Witness Name: Jessie Owen
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UK COVID-19 INQUIRY

CORPORATE WITNESS STATEMENT OF JESSIE OWEN

I, Jessie Owen, will say as follows: -

1.SECTION 1: INTRODUCTION AND EXECUTIVE SUMMARY

1.1. I am a senior civil servant and serve as a Director in the Cabinet Office. I have held this position since April 2021. Prior to this, I was Deputy Director for Testing and Tracing Delivery in the COVID-19 Taskforce (CTF) from September 2020 until late February 2021 when I temporarily took over the role of Acting Director of the same team until early April 2021.

1.2. This corporate witness statement is produced to address questions that have been raised in a Request for Evidence pursuant to Rule 9 of the Inquiry Rules 2006 and sent to the Cabinet Office on 6 September 2024 (the 'Rule 9').

1.3. This statement sets out the role and responsibilities of the Cabinet Office, including No.10, in relation to testing, tracing and isolation (TTI) during the COVID-19 pandemic. This statement has been prepared with the assistance of Counsel and the Government Legal Department (GLD).

1.4. The relevant period for Module 7, as specified by the Inquiry, is from 1 January 2020 to 28 June 2022. As above, I was Deputy Director for Testing and Tracing Delivery in the CTF from September 2020 until late February 2021 at which point I took over the role of Acting Director for Testing and Tracing, covering for Oliver Munn, until 2 April 2021. For the period when I was not in the CTF, and for other details provided, my statement relies entirely on papers and accounts provided by others who worked in the Cabinet Office including No.10 at the time.

1.5. Due to the magnitude of work undertaken across government, academia, industry, healthcare, and internationally, as well as the volume of material that relates to the

development and delivery of the TTI programme, it is not possible to provide a comprehensive account of every activity carried out by the Cabinet Office including No.10 during the relevant period. Instead, an overview of events is provided.

1.6. The Cabinet Office has provided the Inquiry with evidence regarding the procurement of testing equipment, supplies and services, for Module 5 of the Inquiry. Where relevant, this statement replicates at high level the information provided in the corporate statements for Module 5.[1]

Executive Summary

1.7. The Department of Health and Social Care (DHSC), led by the Secretary of State for Health and Social Care (Health Secretary), was the department responsible for TTI before and throughout the pandemic. The TTI system was operated by NHS Test and Trace (NHST&T), later replaced by the UK Health Security Agency (UKHSA). The Cabinet Office including No.10 played an important role in relation to TTI, including but not limited to: supporting the design and delivery of an ambitious strategy from early on in the pandemic; establishing effective governance structures; encouraging public and industry engagement with the TTI programme; and facilitating joined-up working across government.

1.8. At the outset of the pandemic, the UK had very limited capability and infrastructure to test for cases of the novel coronavirus and trace their contacts. Setting up a test and trace system on the scale and at the speed demanded by the virus posed an unprecedented challenge. The UK Government worked to meet that challenge in collaboration with the wider public sector, industry, academia, local government and others. In the event, the UK's testing programme became the biggest in Europe, with nearly 400 million tests carried out by mid-December 2021, twice the number in France and more than four times the number in Germany.[2]

1.9. Coming out of the first lockdown, as NHST&T was established, the UK Government's aim could be summarised as seeking to reopen the economy and society as extensively as possible while keeping the reproduction number (Rt) below 1. According to estimates from UKHSA's September 2021 'Canna model' assessment of the impact of TTI on COVID-19 transmission, in several periods of the pandemic (August 2020, November 2020, January to April 2021), TTI was critical in reducing Rt to below 1 and thereby preventing exponential

[1] JO/001 [INQ000497031]
[2] JO/002 [INQ000575410]

growth in infections. As well as bringing incidence rates down, UKHSA also assessed that TTI helped to reduce the duration and economic impact of non-pharmaceutical interventions (NPIs) such as lockdown and other social restrictions.[3] The data collected by the TTI system was also vital for the Government's understanding of the prevalence and evolution of the virus, which helped to inform the development and evolution over time of the overarching strategy for managing the pandemic.

1.10. As well as the traditional role for TTI - finding *positive* cases and acting on those results so as to break chains of transmission across the country and in higher-risk settings - the development of lateral flow devices (LFDs) meant rapid self-testing could increasingly be used to help individuals to manage their own risk. These devices found a huge number of *negative* results, giving individuals the confidence that they could safely, for example, go to work or visit an elderly relative.

1.11. There were of course constraints and trade-offs in the TTI approach. There were scientific constraints - the tests needed to effectively detect the virus, and consistently effective LFDs for COVID-19 were not developed until summer 2020. There were operational constraints - building testing laboratories takes time, as does procuring LFDs internationally at a time of huge global demand. There were enormous fiscal costs - the TTI budget in the financial year 2020-21 exceeded that of the Home Office, and the programme cost £15.7 billion in the financial year 2021-22.[4] Even then, there were limits on testing capacity, and at times therefore a need for prioritisation of access. Throughout, the effectiveness of the TTI programme relied on public uptake of the testing that was offered, and compliance with trace and isolate policies - public engagement was not guaranteed and individuals' ability and willingness to engage with the TTI programme was not equal. Finally, TTI had implications for the wider economy, most notably in the 'pingdemic' when so many contacts were asked to self-isolate there were risks to the staffing of critical sectors and infrastructure.

1.12. The Cabinet Office's role in this context was three-fold: first, to provide advice to the Prime Minister and the Chancellor of the Duchy of Lancaster (CDL); second, to be a 'critical friend' to NHST&T (later the UKHSA); and third, to facilitate cross-government collaboration and decision-making, particularly where the constraints, trade-offs or externalities reached more widely than the remit of the lead department, DHSC.

Statement overview

[3] UKHSA Canna Model Assessment JO/003 [INQ000262568]; see also advice contained within JO/004 [INQ000575291]
[4] JO/005 [INQ000086652], page 17

1.13. This statement outlines the work of the Cabinet Office including No.10 in relation to TTI policy and delivery over the course of the pandemic.

1.14. For context, **Section 2** begins by explaining the general role of the Cabinet Office including No.10 at the centre of the UK Government. As the Inquiry has heard in earlier modules, the Cabinet Office including No.10 coordinates the effective functioning of government. This includes: advising on overall strategy, facilitating collective agreement, determining the structures for the making of decisions and the assurance of progress, providing challenge, and acting as a point for escalation where needed. The Cabinet Office including No.10 also plays a key role in providing advice to the Prime Minister and other ministers about the issues and priorities on which they should focus their time and influence.

1.15. The nature of the involvement of the Cabinet Office including No.10 in any one policy area evolves to reflect the priorities of and demands facing the Government and its ministers at any given time. As Section 2 sets out, the role of the department in TTI was limited prior to COVID-19 but then expanded and evolved as the response to the pandemic unfolded. Section 2 outlines at a high level the structures within the Cabinet Office that were set up in response to the pandemic, and introduces the key teams within the department and across the wider government and TTI system that worked to progress the TTI agenda in response to COVID-19.

1.16. **Section 3** details the role and involvement of the Cabinet Office in developing test and trace capabilities to respond to COVID-19. The section describes the role of the Cabinet Office in supporting the initial scale-up of test and trace in the first half of 2020, before explaining the department's work to introduce large-scale testing as new rapid testing technologies became available from summer 2020. The section explains the development of NHST&T and how the Cabinet Office worked with NHST&T and other parts of government to ensure the TTI system could adapt to challenges arising through the COVID-19 response.

1.17. **Section 4** focuses on the Cabinet Office's work in relation to self-isolation policy both domestically and in relation to international travel. The section describes the Cabinet Office's work to consider ways to maximise compliance with self-isolation guidance, including through the provision of financial support, and outlines how the Cabinet Office helped to manage the economic and social impacts of self-isolation through the introduction of regular testing and exemptions for workers in critical services.

1.18. **Section 5** sets out the role of the Cabinet Office in maximising public engagement with TTI policies, which was key to reducing transmission of COVID-19, particularly in the absence of a vaccine or drug-based treatment. The section describes the role of the Cabinet Office

Comms Hub in supporting the development of public messaging in relation to TTI. The section also explains the way in which the Cabinet Office supported other government departments to explore incentives to encourage public compliance and manage enforcement of policies at the local level.

1.19. **Section 6** explains the Cabinet Office's work to maximise the accessibility of NHST&T, and support those following self-isolation guidance. The section describes the work of the Equality Hub in this regard, and explains the important role of public communications in encouraging compliance with test, trace and isolate policies.

1.20. **Section 7** focuses on lessons learned, outlining the Cabinet Office's involvement in a number of exercises to review and reflect on the response to COVID-19 so that learnings can be identified for future planning.

2.SECTION 2: ROLE OF THE CABINET OFFICE INCLUDING NO.10

The general role of the Cabinet Office including No.10

2.1. As described in corporate statements for earlier modules of the Inquiry, the Cabinet Office, including No.10, has a unique role at the centre of UK Government.

2.2. The Cabinet Office has responsibility for "supporting collective government, helping to ensure the effective development, coordination and implementation of policy".[5] A key part of this role is supporting collective decision-making through Cabinet and its committees. As the Cabinet Manual[6] sets out, "Cabinet is the ultimate decision-making body of government. The purpose of Cabinet and its committees is to provide a framework for Ministers to consider and make collective decisions on policy issues…The Cabinet system of government is based on the principle of collective responsibility. All government ministers are bound by the collective decisions of Cabinet, save where it is explicitly set aside, and carry joint responsibility for all the Government's policies and decisions".[7]

2.3. Not all government decisions require collective agreement. The Cabinet Manual does not give definitive criteria for issues which engage collective responsibility, but makes clear that "proposals will require consideration by a Cabinet committee if: the issue is likely to lead to significant public comment or criticism; the subject matter affects more than one department; and/or there is an unresolved conflict between departments".[8] The Cabinet Manual also sets out that "policy proposals with public expenditure implications will not be agreed unless Treasury ministers are content. If necessary, issues can be referred to the Prime Minister or, if he or she so decides, to Cabinet for a decision".[9]

2.4. The Cabinet Office enables collective decisions and provides direct policy and implementation advice to the Prime Minister, the CDL[10] and other Cabinet Office Ministers. It

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[5] See description of Cabinet Office available at: JO/006 [INQ000086870], page 1

[6] The Cabinet Manual sets out the main laws, rules and conventions affecting the conduct and operation of government, and is available at: JO/007 [INQ000182315]

[7] As per the Cabinet Manual: Collective responsibility "means that a decision of Cabinet or one of its committees is binding on all members of the Government, regardless of whether they were present when the decision was taken or their personal views. Before a decision is made, ministers are given the opportunity to debate the issue, with a view to reaching an agreed position. It is for the Prime Minister, as chair of Cabinet, or the relevant Cabinet committee chair to summarise what the collective decision is, and this is recorded in the minutes by the Cabinet Secretariat." Collective responsibility "requires that Ministers should be able to express their views frankly in the expectation that they can argue freely in private while maintaining a united front when decisions have been reached. This in turn requires that the privacy of opinions expressed in Cabinet and ministerial committees, including in correspondence, should be maintained." JO/007 [INQ000182315, page 31]

[8] See Cabinet Manual: JO/007 [INQ000182315], page 33

[9] See Cabinet Manual: JO/007 [INQ000182315], page 35

[10] The CDL is a member of the Cabinet. During the relevant period ministerial responsibilities included: oversight of all Cabinet Office policy; oversight of constitutional policy and enhancement; oversight of Cabinet Office

draws on policy advice, expertise, data and analysis from departments with lead responsibility for specific issues, such as HM Treasury (HMT) for the economy, and the DHSC for public health.

2.5. Throughout the pandemic, including in the context of work relating to TTI, many decisions rightly continued to be taken within individual departments. Where collective decisions were not required, the role of the Cabinet Office was, as is typical for the centre of government, focused around strategic coordination, ensuring collaboration between the relevant parts of government, assuring progress and providing challenge to help strengthen policy-making and ensure alignment with the Government's overarching strategic objectives.

2.6. The decision as to how and to what extent the Cabinet Office supports or challenges departments is always a matter of judgement. Senior officials and ministers use a range of factors - from political direction and appetite to more intangible factors like confidence in the management of an issue in a department or if a neutral broker on a contentious matter between departments is required - to decide where the department needs to step in.

2.7. The Cabinet Office also has responsibility for "coordinating the Government's response to crises",[11] working closely with Lead Government Departments (LGDs).

2.8. As the Government's website explains, "The Prime Minister is the leader of His Majesty's Government and is ultimately responsible for the policy and decisions of the Government".[12] He or she is advised and supported by officials and special advisers (temporary civil servants appointed directly by ministers who can, in addition to other roles, provide political support) based in No.10. Together they help the Prime Minister "to establish and deliver the Government's overall strategy and policy priorities, and to communicate the Government's policies to Parliament, the public and international audiences".[13]

2.9. Teams based in No.10 are part of the Cabinet Office. Teams based in No.10 ordinarily include (but are not limited to) a private office, the 'PM Post' team and a press office. The precise configuration of teams based in No.10 evolves over time at the discretion of the Prime Minister. During the relevant period it also housed a policy unit (throughout), a data and science team (from summer 2020) and a delivery unit (from spring 2021). In addition, an interim COVID-19 team was set up in No.10 in March 2020 (and subsequently merged into

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responsibilities on national security and resilience; and supporting coordination of the cross-government and devolution aspects of the response to COVID-19.

[11] See description of Cabinet Office available at: JO/006 [INQ000086870], page 1

[12] See in particular the corporate witness statement of Simon Case on behalf of the Cabinet Office for Module 2: JO/008 [INQ000092893], paragraphs 2.33-2.38.

[13] 10 Downing Street is described at: JO/009 [INQ000086873]

the CTF). These teams, dependent on the Prime Minister's priorities, will have engaged with issues relating to TTI during the period. Hereafter, when describing the department's work I will typically refer to the Cabinet Office including No.10 with the shorthand 'the Cabinet Office'.

