travel Taskforce between the Department and DfT and to consider test to release **(BD3/372 - INQ000090181)**. DfT led on a paper regarding test to release for international travellers, with input from the Department, that was considered by COVID-O on 3 November 2020 **(BD3/373 - INQ000090875)**. In mid-November 2020, the Global Travel Taskforce released a report outlining 13 recommendations for recovery for the travel and tourism sectors. The recommendations on public health measures outlined in the report included introducing test to release in England to allow participating travellers from non-exempt countries to reduce their period of self-isolation and developing a pre-departure testing proposal with partner countries on a bilateral basis **BD/374 - INQ000071627).**

387. On 24 November 2020, the Transport Secretary announced that, from 15 December 2020, passengers arriving in England from countries not on the travel corridor list could be released from self-isolation if they took a private COVID-19 test after 5 full days of self-isolation and had a negative test result **(BD3/375 - INQ000593066)**.

388. On 11 December 2020, following advice from the 4 UK CMOs, the self-isolation period for those returning from high-risk countries was reduced from 14 to 10 days across the UK, alongside the corresponding reduction in the self-isolation period for contacts of positive cases.

Further Border Measures

389. In January 2021, following the emergence of variants that could threaten the success of the UK's new vaccination programme, the government introduced stricter measures at UK borders including pre-departure testing, the closure of travel corridors and managed quarantine for new arrivals **(BD3/376 - INQ000054496)**.

390. On 15 January 2021, in response to increasing concern over the transmissibility and virulence of new strains of COVID-19 evolving internationally, as well as lack of scientific clarity on the impact on the nascent vaccination programme of what, at the time, appeared to be increasing mutability of the virus, COVID-O agreed that all inbound passengers should be required to take a COVID-19 test up to 72 hours before departure, in addition to the existing 10-day isolation period **(BD3/377 - INQ000091666)**. Where proof of a

negative test result was not provided, individuals were not permitted to board transport for travel to England. Where a positive test result was returned, travel was denied. An immediate fine of £500 was applied to any non-exempted individual who failed to comply with pre-departure testing **(BD3/378 - INQ000593070)**.

391. Certain reasonable excuses for not undergoing testing were permitted. In addition, there were mitigations for arrivals from countries where testing was inaccessible. In these circumstances, permission could be granted for a test to take place on arrival instead. **(BD3/379 - INQ000593071)**.

392. The Department provided advice on pre-departure testing and options for additional contingency measures through a submission on 15 January 2021. The Department noted that, while pre-departure testing could significantly reduce the proportion of people travelling to and entering England while infectious, a significant proportion of residual infections would still reach the UK. The Department advised that with tests up to 72 hours before flight, around 90% of travellers who had contracted COVID-19 would not be identified through pre-departure testing and could become infectious before travelling, once travelling or in the UK. The Department provided 2 options which could be added to existing measures to further reduce transmission:

    a. Taking a test on day 7 – The Department advised that taking a test on day 7 would provide an additional layer of protection in identifying asymptomatic cases and preventing them from exiting self-isolation whilst still infectious. Around 94% of travellers who had COVID-19 could be identified through a test on day 7.

    b. Testing of contacts – The Department suggested that this would identify transmission between the person arriving and their contacts and could allow the requirement for extended self-isolation of any second-generation cases and isolation for their contacts **(BD3/380 - INQ000593072)**.

393. As DfT led on the policy advice and implemented the regulations, further questions relating to pre-departure testing should be directed to DfT.

394. On 14 January 2021, the Secretary of State sent a letter to the Chancellor of the Duchy of Lancaster, which proposed a ban on foreign nationals entering the UK **(BD3/381 - INQ000527972)**. On 15 January 2021, following further concerns about variants of concern first identified in Brazil and South America, COVID-O met to discuss stricter

border measures to prevent the spread of new variants of COVID-19 **(BD3/377 - INQ000091666)**. A Cabinet Office paper to COVID-O set out proposed measures for consideration. On the same day, DfT announced that, from 18 January 2021, all travel corridors with the UK would be suspended **(BD3/376 - INQ000054496)**. This meant that all international arrivals, including British and Irish nationals, who had departed from or transited through any country outside the Common Travel Area in the previous 10 days would be required both to take a pre-departure test and to self-isolate immediately for 10 days on arrival. One of the follow-up actions from the COVID-O meeting was for the Department to confirm the process for increasing the frequency of calls to self-isolating international arrivals to a daily occurrence **(BD3/382 - INQ000091668)**.