Role of the Cabinet Office in TTI prior to the COVID-19 pandemic

2.10. The role of the Cabinet Office in preparing for a pandemic was set out in detail in the corporate statements of Roger Hargreaves for Module 1 of the Inquiry. I repeat and enlarge upon various issues specific to TTI preparedness in this statement in order to explain the department's involvement in and understanding of this work at the time of the coronavirus outbreak in January 2020.

2.11. As the Inquiry explored in earlier modules, risk management responsibilities in the UK Government are based on the LGD model, whereby responsibility for risk preparedness and management sits with individual departments.

2.12. The Cabinet Office is responsible for deciding and designating LGDs. An LGD will usually be the department with primary policy responsibility for the risk and the expertise for the area impacted by the emergency scenario. LGDs, with support from other departments and bodies, are responsible for national-level risk anticipation, assessment, prevention and mitigation, preparation, and response. DHSC is the LGD for infectious human diseases and pandemics. In line with the LGD principles, DHSC had and continues to have overall responsibility for putting in place arrangements to respond to the potential impacts of these risks, including diagnostics, contact tracing, isolation and medical countermeasures.

2.13. Specifically within DHSC, as of January 2020, responsibility for responding to public health outbreaks fell to Public Health England (PHE, an executive agency of DHSC) - this included the protocols for testing the small number of suspected cases of dangerous imported infections, tracing and identifying contacts of confirmed cases, offering vaccination or prophylaxis if available, and encouraging them to isolate, in order to minimise onward transmission. These functions were not designed for response to a population-wide pandemic and therefore PHE led the efforts to test, trace and isolate all cases of the novel coronavirus until 16 March 2020, when the decision to cease comprehensive tracing of all community cases was taken in the face of rapidly rising infection levels in the population. Thereafter, DHSC led efforts to scale up testing and tracing capacity in England, with significant increases in capacity from April 2020 onwards. NHST&T was established in May 2020 to work in conjunction with PHE. When the UKHSA became operational in October 2021, bringing together the health protection elements of PHE and NHST&T, these responsibilities

were transferred to the new agency.

2.14. The Cabinet Office is also responsible for producing the public-facing National Risk Register (NRR) and the classified version, the National Security Risk Assessment (NSRA). Both the NRR and NSRA identify and assess the likelihood and impact of the most serious risks facing the UK and its overseas interests, acting as a tool to support emergency planning. The risks in the NSRA are identified and assessed by LGDs, and later tested with non-risk-owning stakeholders and experts including departmental Chief Scientific Advisers (CSAs) and the devolved administrations to enable challenge and identify gaps. DHSC is and was responsible for assessing the risks related to infectious human diseases and pandemics.

2.15. The assessment of risks in the NRR and NSRA was and is based on a Reasonable Worst Case Scenario (RWCS), produced by LGDs in consultation with experts, for example their CSA, other departments and agencies, the intelligence community, industry and sector stakeholders, and external scientific, academic and policy subject experts. The RWCS is neither a prediction of what will happen, nor the most likely scenario, but instead supports risk planning by giving an illustration of the worst manifestation of a risk that can reasonably be expected to occur based on current information and data.

2.16. The NSRA and NRR aid risk preparedness activity by identifying and assessing the likelihood and potential impacts of the most serious risks facing the UK and its overseas interests, and the contingency measures that would be required to respond if the risk were to manifest. However, neither the NSRA nor NRR provide an assessment of the Government's preparedness at any given time for employing the contingency measures identified.

2.17. Alongside its role in producing these risk assessments, the Cabinet Office supports and helps to coordinate contingency planning work undertaken within LGDs. This ordinarily includes high-level coordination of cross-department work, rather than detailed planning within sectors. This means that the Cabinet Office did not and does not routinely have any significant or close involvement in preparedness activity relating to TTI. As above, as the LGD, DHSC and its agencies had and continue to have overall responsibility for contingency planning for infectious human diseases and pandemics, including TTI preparedness. The Cabinet Office, continuing to work closely with the LGD, takes on a leadership role within a response where the scale, severity or complexity of an emergency means that some degree of central government support or coordination becomes necessary. For all risks, the decision to move to a centrally led response remains at the discretion of the Prime Minister.

2.18. The Cabinet Office was not and would not have been expected to be routinely involved in the detailed TTI work led by DHSC and its agencies, for example, establishing, maintaining or

monitoring infrastructure, laboratory capacity, testing technologies or other associated capabilities, nor would the Cabinet Office be expected to assess overall UK preparedness to develop and scale diagnostics for a given disease. This more detailed preparedness work would fall under the responsibility of DHSC as the LGD. DHSC and its executive agencies, notably the UKHSA, would therefore be best placed to summarise and comment on the adequacy of the TTI policies and strategies in place prior to the onset of the COVID-19 pandemic.

2.19. The Cabinet Office's understanding is that prior to the COVID-19 pandemic, PHE's approach to identification, detection, and assessment of imported diseases, and latterly surveillance for further cases, was based on the First Few Hundred Enhanced Case and Contact Protocols (FF100), which were closely aligned with the First Few X Case and Contact Investigation Protocols (FFX) best practice used by the World Health Organisation. The FF100 approach - used to respond to several prior UK outbreaks (including Middle East Respiratory Syndrome (MERS) and Avian Influenza (H7N9)) - involves looking at the first few hundred cases to understand the key clinical, epidemiological and virological characteristics of an emerging infection and inform development of public health guidance to reduce the potential spread and impact of infection in the UK.[14]

2.20. As detailed in Roger Hargreaves' statements for Module 1 of the Inquiry,[15] the Cabinet Office was involved in a number of cross-government influenza pandemic preparedness forums and/or work programmes led (or co-chaired) by DHSC in the years prior to the COVID-19 pandemic. While not specifically focused on preparedness for diagnostics and containing the spread of a pandemic virus, the Cabinet Office was aware at a high level of department-led activity in this area through its involvement in official-level forums such as the Pandemic Flu Readiness Board (PFRB) and DHSC's Pandemic Influenza Preparedness Programme (PIPP) Board, and attendance at other ad hoc meetings.

2.21. The PFRB, which was co-chaired by the Cabinet Office and DHSC as a cross-sector pandemic preparedness forum from 2017-2020, did not go into any particular detail on preparedness work relevant to this module.

2.22. The PIPP Board, which focused specifically on health sector preparedness, and included senior representatives and experts from DHSC and health bodies such as PHE and the NHS, received regular updates on PHE's pandemic influenza preparedness work, including on

[14] JO/010 [INQ000022727]
[15] JO/011 [INQ000195845], JO/012 [INQ000145912], JO/013 [INQ000182612]

work relating to community surveillance and laboratory capacity. Examples of the PHE papers provided to the PIPP Board are exhibited.[16]

Previous pandemics and exercises

2.23. A detailed overview of the learning from previous outbreaks and simulation exercises prior to the COVID-19 pandemic was provided in Roger Hargreaves' statements for Module 1. These are not repeated here. Instead, I refer to a number of specific examples with particular learnings for TTI-related preparedness work.

2015 MERS-CoV

2.24. In February 2016, PHE led a tabletop exercise - Exercise Alice - to explore the challenges of a potential large-scale outbreak of MERS-CoV in the UK. Representatives from PHE, DHSC and NHS England participated in the exercise, with observers from the Cabinet Office (who facilitated parts of the exercise at the PHE's request), the devolved administrations and the Government Office for Science (GO-Science).

2.25. One of the four objectives for Exercise Alice was 'to explore the capability for contact tracing and quarantining of possible MERS-CoV cases'. The exercise report notes a "controversial and wide ranging" discussion on the options to 'restrict the movement of symptomatic, exposed and asymptomatic patients and whether this was voluntary or through the imposition of restriction'. The report notes that the group "did not resolve the quarantine/self-isolation issues" during the exercise, but an action was identified 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". An action from the exercise included to 'develop a MERS-CoV serology assay procedure to include a plan for a process to scale up capacity'. A number of actions were also taken relating to strengthening the ability of the system to trace, collect data from and communicate effectively with potential contacts of MERS-CoV. The full report for Exercise Alice, produced by PHE, is exhibited.[17]

2016 Exercise Cygnus

2.26. Exercise Cygnus was a cross-government exercise conducted in October 2016 to test the UK's preparedness and response to a near-worst-case pandemic influenza outbreak. Exercise Cygnus was led by PHE, on behalf of DHSC, and included 12 other government

[16] JO/014 [INQ000005963]; JO/015 **INQ000057303** JO/016 **INQ000023020**
[17] JO/017 [INQ000001213]

departments as well as the NHS, local public services and several prisons. The Cabinet Office was represented in the planning group and in the exercise itself.

2.27. As per the Exercise report,[18] the scenario for Exercise Cygnus was set in week 7 of the UK's response to a pandemic influenza, at a point when the emphasis was on 'considering the enhancement of public health measures to disrupt transmission and the escalation of surge management and triage of service delivery in order to maintain essential services'.[19]

2.28. The lessons from Exercise Cygnus resulted in the Civil Contingencies Secretariat (CCS) working with DHSC to lead the preparation of the Pandemic Influenza Bill as a legislative vehicle for pandemic response measures. As set out in Roger Hargreaves' corporate statement for Module 1, this Bill ultimately formed the basis for the Coronavirus Act 2020 and informed the Government's initial response to COVID-19.

2.29. The minutes of a Scientific Pandemic Influenza Group on Modelling (SPI-M) meeting on 20 January 2017, following Exercise Cygnus, note a discussion on laboratory capacity during which PHE acknowledged that "there may be lab capacity issues in future, depending on the nature of any outbreak" but that PHE were "confident that everything that could be done to mitigate that [had] been done".[20]

2.30. The Cabinet Office is not best placed to comment on the extent to which learnings from previous pandemics and pandemic exercises in relation to TTI were considered in formulating the Government's initial response to COVID-19, given that the early work to test, trace and isolate those exposed to the novel coronavirus was led by PHE and DHSC. The role of the Cabinet Office in supporting work on TTI in the early months of the pandemic is detailed in Section 3 (notably paragraph 3.1-3.23).

Summary of the Cabinet Office's role in TTI during the pandemic

2.31. Throughout the pandemic, the Cabinet Office provided advice to ministers to inform the Government's overall COVID-19 strategy and ensure that it took account of developments in the test and trace programme.[21] This involved working closely with, among others, the DHSC and its agencies with departmental ownership of related policies, including with NHST&T which led on the supply and procurement of testing equipment as well as the vast majority of

[18] JO/018 [INQ000057310], page 3

[19] Ibid., page 6

[20] JO/019 [INQ000006429], page 3

[21] Examples of government strategies supported by the CTF included: 'Our plan to rebuild' (JO/20 **INQ000086867**; 'COVID-19 Winter Plan' (JO/021 **INQ000137262**; 'COVID-19 Response - Spring 2021 roadmap' (JO/022 **INQ000185087**; and, 'COVID-19 Response: Autumn and Winter Plan 2021' (JO/023 [INQ000480678]). Each strategy included a section detailing the Government's work in relation to TTI, explaining how TTI related to and helped to inform the wider pandemic strategy.

the delivery and rollout of the test and trace programme. In line with the LGD model, ministerial accountability for testing remained with the Health Secretary throughout the pandemic.

2.32. At the start of the pandemic, the existing test and trace capabilities were not sufficient to cope with the scale of demand posed by COVID-19. As the scale and potential impact of the pandemic became apparent, the Government initiated a huge cross-government effort to quickly build, roll out and maintain a new system of national-level capabilities. Given the scale and importance of this work, the Cabinet Office took a close interest in progress. Over time, the Cabinet Office worked to understand existing testing capability, exploring opportunities to support and accelerate DHSC's work to scale up testing capacity, for example through Prime Ministerial engagement with industry.[22]

2.33. As work on testing increased in scale and complexity, the Cabinet Office turned its attention to ensuring effective and innovative structures were in place, which included appointing an external expert Chair, Baroness Harding, to lead the programme that became NHST&T. The Cabinet Office also worked to establish the necessary governance structures to facilitate discussion and collective decision-making by ministers as the response to COVID-19 progressed, including the COVID Strategy and Operations committees (COVID-S and COVID-O). Further detail is provided at paragraph 2.41.3 and in Annex A (paragraph 8.15-8.20).

2.34. Once these government structures were set up, the Cabinet Office worked to ensure that overall strategy continued to take into account progress by NHST&T and provided oversight and assurance for the Prime Minister as the testing programme was rolled out. Given the importance of testing to the Government's overarching strategy, a key role of the Cabinet Office was to seek to ensure that all parties involved were challenged to maximise the scale and effectiveness of the testing programme, in line with the Government's aim to use testing to minimise the spread of the virus, and thereby enable a return to normality in the absence of an effective vaccine or drug-based treatment.[23]

2.35. As capacity increased, the Cabinet Office was involved in helping to determine who would be eligible for tests[24] and exploring the channels through which tests could be delivered most effectively. In line with the changing landscape and the development of new technologies

[22] JO/024 [INQ000233771]; JO/25 [INQ000055915]

[23] Official-level forums such as Senior Officials meetings (see paragraph 2.55.1) were a key mechanism through which policy work and programme delivery was challenged during development and ahead of further ministerial scrutiny at forums such as COVID-O.

[24] See section 'Prioritisation of Testing' (paragraph 3.18-3.20) and NHS Prioritisation Board (paragraph 3.54-3.59)

allowing for rapid testing, the Cabinet Office worked to consider how testing should be used to balance priorities across health, society and the economy.

2.36. The Cabinet Office played a key role in coordinating the Government's response to TTI-related challenges where the input of multiple government departments was required. This included issues such as how to increase compliance with TTI policies throughout 2020 (see paragraph 5.8 - 5.25), how testing could support the reopening and safe operating of educational and workplace settings in early 2021, and later in the summer of 2021, how to respond to very high levels of people being asked to self-isolate through the contact tracing system.

2.37. As was the case throughout the COVID-19 response, one unique role of the Cabinet Office was its work to consider and provide advice to ministers on the trade-offs of different TTI approaches. Whereas the focus of other government departments centred around, for example, the impacts of TTI policies on health (for DHSC), the economy (for HMT) or specific sector-based impacts (for other government departments), the Cabinet Office's role at the centre of government was to look across the board and support decision-makers to understand and balance where possible the trade-offs of different response options.

2.38. The Prime Minister, Boris Johnson, remained close to this work throughout the pandemic, including through regular, often weekly, meetings with Baroness Harding, as Chair of NHST&T, and others closely involved in TTI work including the Health Secretary, the Chief Scientific and Medical Advisors and other officials, which focused on a range of issues from the ambition to roll out a mass population testing programme (see Section 3, notably paragraphs 3.81-3.95), to community testing and surge testing in specific settings and geographical areas.[25] In addition, Baroness Harding on occasion provided written updates on the progress of NHST&T to the Prime Minister and the Cabinet Office.[26]

2.39. The Cabinet Office also worked to support coordination and engagement with the devolved administrations in relation to the development and operational delivery of TTI policies.

Evolution of collective ministerial decision-making meetings in relation to TTI

[25] The Cabinet Office has identified 23 weekly testing meetings held by the Prime Minister between 24 July 2020 and 21 December 2021 and will provide to the Inquiry separately an index of these meetings and the associated material. Documents for meetings with the Prime Minister and attended by Baroness Harding on 14 May 2020 (Agenda: JO/026 [INQ000593214]; Paper: JO/027 [INQ000593213]; Readout: JO/028 [INQ000252831], and see also note on care homes JO/029 [INQ000564774]) and 20 May 2020 (Agenda: JO/030 [INQ000593211]; Paper: JO/031 [INQ000593212]; Readout: JO/032 [INQ000593210]) are exhibited.

[26] See for instance: JO/033 [INQ000593191]

2.40. The Inquiry heard in detail about the evolution of ministerial collective decision-making structures during Module 2. A detailed account of this evolution was provided by the Cabinet Office in a corporate witness statement by the Cabinet Secretary, Simon Case.[27]

2.41. Broadly speaking, the way in which TTI work was considered within central collective decision-making fora as they evolved over the pandemic can be summarised as follows:

2.41.1. *The first stage (up to 15 March 2020)*: During this stage, the first collective ministerial decisions about the response, as distinct from those decisions within the responsibility of a single department, were taken at ministerial COBR meetings.[28] In line with the LGD model, almost all work on testing in the early stage was led within the relevant government departments, primarily DHSC.

2.41.2. *The second stage (mid-March - 27 May 2020)*: During the period when the Ministerial Implementation Groups (MIGs)[29] were in place, testing was predominantly considered in the Health Ministerial Implementation Group (HMIG). Examples of TTI-related work discussed by the HMIG in this period include but are not limited to: prioritisation of testing; the approach to testing in education settings; alignment of TTI policies across the devolved administrations; and financial support for those self-isolating. At this time, the Cabinet Office was also involved in considering the cross-government governance and working structures needed to take forward testing work in the longer term (in particular NHST&T). All four MIGs reported into the Prime Minister's daily morning meeting which brought together key ministers, officials and advisers to discuss the day's priorities and receive an update on progress. Relevant ministers from the devolved administrations were invited to MIG meetings as required.

2.41.3. *The third stage (from 28 May 2020)*: Once the MIGs were stood down and replaced by COVID-S and COVID-O,[30] discussion and collective decisions in relation to TTI work took place primarily in COVID-O. Examples of issues discussed at COVID-O include, but are not limited to: UK testing capacity; targeted testing for disproportionately impacted groups; testing at the border; testing in schools; prioritisation of testing; options for increasing compliance with isolation guidelines; and mass population testing. Updates on work relating to TTI were also presented

[27] JO/008 [INQ000092893]
[28] A chronology of COBR meetings in this early stage is available at: JO/034 [INQ000113573]
[29] Further detail on the MIGs, including why they were stood down, is provided at Annex A, paragraphs 8.8 - 8.20.
[30] Chronologies of COVID-O and COVID-S meetings during the relevant period are available at JO/035 [INQ000177566] and JO/036 [INQ000176781]

to ministers for review and discussion at COVID-S with the objective of helping to ensure that the Government's wider strategy was aligned with the speed and progress of the testing programme. The devolved administrations were invited to COVID-O meetings where a UK-wide approach was needed.

Other meetings with the Prime Minister relevant to Module 7

2.42. Once COVID-O and COVID-S were in operation from May 2020, the Prime Minister's 9:15 C-19 Strategy morning meeting evolved into a Dashboard meeting. In this meeting, the Prime Minister, Chancellor, CDL, Health Secretary, and key officials and advisers (including the Chief Medical Officer (CMO) and the Government Chief Scientific Adviser (GCSA)) would review the latest Dashboard of data, including on testing rates and capacity. The frequency of Dashboard meetings was determined by events and developments in the pandemic and response. Further detail on the Dashboard is provided later in this section of the statement (see paragraph 2.59 - 2.61).

2.43. On a regular or ad hoc basis throughout the relevant period, the Prime Minister held meetings for the purposes of in-depth discussion on specific policy and/or operational issues. These meetings, sometimes referred to as 'updates', 'stocktakes' or 'deep dives' also included key individuals working on the policy area in focus.

2.44. Given the importance of the testing programme to the Government's overall strategy, the Prime Minister and No.10 took a close interest in progress. From August 2020, on a regular, often weekly basis until early 2021, the Prime Minister chaired testing meetings to provide direction on and review the latest progress on increasing the capacity of the testing programme.[31] These meetings initially focused on discussing progress towards the Government's aim of expanding national laboratory testing capacity, and whether this was meeting testing demand, and the feasibility of mass population testing using new rapid testing technologies (see Section 3, notably paragraphs 3.81-3.95). These meetings enabled the Prime Minister to consider progress to ensure that decisions were both informed by and helped to inform the development of the Government's overall response strategy. These testing meetings were typically attended by the Health Secretary, the CMO, GCSA, senior leaders in NHST&T, and senior official representatives from the CTF, HMT and other relevant parts of government where required. The Prime Minister's briefings for these meetings were

[31] The Cabinet Office has identified 23 weekly testing meetings held by the Prime Minister between 24 July 2020 and 21 December 2021 and will provide to the Inquiry separately an index of these meetings and the associated material.

prepared by the CTF. Slide packs and supporting material were typically prepared by DHSC and colleagues from NHST&T.

Devolved administrations

2.45. The devolved administrations are the Scottish Government, the Welsh Government and the Northern Ireland Executive. Ordinarily, legislation provides that certain matters - including health and social care - are devolved to the respective legislatures and administrations in Scotland, Wales and Northern Ireland. This means that Parliament would not normally legislate with regard to devolved matters except with the agreement of the devolved legislature.

2.46. Recognising the shared, cross-border nature of the pandemic, the UK Government worked closely with the devolved administrations to support coordination of the response across the UK, and to coordinate and align efforts in relation to TTI where possible at both the strategic and operational levels.

2.47. The UK Government worked to procure testing equipment and supplies for COVID-19 on behalf of the whole UK. Once tests had been secured and distributed across the UK, deployment was then delivered independently by the devolved administrations, maintaining regular communication with the UK Government to support coordination and strategic alignment where possible. Cross-UK collaboration helped to build a more resilient and agile system, for example, enabling testing equipment and supplies to be more efficiently redistributed if shortages arose in a particular part of the UK.

2.48. The devolved administrations were invited to COVID-O meetings, facilitated by the Cabinet Office, where a UK-wide approach was needed including in relation to TTI issues such as testing and related communications for international arrivals to the UK. In the main, over summer and autumn 2020, the devolved administrations did not attend COVID-O given the majority of matters discussed were devolved in nature. The devolved administrations attended weekly COVID-O meetings for a period over autumn and winter 2020/1[32] and again in autumn 2021 to contribute to cross-UK discussion on issues such as testing requirements at the border.[33] Steers were also regularly given by ministers at COVID-O meetings for departments to ensure collaboration and information-sharing with the devolved administrations.

[32] See for instance: JO/037 [INQ000090170]; JO/038 [INQ000090174]; JO/039 [INQ000090185]
[33] See for instance: JO/040 [INQ000092212]; JO/041 [INQ000092232]; JO/042 [INQ000092228]

2.49. Outside of Cabinet committees, the CDL held regular calls - at times on a weekly basis - with the First Ministers of Scotland and Wales and the First and deputy First Ministers of Northern Ireland. These meetings reviewed the data (supported by the Dashboard) and considered the UK-wide response, including in relation to TTI.[34] medical and scientific advisers worked closely with counterparts in the devolved administrations, and engagement took place at official level. The Joint Biosecurity Centre (JBC), once established as part of NHST&T, helped to improve data sharing on TTI across the UK, both at the local level and with devolved administrations.

2.50. Although there was some variation in the operational delivery and detail and/or timing of policies introduced for TTI across the four UK nations, the approaches taken were underpinned by shared strategic principles and developed using the same evidence base, which enabled a more efficient and resilient TTI system to be established. A detailed comparison of how tracing systems varied across the four UK nations is provided in Chapter 7 of the Technical Report on the COVID-19 pandemic in the UK, authored by the scientific and clinical experts involved in the Government's pandemic response.[35]

Key Cabinet Office teams

Government Commercial Function

2.51. As described in detail in Module 5, Cabinet Office officials from the Government Commercial Function (GCF) led and supported procurement activity relating to TTI, including for instance the procurement of sites (laboratories, testing centres and managed quarantine hotels) and services (including biomedical services and transportation). Cabinet Office staff from GCF were embedded in NHST&T to bolster DHSC's commercial capacity until March 2021.[36]

Civil Contingencies Secretariat (CCS)

2.52. CCS coordinated the initial response to COVID-19, including the establishment of the Dashboard and supported DHSC with the legislative work that led to the Coronavirus Act 2020 in March 2020 which set the framework for implementing and enforcing TTI policy. CCS also continued to support the CTF on an ad hoc basis throughout the pandemic, including by facilitating COBR and by monitoring data to understand how TTI policies could impact critical

[34] TTI issues considered in these meetings included but were not limited to: operational delivery, mass testing, Community Testing, testing at the border and data sharing. See as examples: JO/043 [INQ000199190] and JO/044 [INQ000198980]. A full list of CDL-chaired meetings with ministers from the devolved administrations was provided in Michael Gove's witness statement for Module 2 JO/045 [INQ000235264].
[35] JO/046 [INQ000268204]
[36] JO/001 [INQ000497031]

sectors and workforces (see section entitled 'Pingdemic' and corresponding exhibits at paragraphs 4.20, 4.24 and 4.26).

COVID-19 Taskforce (CTF)

2.53. Within the Cabinet Office, the majority of the policy work on TTI was led by the CTF. The CTF, established within the Cabinet Office in May 2020, was the unit at the centre of government which joined together strategy, analysis and coordination with departments across Whitehall to drive delivery. James Bowler and Simon Ridley provided to Module 2 of the Inquiry a statement[37] describing the establishment and responsibilities of the CTF, and a summary is provided at Annex A (see paragraphs 8.17-8.20.5). Working closely with departments, the CTF worked to guide the attention of the Prime Minister and other ministers to priority issues, and facilitate collective decision-making where appropriate. The CTF played a key role in advising on the Government's overall strategy and helped ensure the decisions taken by the Government in relation to the broader handling of the pandemic were informed by expert advice and aligned with developments in respect of TTI.

2.54. The CTF had three main roles:

2.54.1. **Strategic leadership and coordination**: the CTF coordinated and advised on strategy for the COVID-19 response, working with HMT, medical and health experts including the CMO and GCSA and other departments to ensure the strategy reflected a wide range of inputs and considerations. This included preparing a number of strategies throughout the pandemic which steered the overarching government response. As part of this role the CTF senior leadership met regularly - often daily - with the Prime Minister to consider the strategy and direction or to provide updates. The CTF was also the secretariat for the COVID-19 Cabinet committees: the COVID Strategy committee (COVID-S) and COVID Operations committee (COVID-O).

2.54.2. **Data and analysis**: the CTF equipped decision makers with a single analytical picture that included the health, economic and social impacts of COVID-19 . The CTF's analytical capability comprised thematic teams covering health, science, economics, behavioural insights, social policy and public services, plus long range foresight and data science functions. The CTF worked very closely with analysts across government, and with the Scientific Advisory Group for Emergencies (SAGE) and its subgroups, to reach cross-government consensus and present

[37] JO/047 [INQ000248852]

ministers with the best collective understanding of the evidence, while noting the uncertainties. The Data and analysis team established data flows from departments feeding the Dashboard (see paragraph 2.60-2.61), as well as a range of other data assets (e.g. a daily data brief, interactive forecasting/modelling tools and bespoke data packs). The Cabinet Office's role in the collation and provision of data for decision making in relation to TTI is expanded below.

2.54.3. **Delivery and development of policy:** a very wide range of government departments and other bodies were responsible for developing COVID-19 policy and delivering it on the frontline. From the centre of government, the CTF looked across the response, bringing the range of departmental views together to consider the health, economic and social impacts and help ensure that ministerial decisions were implemented effectively. For much of the relevant period, the CTF had a central Programme Management Office (PMO) which monitored the delivery of projects and programmes across Government that were critical to the Government response. The CTF Field Teams provided thematic and geographic-based research and reporting from across the UK.