395. On 21 January 2021, in response to discussion of travel restrictions on South Africa, COVID-O discussed the implementation of stricter measures at the border **(BD3/383 - INQ000091818)**. Further discussions on stricter border restrictions took place at a COVID-O meeting on 26 January 2021 **(BD3/384 - INQ000091682)**. A Cabinet Office paper to COVID-O outlined various measures which formed the basis for discussion, such as the use of government-managed quarantine facilities for arrivals from red-listed countries. The PM decided that the Department should have delivery responsibility for managed quarantine **(BD3/385 - INQ000092305)**. Throughout late January 2021 to early February 2021, the Department provided advice to the Secretary of State on the implementation of managed quarantine and mandatory testing **(BD3/386 - INQ000593074; BD3/387 - INQ000593075; BD3/388 - INQ000527977; BD3/389 - INQ000565580; BD3/390 - INQ000565579; BD3/391 - INQ000565581)**.

396. On 27 January 2021, the Prime Minister made a statement to the House of Commons, in which he indicated that the government was taking additional steps to strengthen the country's borders to stop new COVID-19 strains from entering the UK. He announced that anyone arriving in the UK from the 22 countries covered by the government's travel ban, where there was a risk of known variants, and who could not be refused entry would be required without exception to isolate in government-provided accommodation such as hotels. He announced that the Department was working to establish those facilities as quickly as possible **(BD3/392 - INQ000593073)**.

397. On 8 February 2021, the Department provided a paper for COVID-O on mandatory testing **(BD3/393 - INQ000108596; BD3/394 - INQ000593076)**.

398. On 9 February 2021, the Department announced a suite of measures to introduce tougher measures and enforcement rules for passengers **(BD3/395 - INQ000565583)**. From 15 February 2021, all arrivals into England would be required to take COVID-19 tests on day 2 and day 8 of their 10-day quarantine and those who had been to a 'red list' country (those on the UK's travel ban list) in the previous 10 days were required to purchase a 'quarantine package' covering accommodation in a government-approved quarantine facility and testing. Further information on the Managed Quarantine Service (MQS) is set out below from paragraph 401.

399. On 12 February 2021, the Secretary of State approved the regulations for these new measures **(BD3/396 - INQ000565584)**.

400. The Health Protection (Coronavirus, International Travel) (England) (Amendment) (No. 7) Regulations 2021, which came into force on 15 February 2021 **(BD3/397 - INQ000234291; BD3/398 - INQ000527979; BD3/399 - INQ000234292; BD3/400 - INQ000234294; BD3/401 - INQ000234743; BD3/402 - INQ000234295; BD3/403 - INQ000234745; BD3/404 - INQ000234746; BD3/405 - INQ000234293)**, amended the International Travel Regulations to introduce a new system of:

    a. managed quarantine – for travellers who had been in one of the designated countries which posed a high risk to the UK from importation of a variant of concern (a 'red-list country') in the 10 days prior to arrival in England

    b. mandatory testing – for all travellers who had been outside the Common Travel Area in the 10 days prior to arrival in England

Managed Quarantine Service

401. Corporate Travel Management (CTM) was responsible for identifying and contracting with the individual hotels that supported the Managed Quarantine Service (MQS). DHSC entered into a direct award with CTM on 13 November 2020 and ensured that CTM administered a booking portal to accommodate payments using debit or credit cards. CTM also provided a call centre for travellers who needed additional assistance in making their booking.

402. The Managed Quarantine Service was established on 15 February 2021 to oversee managed quarantine facilities and enhanced testing for passengers entering England

from red list countries which posed the highest risk to public health. As outlined above in paragraph 398, the managed quarantine service was established as part of the government's stricter border measures.

403. Following the relevant COVID-O decision on 26 January 2021 and the Prime Minister's announcement on 27 January 2021, the Department moved quickly to stand up managed quarantine hotels. A minimum viable product was delivered in February 2021, with the service then growing in the following months to match growing demand and making continuous improvement in response to lessons learned. Over 247,000 'red list' passengers from more than 50 countries stayed in managed quarantine hotels **(BD3/406 - INQ000593106)**.

404. The Department held weekly meetings with CTM's senior leadership where operational performance issues were discussed and escalated as appropriate. Performance against the contract was managed and assessed according to the contractual arrangements. Overall performance, including in relation to complaints, was discussed regularly between Departmental officials and CTM and any areas requiring improvement were addressed **(BD3/407 - INQ000593090)**.