2.55. As part of its role in the delivery and development of policy, the CTF had a number of focused teams that worked with other government departments on a range of areas in response to the pandemic. While responsibility for delivery in these areas lay with departments and other relevant bodies, the focused teams in the CTF contributed to policy development and helped ensure that collectively agreed policies were delivered effectively. This was an important way in which the CTF helped to ensure that the different components of the COVID-19 response balanced the health, economic and social impacts. The areas covered by teams within the CTF as relevant to TTI include:

2.55.1. **Test, trace and isolate**: this work included updating ministers and No.10 on the testing programme, ensuring alignment with the broader government strategy; ensuring that the testing deployment programme, led by DHSC and the NHS, was developing in line with the strategic objectives set for NHST&T; facilitating ministerial collective agreement (on issues such as changes to self-isolation policy); considering alignment in relation to TTI policies in the devolved administrations; and supporting the response to issues requiring cross-government collaboration (e.g. the approach to testing at the border and within education settings). The CTF developed very close working relationships and flows of communication on TTI with counterparts in NHST&T and UKHSA, including

through regular Senior Officials meetings.[38] It also worked closely with teams across government, in particular those in DHSC, HMT, the Department for Education (DfE) and the Department for Transport (DfT).

2.55.2. **Compliance and enforcement:** this area included supporting the monitoring of adherence to non-pharmaceutical interventions and making sure that support and guidance were in place for organisations responsible for enforcing the regulations. The CTF worked closely in this area with the Ministry of Housing, Communities and Local Government (MHCLG) (later, from September 2021, the Department for Levelling Up, Housing and Communities (DLUHC)), as well as with DHSC, the Department for Business, Energy and Industrial Strategy (BEIS), the Home Office, MoJ; and local authorities. The role of the CTF in maximising compliance with TTI policies is expanded upon in Section 5.

2.55.3. **Regulations**: the regulations team assisted DHSC to translate the strategic and policy intent agreed by the Prime Minister or by other ministers through Cabinet committees accurately into regulations. The CTF team also provided advice to ministers on the legislative implications of different policy options (e.g. self-isolation, and the design of roadmap steps) as well as advising on how certain measures could be implemented (e.g. through public guidance or using legislation as a vehicle). The Regulations team worked closely with DHSC and GLD which were responsible for drafting and making any amendments to regulations which were then signed off by the Health Secretary. As policy was designed, the CTF coordinated the input of other relevant departments (e.g. BEIS, DfT and DCMS) by, for example, preparing detailed tables on the regulations which supported decision-making.[39] The CTF also worked to advise on Parliamentary matters in relation to the legislation.

2.55.4. **Travel and borders**: this area included consideration of, and advice on, restrictions to travel within England and at the border, including how to manage the risk of transmission through TTI for those arriving in England from other countries.

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[38] As examples of Senior Officials meetings relevant to TTI, I exhibit the papers and readout for the meetings on: 5 August 2021, including a discussion about the response to variants (JO/048 [INQ000575344], JO/049 [INQ000575345], JO/050 [INQ000575346], JO/51 [INQ000575348]); 26 August 2021, including discussions on public behaviours and paid-for testing (JO/052 [INQ000575340], JO/053 [INQ000575341], JO/054 [INQ000575342], JO/055 [INQ000575343]) and 23 September 2021, including a discussion on the transition to end-state TTI (JO/056 [INQ000575330], JO/057 [INQ000575331], JO/58 [INQ000575332], JO/059 [INQ000575333], JO/060 [INQ000575334]). Following the 23 September 2021 meeting updated Terms of Reference for the group were circulated (JO/061 [INQ000575335]). The Cabinet Office has disclosed relevant documentation for Senior Officials meetings to the Inquiry.

[39] JO/062 [INQ000198154]; JO/063 [INQ000198173]

Further detail on the CTF's role in relation to TTI and travel is provided in Section 4 (paragraph 4.34 - 4.50).

2.55.5. **Local action**: this area included consideration of the alignment between the approach to managing COVID-19 on a local basis and the national strategy. This included seeking to engage with local stakeholders, supporting the process for providing collective agreement to changes within the tiering system, and facilitating key discussions with local government on the restrictions and support (including in respect of TTI) in each area, working closely with DHSC, NHST&T / UKHSA, and MHCLG.[40]

2.55.6. **Social contact:** this area included consideration of policies relating to social contact between people from different households in order to limit transmission, while mitigating — to the extent possible — the societal impact. The CTF worked closely in this area with medical, health and behavioural experts as well as other departments.

2.55.7. **Health and adult social care**: this area included the assessment of NHS capacity and methods to increase capacity; policy measures to limit nosocomial infections in health and social care settings including testing and visiting protocols; and, policy measures to protect and support health and social care workers and patients (e.g. mandatory vaccine considerations). The CTF worked closely with DHSC, PHE and NHS England.

2.55.8. **Disproportionately impacted groups**: this area included consideration of policy insofar as it related to those demographic groups most impacted by the pandemic and the Government's response, such as COVID-19 regulations and guidance. The CTF worked closely with DHSC, the Deputy CMO (DCMO) and MHCLG/DLUHC. The CTF's role in considering disproportionately impacted groups in the development and application of TTI policy is provided throughout Section 6.

Other key Cabinet Office teams

[40] As described in the Cabinet Office's corporate statement for Module 2 (JO/047 [INQ000248852]), the CTF Field Teams provided thematic and geographic-based research and reporting from across the UK to support and shape the Government's response to COVID-19 (see paragraphs 2.54.3, 2.57.9, 3.78, 5.12, 5.15 and 5.20 of this statement). The CTF also regularly joined a Regional Leaders call convened by MHCLG/DLUHC which brought together a group of nine local authority chief executives to provide updates and discuss COVID-19 priorities and policies.

2.56. The CTF worked closely with other Cabinet Office teams on TTI including but not limited to:

2.56.1. The COVID-19 Communications Hub (Comms Hub), which was established in March 2020 to ensure efficient and effective delivery of cross-government public communications in relation to the pandemic. The Comms Hub led the Government's overall public communication strategy, working closely with DHSC and No.10 to shape and strategically align government campaign activity. The Comms Hub worked closely with NHST&T to shape public messaging in relation to TTI and help ensure that communications were supporting the effective delivery of the Government's overall strategic objectives.

2.56.2. The Equality Hub (renamed in October 2024 as the Office for Equality and Opportunity (OEO)) which is the unit responsible for cross-government policy on disability, ethnic disparities, gender equality, Lesbian Gay Bisexual and Transgender (LGBT) rights and the overall framework of equality legislation for the UK (Equality Act 2006 and Equality Act 2010). See Section 6 for detail on the CTF and Equality Hub's work to address disproportionate impacts of the pandemic.

Cabinet Office engagement with other parts of the TTI system

2.57. The Cabinet Office worked with a wide range of government departments, agencies and organisations in relation to TTI during the pandemic. An overview is provided below:

2.57.1. Throughout the pandemic, the Cabinet Office worked very closely at both official and ministerial level with colleagues from **DHSC** as the LGD on issues relating to TTI. In addition to engagement through the ministerial decision-making forums described above, the Prime Minister and other Cabinet Office ministers engaged bilaterally or in smaller groups with ministers from DHSC throughout the pandemic. Similarly, regular official-level engagement between the two departments took place throughout the relevant period.

2.57.2. The Cabinet Office worked closely with **NHST&T** from the point it was established as a part of DHSC in May 2020. The External Chair, Baroness Harding, reported directly to the Prime Minister until late 2020, and regular ministerial and senior official level meetings were held throughout the relevant period, including once NHST&T became part of **UKHSA** in 2021.

2.57.3. The Cabinet Office also worked closely with **PHE** - and later, its successor the **UKHSA** - as the agency which initially led efforts to develop a test for and trace

cases of the novel coronavirus, and which throughout the pandemic response supported decision-making through the provision of data and expert advice.

2.57.4. The Cabinet Office worked closely with a broad range of **other government departments** to respond to specific issues relating to TTI policies. This included, but was not limited to: DfE on testing in educational settings; the Home Office on policies relating to compliance and enforcement; DfT on testing of hauliers travelling to France in December 2020; the Ministry of Justice (MoJ) on guidance to support businesses with enforcing regulations; BEIS on how TTI policies would impact and be implemented by businesses; the Foreign, Commonwealth and Development Office (FCDO) on international matters; and MHCLG/DLUHC in relation to how TTI policies translated to the local level.

2.57.5. Throughout the pandemic, the Cabinet Office relied on the advice of **expert advisory groups and individuals** including but not limited to: SAGE, the CMO, DCMO, GCSA, GO-Science and the JBC (which became part of UKHSA in October 2021). Expert advisers and advisory body representatives were regularly invited to attend ministerial meetings to support decision-making. Advice from such experts also helped to inform wider strategic advice provided to ministers by the CTF and other parts of the Cabinet Office.

2.57.6. The CTF worked with **local authorities** to help ensure that the experiences, successes and challenges faced at a local level were reflected in advice to decision-makers on the Government's response to the pandemic. For example, the CTF conducted virtual and in-person visits to local areas, attended Regional Leaders calls led by MHCLG, and established a Local Authority Delivery Board to support local authorities. The primary relationships between central government and regional/local entities were held by other parts of government such as NHST&T and MHCLG.

2.57.7. Other parts of government generally held the direct working relationships with **private sector companies** supporting the test and trace efforts, including PHE/UKHSA, NHST&T, DHSC and BEIS. Though the Cabinet Office did not routinely engage with the private sector throughout the pandemic, No.10 officials and advisers encouraged and supported engagement with industry and academia to create momentum and impetus for the test and trace work. This was particularly true through 2020 as work was being done to scale test and trace systems and as new technologies were being developed (see for example, the diagnostics industry

roundtable event organised by No.10 in March 2020, described at paragraph 3.9).[41]

2.57.8. The Cabinet Office did not routinely have direct engagement with **NHS England** in relation to TTI - this relationship was held by DHSC/NHST&T. The Cabinet Office did, however, engage closely with NHS England on the broader pandemic response, with senior NHS leaders invited to attend meetings such as COVID-O and other meetings with the Prime Minister, at which issues relating to TTI were discussed.

2.57.9. The Cabinet Office did not routinely engage directly with **third sector** or **community-level** organisations in relation to TTI. However, CTF field teams visited different regions throughout the pandemic to understand how policies were working for local authorities, communities and individuals on the ground.

2.58. The Cabinet Office has separately provided the Inquiry with a list of key individuals involved in work relating to TTI. Key individuals with whom the Cabinet Office engaged are referenced throughout this statement, as appropriate.

Data, analysis and expert advice

2.59. A key part of the Cabinet Office's role in facilitating decision-making during the pandemic was working to ensure that decision-making was supported by relevant data, analysis and expert advice. Many government departments held data relevant to the response and conducted analysis aligned to their departmental interests and responsibilities. SAGE and its sub-groups provided expert scientific advice. The Cabinet Office worked to integrate these various inputs and present a single, integrated picture to support decision-making across government. The structures and processes for collating and reporting data evolved in line with the response during the course of the pandemic.

2.60. From 15 March 2020, a COVID-19 Dashboard of relevant data was created, operated initially by CCS.[42] The Dashboard provided a range of data available at the time related to COVID-19 including on mortality, infection, health, testing, restrictions and mobility, the economy and the public sector. The range of data sources covered by the Dashboard expanded over time; a wide range of data came through the NHS, NHST&T, the vaccine programme and other public health infrastructure for which DHSC was responsible.

[41] Dominic Cummings' witness statement for Module 2 (para 370-382) also describes the role of No.10 advisers in engaging scientists and those developing testing technologies to explore the potential for rapid, large-scale testing (JO/064 [INQ000273872])
[42] JO/065 [INQ000146582]

2.61. In summer 2020, the CTF assumed responsibility for the Dashboard, which was used to present regular, often daily, updates to the Prime Minister and other decision makers, and to brief Cabinet and other ministerial meetings. This continued until February 2022.

2.62. Another important source of data and insight on testing and tracing in England came from the JBC. The JBC was first established within DHSC in May 2020, and later formed part of NHST&T.[43] Senior officials from the Cabinet Office, including the Cabinet Secretary, were involved in helping to design the role and longer term remit of the JBC. By providing evidence-based, objective analysis and assessment, the JBC helped to inform both local and national decision-making in relation to testing, contact tracing and local outbreak management in England. Data from the JBC fed into the Dashboard. Data relating to the operational delivery of NHST&T was published online to support understanding and management of COVID-19 at a regional and local level and the JBC worked closely with local responders and Directors of Public Health (DPH) in England to help identify and respond to local outbreaks. This work continued until October 2021, at which point the JBC became part of the UKHSA.[44]

2.63. Officials from the CTF worked closely with analysts, data scientists and scientific experts across government, including SAGE and its subgroups, to provide ministers with the best collective understanding of the evidence and to advise on specific issues. The analytical community included, among others: the CTF data and analysis team; SAGE and its subgroups; CMO and GCSA; the different functions that ultimately formed part of the UKHSA including PHE and the JBC; the Office for National Statistics (ONS); HMT; BEIS; and, the Behavioural Insights Team (BIT).

2.64. Key official advisers on COVID-19, including but not limited to the GCSA and CMO (and DCMOs where appropriate), were invited routinely to meetings with the Prime Minister and provided input to the vast majority of CTF-drafted papers for ministerial meetings and the Prime Minister. Senior officials in the CTF and the Directors General met regularly with the CMO and GCSA and there were open channels of communication. The CTF also included a Science and Projects team which acted as a central docking point for SAGE, working closely with the SAGE and the SPI-M secretariats to ensure commissioning and inputs aligned with the broader work and its sequencing.

2.65. Modelling was part of the suite of data, analysis and expert advice that supported the development of policy and strategic decision making during the pandemic. Modelling of different strategic approaches to TTI was generally undertaken by experts outside of the

[43] JO/066 [INQ000086782]
[44] JO/067 [INQ000203662]

Cabinet Office and used to help demonstrate the anticipated outcomes of a policy response before decisions were taken. No.10 data scientists and the CTF's Analysis and Data team supported the CTF to ensure that comprehensive and balanced advice, underpinned by a range of data and modelling, was presented to ministers to inform decision-making.

2.66. During the pandemic response, the CTF's Analysis and Data team produced 'Spotlight' reports which provided a summary of the latest scientific and expert insight on a specific issue and included a comment on the significance of the issue and implications for policy and strategy making. Reports relevant to TTI covered, for example: barriers to self-isolation compliance[45]; the effectiveness of LFDs[46]; the impact of NHST&T on transmission[47]; and testing compliance.[48]

2.67. Throughout the pandemic, the Joint Intelligence Organisation (JIO), based in the Cabinet Office, worked to understand the implications of COVID-19 for the UK's national security. In April 2020, on the request of No.10, the JIO established the International Comparators Joint Unit (ICJU) in partnership with FCDO to assess international responses to the pandemic including key countries' public policy decisions and whether similar approaches could be adopted in the UK. Throughout the relevant period, the ICJU produced a number of documents relating to test and trace programmes internationally, which supported the CTF to understand the trade-offs of different approaches and to learn lessons to inform the development of the UK's strategic approach to TTI. Examples of the ICJU reports are exhibited.[49] The JIO also subsequently established a multidisciplinary expert group - the International Best Practice Advisory Group (IBPAG) which worked to quality-assure the ICJU's analysis.

[45] JO/068 [INQ000575314]
[46] JO/069 [INQ000575315]
[47] JO/070 [INQ000575317]
[48] JO/071 [INQ000575309]
[49] JO/072 [INQ000196540]; JO/073 [INQ000196542]; JO/074 [INQ000196581]

3.SECTION 3: Developing Test and Trace

Supporting the initial scale up of test and trace capabilities

3.1. In January 2020, prior to the first COVID-19 case being reported in the UK, work started in government - led by PHE and DHSC - to develop a test and expand diagnostic capabilities for the novel coronavirus. At this time, in line with scientific advice, the focus was on testing, tracing and isolating symptomatic individuals.[50]

3.2. As explained in Section 2, in line with the LGD model, DHSC is responsible for public health protection and responding to emerging infectious diseases. At the outbreak of the pandemic, therefore, the Cabinet Office ordinarily had limited involvement in policy and strategy work relating to TTI.

3.3. At the beginning of the pandemic, only NHS pathology laboratories, a few research sites and public health laboratories in the UK had the ability to test for COVID-19, using the only widely recognised testing methodology available: Reverse Transcription - Polymerase Chain Reaction (RT-PCR). RT-PCR testing was, at the start of the pandemic, considered to be the 'gold standard' for testing, generating a very small number of false negatives (high sensitivity) and equally a small number of false positives (high specificity). As an established and widely recognised testing methodology, initial focus on increasing testing capacity centred around the scale up of RT-PCR testing.

3.4. Between January and early March 2020, there were relatively small numbers of cases and the aim of contact tracing was to identify and manage all contacts using existing public health infrastructure, processes and testing capacity available. Early contact tracing, along with self-isolation, focused on delaying community transmission of COVID-19 in the UK and followed existing guidance and protocols for managing high consequence infectious diseases and undertaking large-scale contact tracing, led by PHE and DHSC.[51]

3.5. In this early stage, the Cabinet Office worked to understand the progress of test and trace work across government in order to update and provide advice to the Prime Minister, and to understand where further support from central government may be needed. The Cabinet Office was not, however, closely involved in PHE/DHSC's detailed work in this initial period to test, trace and isolate contacts, nor is the department able to comment on how any existing capacity, infrastructure, policies and capabilities were used to respond to the initial cases of the novel coronavirus. UKHSA/DHSC would be best placed to comment on this.

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[50] See SAGE minutes on 28 January 2020, page 1: JO/075 **INQ000087566**

[51] JO/076 **INQ000203933**, page 214

3.6. On 6 March 2020, the Prime Minister announced[52] a £46 million funding package for COVID-19, £5 million of which was allocated to developing rapid diagnostics. On the same day, and to demonstrate publicly the Government's effort to develop and scale diagnostics, the Prime Minister visited Mologic, a laboratory in Bedfordshire, which was working to develop rapid diagnostic testing kits. The Prime Minister's briefing for this visit is exhibited.[53]

3.7. By mid-March 2020, at the time the World Health Organisation (WHO) was encouraging countries to "test, test, test",[54] concern was being raised within No.10 about the UK's ability to scale testing to the levels required to respond to COVID-19, particularly in relation to limitations in PHE's capacity for operational delivery of testing and contact tracing on a large scale.[55]

3.8. On 14 March 2020, CDL chaired a meeting to explore ways that the Cabinet Office could help DHSC to increase testing capacity, including by providing commercial experts to assist with procurement.[56] The Cabinet Office's work to support the procurement efforts relating to testing is set out in detail in the corporate statements provided to the Inquiry for Module 5.

3.9. To accelerate progress on the UK's testing capacity, No.10 organised a roundtable meeting on testing and diagnostics.[57] The meeting, chaired by the Health Secretary and attended by the Prime Minister, took place on 17 March 2020. The meeting brought together representatives from public sector health organisations, private sector companies (including Amazon, Boots, Roche, Thermo Fisher, Altona, and Randox), academia and the scientific community, with ministers and senior leaders from across government and the NHS. A full list of attendees is available in the exhibited briefing provided to the Prime Minister for the meeting.[58] Discussion at the meeting covered: how industry could support the Government to rapidly expand testing capabilities; how to approach procurement and anticipated challenges; timelines for maximising capacity; regulatory barriers; and options for overcoming challenges in operational delivery. A note recording the outcomes was circulated later that day.[59]

3.10. As the volume and scale of decisions that needed to be taken within a whole-of-government response continued to grow, four new MIGs were established in mid-March 2020, as set out

[52] JO/077 [INQ000086750]
[53] JO/078 [INQ000575363]
[54] JO/079 [INQ000575407]
[55] JO/080 [INQ000575393]
[56] JO/081 [INQ000411831]
[57] JO/082 [INQ000471002]
[58] JO/083 [INQ000119570]
[59] JO/084 [INQ000478783]

in Section 2. Through these MIG meetings, primarily the Health MIG (HMIG), the Cabinet Office maintained oversight and coordinated engagement between the key stakeholders involved in cross-government work on TTI. The Prime Minister's daily 9:15 C-19 Strategy meetings, and other ad hoc 'deep dive' meetings were also key forums through which ministers and senior officials were updated on the progress of work relating to TTI in this period.

3.11. The following paragraphs provide illustrative examples of these ministerial meetings and the issues with which the Cabinet Office was involved in this early period. Broadly, in this period and through such meetings, the Cabinet Office sought to support DHSC as the LGD responsible for shaping the initial strategy for testing and tracing work, to determine how quickly the scaling up of testing and tracing capabilities could be achieved and to agree how the work on test and trace was communicated to the public as part of the broader COVID-19 strategy.

3.11.1. At the first HMIG meeting on 18 March 2020, DHSC shared its Testing Action Plan,[60] which built on the discussion at the No.10 roundtable on 17 March. The paper outlined a four-pronged approach to rapidly increasing testing capacity, with the overarching objectives of: protecting lives and particularly vulnerable people; providing clinical and social care staff with the knowledge of whether they were contagious in order to use resources efficiently; and, enabling those among the general public suffering symptoms to know what measures they should take.

3.11.2. At a 9:15 C-19 Strategy meeting on 19 March 2020, the Prime Minister said that there was a need to "inject more hope" into public messaging and that the testing story offered an opportunity for this.[61] No.10 took an action from the meeting to work with DHSC to develop "messaging on testing, and how this [would] assist [with] getting the economy moving by getting people back into work".[62] At this meeting, it was also noted that work to enable international procurement leads to be pursued should be undertaken quickly as there was a need to buy as many testing kits as possible.

3.11.3. Further discussion on testing took place at a 9:15 C-19 Strategy meeting on 20 March 2020, where the Prime Minister asked DHSC to work with the CDL, CMO, GCSA and all departments to articulate a three-month battle plan to tackle the virus, bringing together all relevant activity alongside key milestones and targets,

[60] JO/025 [INQ000055915]
[61] JO/085 [INQ000056262], page 7
[62] JO/086 [INQ000056055]

including in relation to testing.[63] CCS was also asked to work with DHSC to include more detail on testing in the Dashboard.[64]

3.11.4. Ministers discussed DHSC's three-month battleplan[65] at an HMIG meeting on 22 March 2020[66] before further discussion with the Prime Minister at a C-19 Strategy meeting later the same day focused specifically on the battleplan. The proposed battleplan included 'Testing' as one of seven workstreams and identified a Senior Responsible Officer (SRO) as well as outlining necessary funding commitments and key performance indicators that would help to measure progress in the coming months.

3.11.5. Testing was discussed at the 9:15 C-19 Strategy meeting on 24 March 2020. The actions from this meeting included for HMT to expedite approval for the purchase of certain antibody tests and for DHSC to accelerate the case testing programme and analyse any blockers where government intervention may be needed.[67]

3.11.6. At a 9:15 C-19 Strategy meeting on 26 March 2020, in the context of a discussion on bringing all data together within a single source of truth for Prime Ministerial meetings, CCS was asked to work with DHSC and the NHS to ensure that more granular data on the roll-out of testing (including projections) and supply of necessary components (e.g. swabs and reagents) was included in the Dashboard. There was also discussion about the need for clarity in public communications about the criteria for testing.[68]

3.11.7. On 29 March 2020, testing was discussed as part of a wider meeting with the Prime Minister on NHS capacity. A slidepack[69] outlining the latest progress and data on testing was provided for the meeting alongside a paper on the next steps for industrialising UK testing capacity.[70]

3.11.8. At a 9:15 C-19 Strategy meeting on 1 April 2020, the Prime Minister expressed concern that there was 'public alarm about testing, and confusion as to why more was not being carried out'. He emphasised the importance of rolling out further testing and clear communications to the wider public on the UK's approach to

[63] JO/087 [INQ000056265]
[64] JO/088 [INQ000056066]
[65] JO/089 [INQ000055926]
[66] JO/090 [INQ000055942]
[67] JO/091 [INQ000056105]
[68] JO/092 [INQ000056119]; JO/093 [INQ000056267]
[69] JO/094 [INQ000575360]
[70] JO/095 [INQ000575329]

provide reassurance that everything possible was being done.[71] DHSC took a number of actions[72] from this meeting including to provide a detailed plan for the testing strategy, to engage pharmaceutical companies that could support the provision of testing reagents, to accelerate the launch of the contact tracing app, and to improve public understanding of the Government's approach to testing.

3.11.9. At a 9:15 C-19 Strategy meeting on 2 April 2020, the Prime Minister expressed concern about questions on testing at the previous day's press conference. He asked why only 2,000 NHS staff had been tested.[73] The Prime Minister asked for the focus that day to be on testing and the communications narrative around testing.[74] The Cabinet Office took an action to work with No.10, DHSC and Go-Science to agree the communications narrative for the press conference that evening and a clear objective for the testing programme across the UK. That afternoon, at the No.10 press conference, the Health Secretary announced publicly DHSC's target to reach 100,000 tests per day by the end of the month.[75] See paragraph 3.22 for further detail on the Cabinet Office's role in relation to the setting of this target.

3.11.10. At a 9:15 C-19 Strategy meeting on 3 April 2020, the Health Secretary asked that DHSC's testing strategy be published later that day.[76] DHSC took an action from the meeting to work with No.10 to keep strengthening the testing plan, which would be signed off by No.10 and senior Cabinet Office officials prior to publication.[77] The testing strategy was published on 4 April 2020.[78]

3.11.11. At an HMIG meeting on 9 April 2020, the Health Secretary noted that efforts to increase testing meant that "some spare capacity already existed" which would allow testing eligibility to be expanded.[79] In this context, a paper entitled 'Expansion of Swab Testing for Key Workers' was provided by DHSC for discussion.[80] Ministers agreed DHSC's proposed model as outlined in the paper which would prioritise testing for: patients (both in hospital and community settings, on the

[71] JO/096 [INQ000088605]
[72] JO/097 [INQ000088329]
[73] JO/098 [INQ000088606], page 4
[74] JO/099 [INQ000088339]
[75] JO/100 [INQ000086583]
[76] JO/101 [INQ000088607], page 6
[77] JO/102 [INQ000061791]
[78] JO/103 [INQ000106325]
[79] JO/104 [INQ000083704], page 3
[80] JO/105 [INQ000083645]

advice of a medical professional); key health and social care staff; key workers; and, mass population testing. Cabinet Office and DHSC took an action from this to work together to produce a list of key workers in light of the decision taken.[81]

3.11.12. At 9:15 C-19 Strategy meetings on 9 and 10 April 2020, ministers discussed the importance of ensuring that accurate data relating to testing across England and the devolved administrations was being obtained and recorded in the Dashboard so that this could inform policy decisions. The minutes for these meetings are exhibited.[82]

3.11.13. Following a deep-dive meeting[83] on the Adult Social Care Strategy on 13 April 2020, DHSC was asked to clarify the position regarding the provision and timeline of testing for care home staff and residents. Testing for care homes returned to a 9:15 C-19 Strategy meeting on 28 April 2020 at which DHSC was asked to prioritise testing of all care home workers, regardless of symptoms, given the noted rise in infection rate in care homes.[84]

3.11.14. At a 9:15 meeting on 14 April 2020, it was again noted that testing capacity was higher than demand, with lower uptake than expected from key workers in the health service. At this meeting, ministers were also informed that polling showed strong public support for issues such as testing where the Government was communicating a clear plan.[85] Later that day, the Prime Minister held a deep-dive discussion on testing, at which the Health Secretary provided a progress update on work relating to each pillar of DHSC's testing strategy.[86] As a result of the meeting, DHSC was asked to produce a plan for increasing the rate of testing, setting out the maximum testing capacity required for different incidence-rate scenarios and how the capacity would link to strategic options on social distancing easements. DHSC was asked to work closely with the Cabinet Secretariat and No.10 on the latter in particular.[87]