405. Refunds could be requested for several reasons, including where the individual no longer required or had not used their test or package (booking cancellations), or where the individual received an exemption from MQS after they had begun their stay in a managed quarantine facility. The following exhibits outline a full list of refund scenarios **(BD3/408 - INQ000593095; BD3/409 - INQ000593096; BD3/410 - INQ000593097)**.

406. Between February and September 2021 there were around £16.8 million of credit card chargebacks made to CTM following payments for test kits or quarantine hotels. Most chargebacks were for testing kits where there was just one invoice, with no way of knowing if the chargebacks were valid without contacting the traveller. As of December 2021, cases referred to Qualco for debt collection totalled £51 million, with the debt position near £65 million **(BD3/411 - INQ000595356)**. To address this, DHSC approved the following immediate mitigating actions to start from September 2021:

    a. sending new invoices to travellers confirmed as staying in hotel quarantine facilities

b. re-invoicing all travellers who had paid for T&T kits, although if the reason for the chargeback was that they had not received the kit, DHSC had no proof to determine otherwise

c. identifying all fraud from amber travellers and sending invoices and/or launching legal proceedings

d. pursuing amber cases where they had a refund and chargeback, after determining if this was criminal activity

407. At the peak of the Managed Quarantine Service, more than 2% of passengers tested positive, including those with variants of concern. In total, over 3,000 travellers from red listed countries were identified with a COVID-19 infection and prevented from transmitting the virus to others through their stay in managed quarantine hotels.

408. While the primary purpose of the managed quarantine hotels was to mitigate the ingress of variants of concern into the wider community, the establishment of the hotels contributed to the continued employment of large numbers of people, often those on low wages and in parts of the country with high levels of deprivation. The programme kept around 10,000 people from the furlough scheme and enabled large numbers of hotels to continue to operate when they otherwise faced closure.

409. After COVID-19, the managed quarantine hotels supported the repatriation of individuals from Afghanistan and Ukraine. The hotels hosted over 15,000 people repatriated from Afghanistan (mostly families and children) and supported the repatriation of individuals needing to leave Ukraine at very short notice.

410. The responsibilities of MQS moved to UKHSA on 1 April 2022.

SECTION 6: DETAINED SETTINGS

411. While testing, tracing and self-isolation policies impacted most sectors across society, some settings required a more tailored approach. How policies were applied to individuals in secure and detailed facilities required particular consideration. This section explains the role that the Department played in relation to testing, tracing and self-isolation in detained facilities between 1 January 2020 and 28 June 2022.

Health Responsibilities in Detained Settings

412. Detained facilities include prisons, mental health facilities, immigration detention, secure children's homes, secure training centres and young offender institutions.

413. People in secure and detained settings are entitled to the same healthcare and preventative measures they would receive if living in the community. However, due to the specific vulnerabilities of those present within detained settings, and because detained settings commonly have large populations of adults and children living in close vicinity, people in detained settings often present with more complex medical and healthcare needs than those of similar ages within the general population **(BD3/412 - INQ000565624)**.

414. As a result, there are challenges with provision of healthcare in detained settings, particularly the variability in range and quality of services and staffing levels between centres **(BD3/413 - INQ000565623)**. This is especially true during outbreaks of infectious disease, which often pose a specific set of challenges and demand close liaison between stakeholders and effective pre-planning to ensure a robust and equitable response and minimal disruption to operational processes **(BD3/412 - INQ000565624)**.

415. NHSE is responsible for commissioning healthcare services in detained settings, including GP, nursing, dental and optometry services **(BD3/414 - INQ000565590)**.

416. The Department is responsible for promoting continuity of care and ensuring that NHSE, UKHSA and other relevant non-departmental public bodies collaborate with each other and with other agencies in providing services in secure and detained settings, including for infectious diseases and health protection incidents, by identifying needs, advising on the evidence base and developing effective governance.

417. The Department has 3 national partnership agreements (NPAs) with the Home Office, NHSE, UKHSA, the Ministry of Justice (MoJ) and His Majesty's Prison and Probation Service (HMPPS) which set a framework of collaboration between agencies. The NPAs cover prisons, immigration removal centres, and the children and young people's secure estate, with the aim of ensuring that threats to health within detained settings are identified and effectively managed **(BD3/415 - INQ000593100)**.