3.11.15. Another deep-dive meeting, this time on contact tracing, was held by the Prime Minister on 17 April 2020. The Health Secretary provided an update on work to develop a contact tracing app ('the app'), which would work initially on self-

[81] JO/106 [INQ000083705]
[82] JO/107 [INQ000088626]; JO/108 [INQ000088611]
[83] JO/109 [INQ000088629]; JO/110 [INQ000088696]
[84] JO/111 [INQ000088705]
[85] JO/112 [INQ000088630], page 4-5
[86] JO/113 [INQ000088699]
[87] JO/114 [INQ000088698]

diagnosis but could later be based on testing once more widely available - the app was noted to be in beta testing, with a live test at scale to be carried out on the Isle of Wight in the coming weeks. The Health Secretary said timing for the app would depend on how the trial went as well as the degree of confidence the Government wanted before rollout. At this meeting, ministers discussed a range of risks and challenges associated with contact tracing including but not limited to: privacy concerns; public messaging challenges about changes to isolation rules in certain areas during pilots; access to mobile phones; and, scalability and timing challenges.[88] The actions from this meeting included for DHSC to 'produce a timeline for the whole test, track, trace and certify programme', working with the Cabinet Secretariat to explore how plans to ease social distancing could be developed in parallel.[89]

3.11.16. Continuing to face the issue of demand for testing being lower than capacity, at a 9:15 C-19 Strategy meeting on 20 April 2020, the Health Secretary said the plan was to expand eligibility for testing to all key workers before considering a further expansion for the entire population if demand did not increase naturally. The Health Secretary noted that consideration would be needed before moving to whole population testing to avoid the risk of queues at testing centres as had been experienced earlier in the month.[90] Later that same day, the issue of surplus testing capacity was discussed in the context of public sector workforces at a GPSMIG meeting;[91] and, at a deep-dive meeting on the role of the Ministry of Defence (MOD) in the pandemic response, MOD was asked to work with MHCLG and DHSC to increase mobile testing in support of the broader testing objectives.[92]

3.11.17. At a 9:15 C-19 Strategy meeting on 22 April 2020, the Health Secretary said that the plan to stimulate demand for tests through employers had not been working so guidance would be updated later that week which would make 10 million more people eligible to book a test directly. The Health Secretary noted there were then two further options for widening eligibility: to compel all public sector workers not at work due to COVID-19 to get a test, noting that this would bring statutory challenges and may need to involve the police; or to widen eligibility to everyone, whether symptomatic or not.[93] DHSC took an action from this meeting to make

[88] JO/115 [INQ000088664]
[89] JO/116 [INQ000088424]
[90] JO/117 [INQ000088616], page 7
[91] JO/118 [INQ000083600]
[92] JO/119 [INQ000088439]
[93] JO/120 [INQ000088635], page 7-8

sure that the upcoming announcement that testing was open to all key workers was firm in communicating that key workers who were self-isolating "should" get themselves - or the relevant member of their household - tested, and go back to work if the test was negative. DHSC was also asked to work with MHCLG and LRFs on helping people access testing sites, recognising that some testing sites were difficult to access via public transport and other people were being discouraged from travelling to testing sites if they were symptomatic. The action noted that this work should include a strong communications plan, increasing mobile capacity and sending tests to homes.[94]

3.11.18. Updates were provided by DHSC and the NHS on the development of the contact tracing app at a ministerial deep-dive meeting on test and trace work on 22 April 2020. The committee agreed that the plans for the Isle of Wight trial of the app should be progressed and the proposed 15,000 staff should be recruited for the test and trace programme to operate the tracing centres.[95]

3.11.19. Testing was discussed at a 9:15 C-19 Strategy meeting on 28 April 2020 within the context of a discussion on managing the impact of COVID-19 in prison settings. It was noted that "testing of prisoners and staff had been limited to symptomatic prisoners" but that "enhanced testing would be crucial in the following weeks to enable the different cohorts to be marshalled quickly and for prisoners to be tested on arrival, and transferred when they showed symptoms".[96]

3.11.20. At a 9:15 C-19 Strategy meeting on 30 April 2020, senior officials from DHSC updated ministers on how the test and trace programme would work in practice. The readout[97] and papers[98] for the meeting are exhibited. The Prime Minister made clear that he considered the test, trace and certify programme to be critical to the success of easing social distancing measures in the short term. Concluding this meeting, the Prime Minister acknowledged the potential for some malicious use of the app (if users falsely reported symptoms causing others to have to self-isolate) and some measure of inaccuracy, but said that work should continue, with the plans to be examined again before the programme was finalised.[99]

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[94] JO/121 [INQ000088458]
[95] JO/122 [INQ000088636]
[96] JO/123 [INQ000088622]
[97] JO/124 [INQ000198076]
[98] JO/125 [INQ000088692]; JO/126 **INQ000062075**
[99] JO/127 [INQ000088694], page 10

3.11.21. A further update on progress was provided by DHSC to ministers at an HMIG meeting on 1 May 2020. The exhibited paper was provided to support this discussion.[100] The meeting primarily focused on the development and upcoming Isle of Wight trial of the NHSX app. The minutes for this meeting are exhibited.[101] DHSC took a number of actions[102] from this meeting to collaborate with other parts of government, including with: DfE on testing in schools; DCMS on data and privacy issues; the devolved administrations on interoperability of the programme technology; and HMT in relation to minimising the potential for false positives from antigen testing. Further detail on the Cabinet Office's work in relation to the app is provided in the sub-section titled 'Contact Tracing app' (starts paragraph 3.32).

3.11.22. At a 9:15 C-19 Strategy meeting on 5 May 2020, the Prime Minister requested a roadmap to the supply of a minimum of 500,000 antigen tests in the eight weeks subsequent to 4 May 2020 and further advice on asymptomatic testing. At this meeting the Health Secretary said he was minded to adopt a voluntary approach to self-isolation to begin with.[103]

3.11.23. A deep-dive discussion took place on 8 May 2020 chaired by the First Secretary of State to consider international comparators on test and trace. The paper provided by the FCDO to support this meeting is exhibited.[104] Further work was taken forward after this meeting, led by FCDO, to consider how other countries were approaching test and trace and where the UK could learn from their experience.

3.12. Alongside work through the MIGs, during this early stage and throughout the relevant period, the Prime Minister, and No.10 officials and advisers, supported engagement with key stakeholders to help strengthen the UK's ability to expedite the scaling of the testing programme. Judgement was exercised as to when the influence of the Prime Minister or No.10 may be beneficial in this regard, for example to strengthen important stakeholder relationships, unblock challenges that had the potential to compromise the UK's handling of the virus, or expedite delivery. One example of this was the roundtable event on testing and diagnostics organised by No.10 on 17 March 2020, discussed above at paragraph 3.9. Cabinet Office including No.10 also used its influence in the early period, as requested by DHSC, to support the "global lobbying strategy of main testing suppliers to increase UK

[100] JO/128 [INQ000083666]
[101] JO/129 [INQ000083707]
[102] JO/130 [INQ000198078]
[103] JO/131 [INQ000198080]
[104] JO/132 [INQ000088574]

allocation" of tests.[105] The Prime Minister directly engaged major manufacturers to help maximise UK access to tests within the global context, secure supply and mitigate the impact of export bans.[106]

3.13. Throughout this early period and to support the ministerial meetings noted above, officials from the Cabinet Office including No.10 worked across government to tackle the emerging challenges relating to the test and trace programme which, as described above, included among other issues, system capacity and data collection. Deep-dive meetings on particular issues were held at official level, sometimes by the Cabinet Secretary, or other senior officials or No.10 advisers, scheduled on an ad hoc basis as required. For example, the Cabinet Secretary chaired a cross-government deep-dive meeting on 21 April 2020 to scrutinise the delivery plan for the programme of work relating to test and trace and to consider issues such as whether the right structures were in place, whether resources were allocated appropriately, the levels of confidence in delivery targets and any obstacles to successful delivery.[107] As a further example, on 28 April 2020, the Prime Minister's adviser, Dominic Cummings, chaired a meeting on test and trace to agree the approach and decisions for an upcoming meeting with the Prime Minister.[108]

3.14. The following paragraphs outline the Cabinet Office's involvement in a number of DHSC-led pieces of work relating to TTI in this early period.

Early regulations: Coronavirus Act 2020

3.15. Regulations relating to COVID-19 were all owned by DHSC.[109] In the early months of 2020, as set out in Katharine Hammond's statement for Module 1 of the Inquiry, CCS was closely involved in the legislative work that by 25 March 2020 resulted in the Coronavirus Act 2020 receiving Royal Assent. CCS's work involved: managing the decision-making process which set the requirement for the Coronavirus Regulations, through COBR[110]; supporting DHSC to help ensure that the new regulations captured all the necessary powers and would be suitable for all four UK nations; acting as policy owner for clauses related to excess deaths within regulations; and, providing advice in relation to provisions in the Civil Contingencies Act, owned by CCS.

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[105] JO/133 [INQ000575423]
[106] JO/134 **INQ000233793** page 29
[107] JO/135 [INQ000198060]
[108] JO/136 [INQ000198071]
[109] Regulations include: the UK Coronavirus Act 2020, the Health Protection (Coronavirus, Restrictions) (Self-Isolation) (England) Regulations 2020, and the Health Protection (Coronavirus, International Travel) (England) Regulations 2020.
[110] JO/137 **INQ000052081**

3.16. CCS played a more active role supporting DHSC with the legislative work for the Coronavirus Act 2020 than would usually be the case for a number of reasons, as articulated in Katharine Hammond's statement for Module 1. First, CCS was aware of the pressure that DHSC was under given the wider pandemic response, as well as the request from DHSC's Permanent Secretary for the Cabinet Office to lead on cross-cutting issues. CCS also recognised the challenge for DHSC of coordinating legislation in collaboration with the devolved administrations within a department that usually works on England-only policy. On that basis CCS offered to host the initial Bill Team. Later, when it was clear that the Bill would be taken through Parliament by Health ministers, DHSC established a Bill team to take forward this legislative work. CCS continued to support DHSC's Bill team with the four nations alignment element of the legislation and officials from the Economic and Domestic Secretariat (EDS) helped to support coherence of the Bill more broadly. CCS supported collective agreement of the Coronavirus Bill through a COBR meeting on 11 March 2020[111] and the Bill received Royal Assent on 25 March 2020.

3.17. The Coronavirus Act 2020 provided the legislative framework for implementing and enforcing TTI policy, granting powers exercisable by the Secretary of State and public health officials in relation to mandating testing and isolation for people suspected or at risk of being infected with coronavirus, and permitting the imposition of fines for non-compliance.

Prioritisation of testing

3.18. At various points during the pandemic response, constraints on testing capacity meant that the Government had to decide how to prioritise and allocate the available resources. Throughout the response, the Government's priority was to protect those most vulnerable as well as those in high-risk settings.

3.19. The first decisions about testing prioritisation in early 2020 were taken by PHE and DHSC in collaboration with the NHS and following the advice of clinical experts. On 14 March 2020, a PHE publication on gov.uk noted that testing would need to be prioritised for those 'most at risk of severe illness'[112] in line with the aim to save lives, protect the most vulnerable and relieve pressure on the NHS.[113]

3.20. As described in paragraph 3.11.11, on 9 April 2020, ministers discussed how testing should be prioritised as capacity grew.[114] Ministers agreed with DHSC's proposed model for

[111] JO/138 [INQ000056220]
[112] JO/139 [INQ000575414]
[113] This priority was echoed in DHSC's testing strategy published on 4 April 2020 JO/103 [INQ000106325]
[114] Paper for HMIG meeting on 9 April: JO/105 [INQ000083645]

prioritisation, starting with patients before expanding to key health and social care staff, other key workers and then to wider mass population testing. The Cabinet Office worked with DHSC in the weeks after this meeting to determine which professions would be categorised as key workers in light of the decision taken; this built on the earlier list of key workers whose children could still go to school from 20 March 2020. The list of key workers[115] was in place by 23 April 2020 when the expansion of priority testing for key workers was announced by the Health Secretary.[116]

5-pillar testing plan

3.21. On 2 April 2020, the Health Secretary announced a new 5-pillar plan, designed by DHSC, for increasing the UK's testing capacity.[117] The Cabinet Office was aware of the 5-pillar approach, having reviewed the Health Secretary's speech prior to the press conference, but was not closely involved in the design of the pillars, which was led by DHSC.

100,000 testing target

3.22. As part of the announcement of the 5-pillar plan on 2 April 2020, the Health Secretary announced the Government's ambition to increase testing capacity to 100,000 tests a day across the UK by the end of the month.[118] As the LGD for testing, DHSC was responsible for setting targets in relation to testing, informed by expert advice and signed off ministerially by the Health Secretary. The Cabinet Office encouraged the rapid expansion of testing capacity with the aim of reducing transmission of the virus. Political advisers were also aware that the UK was making slower progress compared to other countries. In his statement to the Inquiry for Module 2, Dominic Cummings notes that he and the Prime Minister had told the Health Secretary to aim for 100,000 tests per day,[119] a target which the Health Secretary said at a 9:15 C-19 Strategy meeting on 2 April 2020 that DHSC was confident could be met by the end of April 2020. At that meeting, the Health Secretary said there were risks with setting such a target publicly but, Dominic Cummings notes, "[he] *announced it anyway later that day to the media without coordinating in Whitehall in advance* [...]".[120]

National Testing Strategy

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[115] JO/140 [INQ000593207]
[116] JO/141 [INQ000237529]
[117] JO/142 [INQ000237310]
[118] JO/100 [INQ000086583]
[119] JO/064 [INQ000273872], page 76
[120] ibid., page 77

3.23. On 4 April 2020, the Health Secretary announced and, on behalf of DHSC, published a national testing strategy entitled Coronavirus (COVID-19): Scaling up our testing programmes.[121] Officials from the Cabinet Office and No.10 reviewed a draft of the strategy on 2 April 2020, relaying concerns to DHSC that the document lacked sufficient detail about the scale and timings of commitments being made, and needed clearer explanation of the rationale behind targets, how the ambition compared to efforts internationally and an indication of what action was requested from the public. The suggestion from No.10 was that publication of the document ought to be delayed so that improvements could be made.[122] The Cabinet Office understands that the Health Secretary accepted the critiques and limitations of the document but decided to go ahead with publication on 4 April 2020 in order to support negotiations with pharmaceutical companies.[123]

Lighthouse Labs

3.24. From March 2020, the Cabinet Office supported DHSC's work to establish a network of diagnostic facilities known as 'Lighthouse Labs' to facilitate large-scale COVID-19 PCR testing in the UK. As the LGD for testing, DHSC led the work to establish, design and monitor the operational delivery of the Lighthouse Labs, working closely with PHE, as well as with the NHS, commercial suppliers, academic institutions and not-for-profit organisations. Ministerial responsibility for testing, including the Lighthouse Labs, rested with the Health Secretary.

3.25. The scaling up of diagnostic capacity, including through Lighthouse Labs, was an important part of enabling large-scale testing to reduce transmission of COVID-19, and therefore the Cabinet Office was keen to understand progress, providing support where possible to help accelerate and/or remove any anticipated barriers to progress. Updates on Lighthouse Labs were generally provided to the Cabinet Office as part of wider updates on testing capabilities.

3.26. From 18 March 2020, at the request of DHSC, commercial specialists from the Cabinet Office were assigned to support DHSC's efforts to procure the required goods and services for increasing testing activity, which included procurement of testing equipment for the Lighthouse Labs. This work is detailed in the corporate statement provided by Gareth Rhys Williams for Module 5 of the Inquiry.[124]

3.27. The Cabinet Office facilitated updates to ministers, as necessary, primarily through deep dive meetings on testing and the Prime Minister's 9:15 C-19 Strategy meetings, and prepared

[121] JO/103 [INQ000106325]
[122] JO/143 [INQ000575323]; JO/144 [INQ000575389]
[123] JO/145 [INQ000575388]
[124] JO/001 [INQ000497031]

briefings to support ministers to engage on this issue. As an example, in the Chair's brief for the Prime Minister for a meeting with Dido Harding on 14 May 2020, Cabinet Office officials recommended probing whether NHST&T had everything it needed to deliver the goal of reaching 500,000 tests by the end of June, a figure that depended in part on the successful establishment of Lighthouse Labs.[125]

3.28. After the initial scale-up of Lighthouse Labs, DHSC provided updates to the Cabinet Office and ministers as part of wider updates on testing capacity.[126] Where issues were highlighted, for example in relation to pressures on capacity, the Cabinet Office worked to offer support to unblock the issue, for example by providing its backing and encouragement for expanding the number and capacity of Lighthouse Lab sites.[127] Similarly, as per its general role, the Cabinet Office worked to anticipate challenges that could impact the testing programme, including in relation to Lighthouse Labs, proactively seeking assurance that DHSC/NHST&T was considering the challenge and putting in place any mitigations. As one example, following a readout from a SAGE meeting on 14 December 2020 which noted the potential for the new SARS-CoV-2 variant emerging in Kent to escape PCR testing, the CTF sought assurance that NHST&T and relevant laboratories were considering the impact of the new variant on the effectiveness of COVID-19 tests.[128] Again, the Cabinet Office facilitated ministerial review where potential challenges needed greater consideration, such as those that underpinned the delivery of wider objectives. For example, Lighthouse Lab capacity was discussed in detail at a COVID-O meeting on 6 August 2020 given plans to increase testing capacity to handle the anticipated pressures of increased transmission over winter.[129]

Scale-up of centralised tracing

3.29. Contact tracing was discussed at ministerial level from the first COBR meeting on COVID-19 on 24 January 2020 where PHE were asked to provide regular updates to COBR on progress.[130] At this time, tracing was being undertaken through existing PHE collaboration with local authorities, and focused on contacts of returnees from Wuhan, China. On 2 March 2020, the CMO told COBR that contact tracing for the source of infection for the latest 2 cases in the UK has been unsuccessful and there was already community transmission in

[125] JO/146 [INQ000575362]
[126] JO/147 [INQ000092043]
[127] JO/148 [INQ000593198], JO/149 [INQ000593199]
[128] JO/150 [INQ000575399]
[129] JO/151 [INQ000090167], page 4-5
[130] JO/152 [INQ000056214]

other European countries.[131] It became clear that there was a need for large scale contact tracing to identify and reduce outbreaks, and improve the data picture on transmission.

3.30. The scale of the tracing task was underpinned by a recommendation from SAGE in May 2020[132] that at least 80% of contacts for an index case needed tracing and isolating within 48 hours of identification for the system to be maximally effective. Undertaking these steps using existing resources and systems during a rapidly growing epidemic proved to be challenging, and so all four nations of the UK established large-scale testing and contact tracing systems.[133] The efforts to build the national tracing capability were led by DHSC and NHST&T, with support provided as described in this section by the Cabinet Office. DHSC and NHST&T will therefore be best placed to comment in further detail about the decisions and considerations given at this time as to how the national-level system was to be established. The Prime Minister was kept updated on progress - on 6 May 2020, for example, the Prime Minister was told that SAGE's view was that controlling transmission during the planned phased reopening in summer 2020 would be dependent on a highly effective test and trace system.[134]

3.31. By late summer 2020, NHST&T was increasing efforts to collaborate with and use the expertise of public health teams at a local level, to complement and further enhance the national-level contact tracing system. The idea was that, alongside the national-level service, local level expertise could be utilised to engage hard-to-reach and vulnerable groups within the community as well as helping with the timely identification and management of local clusters and outbreaks. This work is discussed further in the sub-section 'Further Scaling of Contact Tracing' (starts paragraph 3.60).

Contact Tracing app

3.32. DHSC's 3-month battleplan, presented to HMIG on 22 March 2020,[135] noted the ambition to develop a contact tracing app to complement the ongoing non-app-based contact tracing of cases and contacts and help control the spread of COVID-19. This ambition was announced[136] publicly by the Health Secretary at a No.10 press conference on 12 April 2020.

3.33. The development, delivery and maintenance of the contact tracing app was the responsibility of DHSC, working closely with NHSX (the NHS unit responsible for digital innovation) and

[131] JO/153 [INQ000056217]
[132] JO/154 [INQ000120511]
[133] JO/076 **INQ000203933** page 215-216
[134] JO/155 [INQ000183931]
[135] JO/089 [INQ000055926]
[136] JO/156 [INQ000086581]

later NHST&T. The Cabinet Office was involved with the initial work to develop the app, primarily between April and July 2020. An overview of this work is summarised below.

3.34. In March and April 2020, updates on early progress on the development of the app were provided to ministers at MIG meetings and 9:15 C-19 Strategy meetings with the Prime Minister (see e.g. 17 April 2020, as described at paragraph 3.11.15).

3.35. On 10 April 2020, Apple and Google announced a partnership to develop a contact tracing application programming interface (API) for global rollout.[137] At the time of the announcement, DHSC and NHSX were already working to develop a bespoke system. Over the course of April 2020, the Cabinet Office's work to understand international approaches to contact tracing showed that other European countries were changing their approach, pausing the domestic development of backend technologies and opting to use the technology developed by Google/Apple. The Cabinet Office including No.10 therefore acted as a critical friend, scrutinising DHSC/NHSX's rationale for continuing to develop a bespoke app and challenging whether the UK was right not to follow suit and adopt the Google/Apple technology.[138]

3.36. Between 29 April and 3 May 2020, a team of officials from the Cabinet Office and the Government Digital Service conducted a rapid evaluation into the choice between using an NHSX-developed backend or a Google/Apple-developed API. The Cabinet Office's conclusion from the review was that the NHSX-developed backend technology should continue to be used for the upcoming pilot of the app on the Isle of Wight, but recommended that NHSX assess the pros and cons of their internally-developed backend technology and whether a switch to Google/Apple would be feasible.[139] The Cabinet Office suggested that, in parallel to the NHSX backend technology being developed, a Plan B option using the Google/Apple technology be pursued.[140]

3.37. Throughout April 2020, DHSC was preparing to run a pilot of the new NHSX contact tracing app on the Isle of Wight. The Cabinet Office was not closely involved in the planning for the pilot but requested key information from DHSC to understand the main objectives of the pilot, including the metrics by which success would be measured.[141] A summary note[142] was provided to the Cabinet Office by DHSC on 26 April 2020 which described the aims of the pilot as being: "to test the contact tracing app, updates to the PHE contact tracing system,

[137] JO/157 [INQ000593206]
[138] JO/158 [INQ000575384]
[139] JO/159 [INQ000575387]
[140] JO/160 [INQ000195918]
[141] JO/161 [INQ000593195]
[142] JO/162 [INQ000593194]

and increased testing capacity". Providing further detail of the pilot's objectives, the note described the aim to: "build confidence about how the integrated programme works, to test and refine the various elements including links between the app, the web/phone-based system and swab test requests and results, as well as to ensure we have the right testing and tracing capacity to meet need and demand. We also want some assurance that those who are contacted after contact tracing will comply with the advice that they are given and those people who are ill quickly access the appropriate NHS care". As outlined at paragraph 3.11.21, ministers were updated on the plan for the pilot at HMIG on 1 May 2020 where it was agreed that the pilot should launch the following week.[143]

3.38. On 4 May 2020, DHSC announced that the pilot would begin on the Isle of Wight later that week.[144] Following the announcement, the Cabinet Office continued to work closely with DHSC and NHST&T to ensure that planning for the app was robust. As a result of this work, on 3 June 2020, Tom Shinner, adviser to the Prime Minister, wrote to Baroness Harding outlining a number of concerns with the app.[145] Concerns included: the app's performance (i.e. its ability to detect the desired percentage of contacts and to be used on older phones or where the app was running in the background); the app's usefulness in slowing transmission if reliant on public compliance with self-isolation; the lack of international precedent for a Bluetooth-based contact tracing app; apparent delays to the timeline for rolling out the app nationwide; and the risk of damaging public confidence if an app was launched that did not work as planned. No.10 and Cabinet Office officials worked with Baroness Harding and NHST&T officials to consider the next steps for the app including options to overcome the concerns identified, including for example: piloting the app, technical research and improvements, stakeholder engagement and improved governance.[146]

3.39. At a 9:15 C-19 Strategy meeting on 12 June 2020, the Health Secretary told ministers that 'the app trial on the Isle of Wight had gone well, but there was further work to do to connect the work into wider testing and tracking programmes'.[147] On 18 June 2020, acting on lessons learned from the Isle of Wight pilot, DHSC announced that it would use the interface developed by Google/Apple for its contact tracing app.[148] DHSC would be best placed to provide further detail on the lessons learned from the Isle of Wight pilot.

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[143] JO/128 [INQ000083666]; JO/163 [INQ000083670]
[144] JO/164 [INQ000237334]
[145] JO/165 [INQ000195950]
[146] JO/166 [INQ000593215]; JO/167 [INQ000593216]
[147] JO/168 [INQ000088653]
[148] JO/169 [INQ000308726]

3.40. Over July and August 2020, the Cabinet Office continued to support NHST&T's work to prepare for launching the app. This included, on the basis of evidence from SPI-M and SAGE, encouraging DHSC to consider using geo-location in addition to or instead of Bluetooth technology, given its lower reliance both on high uptake of the app as well as the ability for geolocation data to help identify hotspots which Cabinet Office officials viewed as potentially helpful for avoiding blanket restrictions and better targeting NPIs.[149] Due to Google and Apple's user privacy requirements, however, the app that was ultimately launched across England and Wales on 24 September 2020 did not permit the use of geolocation data - the inability to make use of geolocation data was perceived at the time by Cabinet Office officials as an obstacle to enhanced contact tracing.[150] Due in part to the app's extensive privacy protections and the anonymity of app users, self-isolation notifications issued through the app were only ever advisory and were not legally binding unlike instructions to self-isolate issued through the non-app-based contact tracing system.[151]

3.41. Within three days of its launch, the app had been downloaded over 10 million times. Over time the app evolved to offer a range of services, including: reporting positive test results, local area information, venue check-in (certification), symptom checking, test ordering, self-isolation countdown, links to public health advice, and access to self-isolation payments. Research by the University of Oxford and University of Warwick published in February 2023 estimated that the NHS COVID-19 app prevented around one million cases, 44,000 hospitalisations and 9,600 deaths during its first year.[152]

3.42. The CTF and Cabinet Office Comms Hub supported DHSC's work to develop public messaging and guidance for the app. This included nationwide marketing to support the launch of the app and encourage people to download and use the app as intended. Challenges with public messaging for the app were, on occasion discussed at COVID-O:

3.42.1. In May 2021, for example, when the Government was exploring the role that 'certification' (i.e. showing proof of vaccination status or a negative test) could play in reopening the economy, reducing restrictions on social contact and improving safety, challenges relating to messaging and the app were discussed at COVID-O, including: how to ensure non-English residents could access certification without the app; how to ensure accessibility for people with disabilities through a non-digital route; how to ensure vaccine data for military personnel could be

[149] JO/170 [INQ000575377]; JO/171 [INQ000575429]; JO/172 [INQ000195977]
[150] JO/173 [INQ000196004]
[151] JO/174 **INQ000054050**
[152] JO/175 [INQ000575411]

displayed on the app; and how to ensure interoperability across different systems in the devolved administrations.[153]

3.42.2. During the pingdemic in summer 2021, ministers discussed the need for changes in public messaging around the app in response to growing concern that individuals were deleting the app to avoid self-isolation. Following discussion at COVID-O on 12 July 2021, an action was taken for DHSC and No.10 to agree the sequencing and details of announcements for any changes to the app prior to the Step 4 announcement later that day.[154] Continuing discussions in relation to the pingdemic at COVID-O the following week, a further action was assigned on 19 July 2021 for DHSC to 'continue work to refine the communications relating to the Test and Trace app, to make clear the purpose and rationale for its use to the public'.[155]

3.43. This section has described the Cabinet Office's work as the app was being developed to consider how effective the app would be once launched and suggest ways to strengthen its performance. Any formal reviews or assessments of the app's performance would have been for DHSC (as the LGD) and/or NHST&T (succeeded by UKHSA) to undertake.