Responding to COVID in Detained Settings

418. At the start of the pandemic, detained settings already had strong links to health services and there were recognised governance structures in place. This was particularly important given the challenges of managing an already vulnerable population, with many health comorbidities, in a confined space during a pandemic.

419. From the outset of the pandemic, MoJ worked closely with PHE and the Department to ensure there was specialist advice for responding to COVID-19 in prison settings.

420. On 16 March 2020, MoJ and PHE jointly published guidance under the title 'Preventing and controlling outbreaks of COVID-19 in prisons and places of detention', which was regularly updated throughout the relevant period **(BD3/416 - INQ000106235)**. The guidance covered the following:

    a. what to do if a prisoner or detainee had symptoms of COVID-19

    b. prisoners or detained individuals who were identified as contacts of a case of COVID-19

    c. clinical assessment and healthcare

    d. staff

    e. routine testing for COVID-19 in a prescribed place of detention (PPD)

    f. visitors

    g. management and reporting of a case or outbreak of COVID-19 in a PPD

    h. transition of prisoners or detained individuals into the community

    i. limiting the spread of COVID-19 in PPDs

    j. reducing the spread of respiratory infections, including COVID-19

    k. risk assessment for staff exposures in the workplace

421. Responding to COVID-19 in prisons required significant cross-government collaboration. In April 2020, the government established the Prison Task and Finish Group, a cross-

government group led by the Chancellor of the Duchy of Lancaster and the Lord Chancellor. The Terms of Reference for the group outlined the following **(BD3/417 - INQ000593025)**:

> *"It will support the delivery of plans, as agreed at GPSMIG on 3 April, to manage resilience within the prison estate by: the phased controlled release on temporary licence of a cohort of lower risk offenders; the establishment of temporary additional custodial accommodation to help reduce the risk of contagion; the rapid expansion of electronic surveillance mechanisms for offenders released on temporary licence; the provision of benefits and settled accommodation for this cohort; the introduction of accredited testing for prison staff, and the expansion of PPE provision for prison staff. The group will work across government to ensure the timely and successful implementation of the measures so as to mitigate risks of C19 transmission within prisons, thereby protecting the NHS and saving lives."*

422. The Prison Task and Finish group ran from 7 April 2020 to 15 June 2020. I exhibit actions and decisions from the first and final meetings of the group **(BD3/418 - INQ000593026; BD3/419 - INQ000593042)**.

Temporary Release of Prisoners

423. On 4 April 2020, to limit the spread of COVID-19 in the prison estate, and to protect the NHS, the government initiated the temporary release of risk-assessed prisoners within 2 months of their release date, under the End of Custody Temporary Release Scheme. No high-risk offenders, including those convicted of violent or sexual offences and anyone of national security concern or a danger to children, were considered for release, nor any prisoners who had not served at least half their custodial term.

424. Additionally, no offenders convicted of COVID-19 related offences, including coughing at emergency workers or stealing personal protective equipment, were eligible. Prisoners with symptoms of COVD-19 could not be released without housing and health support being in place. Those who met the stringent criteria for early release were subject to strict conditions and were electronically monitored. They could be recalled to prison for breaching these conditions **(BD3/420 - INQ000593023)**.

Local Safety and Welfare Plans

425. In February 2021, the Secretary of State approved new regulations supporting the health and wellbeing of social care residents, and the Department continued to work with prison governors to support inmates' wellbeing and producing a range of guidance and materials to support prison governors in implementing local safety and welfare plans.

Managing Prison Outbreaks

426. In February 2021, at a Departmental update to the Civil Service Operations Board, MoJ highlighted the increased numbers of prison outbreaks, and the challenge posed by staff absences due to COVID-19. The Department, alongside HMPPS, MoJ and PHE, took measures to reduce transmission, protect staff and maintain security. This included:

    a. testing at a higher rate, ensuring outbreaks of COVID-19 could be identified and controlled earlier, breaking chains of asymptomatic transmission

    b. implementing vaccination for prisoners over 80 years of age in England, which had been introduced from 27 January 2021

    c. NHS vaccinations for all prisoners over 70 and any clinically extremely vulnerable prisoners (2 of the 4 priority groups for national vaccination roll-out), in line with progress in the wider community

    d. increased use of technology by His Majesty's Courts and Tribunals Service (HMCTS) to facilitate remote hearings and to ensure that it was safe for people to attend court when asked to do so, as well as ensuring court buildings were COVID secure **(BD3/421 - INQ000595353)**

Testing

427. The Department worked with MoJ to ensure that any tests used in detained settings were valid and reliable. This is demonstrated in exchanges between Lucy Frazer KC, Minister of State at MoJ, and ministers in the Department of Health and Social Care. For example, on 1 April 2020 Lucy Frazer KC sent a letter to Jo Churchill regarding COVID-19 testing for HMPPS staff **(BD3/422 - INQ000593022)**. This letter outlined MoJ's plans to roll out mobile antibody testing units for HMPPS staff and asked the Department to *"expedite*

PHE approval and confirm that you are content with us to proceed without staff testing model".

428. At this point in the pandemic, antibody tests had not been assured. As such, Lord Bethell, as the minister responsible for COVID-19 testing, responded to Lucy Frazer KC to say that *"our experts are clear that we need to be guided by the science, and that an unreliable test would be more detrimental than no test. Were people to return to work based on inaccurate tests, it could risk them contracting and spreading the virus. It is therefore critical that we establish confidence in the tests before they are rolled out publicly"* **(BD3/423 - INQ000593024)**.

429. On 23 April 2020, COVID-19 testing was expanded to all essential workers in England. A press notice from the Department announced: "*A network of new mobile testing units is being rapidly established. These will travel the country to reach care homes, police stations, prisons and other sites where there is demand for testing. The units have been designed to clinical requirements by army engineers and can be easily set up in under 20 minutes*" **(BD3/424 - INQ000562637)**. By 28 May 2020, HMPPS had referred over 4,000 people for testing **(BD3/425 - INQ000593038)**.

430. In addition to symptomatic testing, asymptomatic testing was carried out in prisons. As set out in paragraph 141 of Statement B, Pillar 4 of the Testing Strategy focused on surveillance testing to understand the rate of COVID-19 infection. Prisons were one of the settings in which surveillance testing was conducted.

431. As described at paragraph 144.I. of Statement B, the COVID-19 in Prison Study (CiPS), which ran from July 2020 to May 2021, was delivered by the University of Southampton, PHE, MoJ and HMPPS. In phase 1, the study estimated the incidence of SARS-CoV-2 infection among residents and staff within 28 prisons across England **(BD3/426 - INQ000562665)**. There were 2 rounds of testing, 6 weeks apart. It also examined how the proportion of positive tests and estimated incidence rate varied according to individual, institutional and factors. In phase 1, the study enrolled 6,315 staff members and 10,466 residents. Participants were tested for SARS-CoV-2 using a swab test. Staff were also tested for antibodies to SARS-CoV-2. Phase 2 focused on SARS-CoV-2 infection in prisons with recognised COVID-19 outbreaks. In 3 prisons where there was an outbreak, all participating staff and residents were tested for SARS-CoV-2 antigens at 3 different timepoints on each prison site, at day 0, 7 days later and then 21 days later.

432. On 23 December 2021, on the advice of UKHSA and in response to the threat posed by the Omicron variant, HMPPS introduced mandatory COVID-19 testing for HMPPS employees (**BD3/427 - INQ000593098)**. All staff working in prisons and approved premises were required to take 2 LFD tests and 1 PCR test each week, prior to commencing duty, to reduce the risk and scale of COVID-19 outbreaks. On 23 December 2021, the Deputy Prime Minister, Lord Chancellor and Secretary of State for Justice wrote to the Chancellor of the Duchy of Lancaster requesting additional COVID-19 tests following the introduction of mandatory testing **(BD3/428 - INQ000532572)**.

Immigration Detention Centres

433. The High Court ruled that the Department took sensible and precautionary measures in relation to protecting detainees at immigration detention centres during the pandemic. As of the week commencing 23 March 2020, there were 736 people in detention, the vast majority of whom were foreign national offenders. The Department followed all PHE guidance on coronavirus and had robust contingency plans in place including measures such as protective isolation.

434. Detainees arriving at an immigration removal centre were medically assessed by a nurse within 2 hours of their arrival and by a doctor within 24 hours. All immigration removal centres had dedicated health facilities run by doctors and nurses which were managed by the NHS or appropriate providers.

435. Handwashing facilities were available in all immigration removal centres and the Department worked closely with suppliers to ensure adequate supply of soap and cleaning materials.

436. Appropriate personal protective equipment was available to contractor and healthcare staff when interacting with detainees being held in isolation.

STATEMENT OF TRUTH

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

Name: Ben Dyson

Date: 11 April 2025

Signature: **Personal Data**