Development, design and operation of NHST&T

3.44. The capability and level to which testing needed to be scaled exceeded the capacity of existing structures within PHE.

3.45. In May 2020, following advice from the Cabinet Secretary,[156] the Prime Minister appointed Baroness Harding as the external Executive Chair of a new Test, Track and Trace Taskforce. At the same time, similar governance structures were set up to oversee work on vaccines and personal protective equipment (PPE), both under the leadership of external Executive Chairs.[157] The appointment of Baroness Harding sought to create clear leadership and accelerate progress on the large amount of cross-government work that was needed to scale the test and trace system, as well as bringing in crucial links with industry. This appointment was announced publicly on 7 May 2020.[158]

[153] JO/176 **INQ000083897** JO/177 [INQ000091937]
[154] JO/178 [INQ000092214]; JO/179 [INQ000092034]
[155] JO/180 [INQ000092056]
[156] JO/181 [INQ000087170]
[157] Kate Bingham and Lord Paul Deighton were appointed to lead the Vaccines Taskforce (VTF) and Personal Protective Equipment (PPE) Taskforce respectively.
[158] JO/182 [INQ000107093]

3.46. Following the public announcement, senior officials from the Cabinet Office worked with Baroness Harding to agree the precise Terms of Reference (ToR) for the new taskforce.[159] These set out that the taskforce was to 'set the direction and ensure effective implementation of the UK's strategy towards Covid-19 testing supply, tracking and contact tracing. It will ensure the necessary supply of tests and ensure that the test, track and trace system is fully integrated, successfully launched and run sustainably and effectively. The taskforce will advise the Prime Minister on what is needed to achieve these aims'. The full ToR are exhibited.[160] The taskforce quickly became known as NHS Test and Trace (NHST&T), a renaming agreed by officials in DHSC and approved by Baroness Harding.[161]

3.47. Under the leadership of the Executive Chair, NHST&T had the Prime Minister's full authority to deliver.[162] Ministerial accountability to Parliament remained with the Health Secretary. Considerable freedoms and independence were afforded to NHST&T to expedite the delivery of testing and tracing. Baroness Harding was given permission to draw upon resources and expertise across government, to bring in external experts as required (subject to the usual rules and processes on appointments) and all government departments were instructed by the Cabinet Secretary to provide any necessary support that NHST&T requested.[163]

3.48. At the same time, it was important for the Cabinet Office to maintain a proportionate level of central oversight of work undertaken by NHST&T given its centrality both to understanding the virus and to the Government's overarching strategy for managing the pandemic and easing restrictions. Baroness Harding therefore initially reported directly to the Prime Minister. Once NHST&T was up and running, the Cabinet Secretary aligned reporting lines so that the Chair of NHST&T reported directly to the Health Secretary from 3 December 2020. In the letter communicating this change in governance arrangements, the Cabinet Secretary noted that as Chair of COVID-O and COVID-S, the Prime Minister would 'retain his close interest in the direction and work of NHS Test and Trace'.[164]

3.49. As described earlier in this statement, setting up a test and trace system on the scale and at the speed demanded by COVID-19 posed an unprecedented challenge, particularly given limited existing capabilities and technologies. For this reason, the Cabinet Office remained closely involved in the work of NHST&T. It was important for the Cabinet Office to have confidence that NHST&T would support the Government's strategic aim of lifting population-

[159] JO/183 [INQ000198087]
[160] JO/184 [INQ000198082]
[161] JO/185 [INQ000575351]
[162] JO/181 [INQ000087170]
[163] JO/186 [INQ000477247]
[164] JO/187 [INQ000575352]

wide restrictions for as many people as quickly as it was safe to do so and that the capabilities to test, trace and isolate would enable new outbreaks to be identified quickly and contained in a targeted way through more precise, localised restrictions.

3.50. Examples of the work undertaken by senior officials and advisers in the initial period after NHST&T was established include but are not limited to: agreeing effective ways of working both between the Cabinet Office and NHST&T, and with other government departments; ensuring that data gathering was effective; providing direction as NHST&T was designed; and agreeing how the work of NHST&T would be communicated to the public when it was launched. These examples are expanded on further below.

3.50.1. **Design of NHST&T**: On 18 May 2020, senior officials and advisers from the Cabinet Office including No.10 held an extended meeting with Baroness Harding, the CMO and GCSA to address some of the outstanding questions[165] relating to the design of NHST&T, given concern about some 'fundamental differences of view as to what [the] programme [was] trying to achieve, and by when'.[166] A follow-up meeting took place on 20 May 2020 between the Prime Minister, Baroness Harding, the CMO, the GCSA and other officials, with the exhibited slide pack[167] provided by DHSC for discussion. As per the readout,[168] the Prime Minister emphasised the importance of the test and trace system in enabling the future easing of restrictions and asked for a clear definition of where the programme would need to be by 1 June 2020 to proceed with lifting restrictions as planned. The meeting was used to agree the next steps for NHST&T and Cabinet Office to take forward to prepare for the launch of NHST&T at the end of the month.[169]

3.50.2. **Communicating NHST&T to the public**: Cabinet Office including No.10 officials and advisers were closely involved throughout May 2020 in shaping the public messaging for the launch of NHST&T.[170] Keen to ensure that public messaging was clear and concise about the Government's approach to testing and what it

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[165] Outstanding questions and concerns held by the Cabinet Office related to, for example: whether the NHST&T plan would work during anticipated periods of higher demand e.g. winter; which aspects of NHST&T would be UK-wide versus England-only; targets for testing and turnaround times; symptoms for triggering contact tracing; length and duration of isolation; testing of asymptomatic individuals; monitoring and recording compliance; plans for data sharing; and the ability of the system to respond to specific outbreaks at the local level. The full list of questions/concerns is available at: JO/188 [INQ000195933]

[166] JO/189 [INQ000195932]

[167] JO/190 [INQ000575383]

[168] JO/191 [INQ000575381]

[169] No.10's involvement in supporting the development of NHST&T during this period is discussed in the witness statement provided by Tom Shinner for Module 2. [JO/192 [INQ000228382], para 6.36-6.41]

[170] Simon Ridley describes the role of Cabinet Office officials and No.10 advisers in shaping the material to be published alongside the launch of NHST&T in his witness statement for Module 2. [JO/193 [INQ000252914], para 97-100]

meant in practical terms for the general public, the Cabinet Office pushed back strongly on initial proposals from NHST&T to publish a longer strategic document alongside the launch of the service. The Cabinet Office was concerned that the longer document proposed by NHST&T was vague, lacked clarity on what the Government was announcing and would generate more questions for the public than those it answered.[171] After a number of iterations, Cabinet Office and NHST&T officials agreed to publish a 'question and answer' style guidance document alongside the launch of NHST&T.[172] The Prime Minister met with Baroness Harding and other senior officials and advisers on the morning of 27 May 2020 to run through the plan for the launch later that day and clarify messaging on a number of outstanding issues such as why the approach was not to test asymptomatic contacts who were self-isolating. The annotated agenda for this meeting is exhibited.[173]

3.50.3. **Data**: Another key area of focus for the CTF and No.10 during this period was working to help ensure that the right data was being collected and effectively integrated into the Dashboard so that the progress of the test and trace system could be understood and factored into decision making. This included data from the Covid-19 Infection Survey (CIS), launched in April 2020.[174] Cabinet Office including No.10 officials and advisers also worked to support the development of the JBC and help to ensure it was being set up in a way that would support delivery of its objectives, including in respect of data sharing between different parts of the test and trace system.[175][176]

3.50.4. **Technology:** Cabinet Office including No.10 officials and advisers worked to support DHSC's efforts to identify where existing or new and unproven test and trace technologies (e.g. point-of-care testing, end-point PCR testing, and genomics) could be utilised in the response to COVID-19. This involved working to encourage innovation, to understand the potential for new technologies to be used and in what timeframe, and to help overcome barriers to making technologies available, including through investment. For example, a meeting was scheduled

[171] JO/194 [INQ000575380]; JO/195 [INQ000252839]
[172] JO/196 [INQ000593208]
[173] JO/197 [INQ000575378]
[174] The Covid-19 Infection Survey (CIS) was commissioned by DHSC in April 2020 and led by the Office for National Statistics (ONS).
[175] JO/198 [INQ000195944]
[176] Ben Warner describes his experience of supporting the development of the JBC in his witness statement for Module 2: JO/199 [INQ000269182], para 182-200

on 27 May 2020 for Will Warr to meet with DHSC officials to go through the detail of each innovative testing technology, including a discussion of what investments could accelerate their delivery.[177] Over summer 2020, the Cabinet Office worked to agree an ambition to use new rapid testing technologies to deliver mass/whole population testing. See further detail in section 'Supporting the development of mass testing' (starts paragraph 3.81).

3.50.5. **Establishing ways of working**: In this early period, as was the case throughout the pandemic, the Cabinet Office supported cross-government coordination at both official and ministerial level. This involved helping to ensure that ministers were regularly updated on the progress of NHST&T work and that decisions were brought to ministers for discussion and collective agreement through forums such as COVID-O as appropriate. The Cabinet Office helped to ensure join-up between different parts of government and NHST&T. As above, from the time that NHST&T was established, the Cabinet Secretary asked that all government departments provide any necessary support that NHST&T requested. Cabinet Office officials then played an important role coordinating TTI-related work on cross-cutting issues (e.g. working across government to respond to the pingdemic and in relation to the provision of testing to employers and business sectors).

3.51. NHST&T was announced by the Health Secretary at the No.10 press conference on 27 May 2020, with the exhibited documents published alongside the announcement.[178]

3.52. Once established, the Prime Minister held regular, often weekly, meetings with Baroness Harding and other senior leaders in NHST&T, keen to ensure that the testing programme was making good progress and would be robust enough to enable the easing of restrictions, which was planned to begin on 1 June 2020. The progress and operational delivery of NHST&T was also regularly reviewed at COVID-O meetings, where ministers discussed delivery concerns,[179] scrutinised the end-to-end NHST&T user journey[180] to identify where improvements could be made, and provided challenge to help ensure that NHST&T could

[177] JO/200 [INQ000575422]

[178] JO/201 [INQ000106458], JO/202 [INQ000107094]

[179] See for instance the Chair's brief for a COVID-O meeting on 4 June 2020 which recommended discussing five principal delivery concerns with the test and trace programme, namely, (i) what data sources were being used to detect outbreaks quickly and accurately; (ii) whether TTCE had the resources to act quickly, (iii) who was taking decisions and what authority was held by different levels of the system and what authorities should be reserved for ministers; (iv) effective communication to the public; and (v) how TTCE was working with the devolved administrations. [JO/203 [INQ000088838]]

[180] JO/204 [INQ000088756]

deliver the ambition set by the Prime Minister whilst adapting to new developments and changes in the pandemic landscape.[181]

3.53. COVID-O continued to review the operational delivery and effectiveness of NHST&T throughout the relevant period. For example, at a COVID-O meeting on 29 June 2020, the PHE representative explained that Leicester had experienced a peak at the same time as other areas across the country in April but had not experienced the same decline in cases since then. Testing had been increased in Leicester 10 days previously: the proportion of tests that had been positive had remained very high at between 10 to 20 per cent while the national average was below two per cent.[182] The slides by PHE and NHST&T set out additional measures being put in place to manage the outbreak, including (for example) regular testing of high-risk workplaces and care homes, and further deployment of walk-in testing.[183] Following agreement by COVID-O,[184] the Health Secretary announced the UK's first local lockdown in Leicester and parts of Leicestershire.[185]

NHS Test and Trace Prioritisation Board

3.54. In July 2020, NHST&T established a Testing Prioritisation Board (TPB) to maintain oversight of testing capacity allocations across the system, and to monitor demand, supply and activity, based on scientific and clinical advice and insight from the JBC. Initially, recommendations made by the TPB were submitted to the Health Secretary for agreement. Senior members of the CTF attended the Board's meetings, and updates on testing prioritisation were regularly provided to COVID-O which maintained oversight of the strategic governance arrangements for testing prioritisation.

3.55. As testing capacity grew, the CTF worked to review the strategic approach to testing prioritisation and advise ministers on how testing capacity could be deployed to support the delivery of other wider social and economic objectives. At a COVID-O meeting on 6 August 2020, for example, the CTF advised the CDL to probe whether recommendations from the TPB should continue to be based on clinical evidence alone, or whether there needed to be an opportunity to feed wider non-clinical considerations into the decision-making process (e.g. the economic benefit of testing key workforces, or the role of testing in increasing confidence around reopening schools). An action was taken from the meeting for the testing prioritisation process to be reviewed to examine whether ministerial views needed to be

[181] JO/205 **INQ000066029**; JO/206 [INQ000091091]
[182] JO/207 [INQ000088764]
[183] JO/208 **INQ000137231**
[184] JO/209 [INQ000088759]
[185] JO/210 **INQ000517380**

brought into the decision-making process earlier to enable rapid trade-off decisions to be made, and for advice to return to a future COVID-O meeting.[186] At a COVID-O meeting on 29 September 2020, ministers agreed that recommendations from the TPB should go to COVID-O or COVID-S for a final decision.[187]

3.56. In September 2020, demand for symptomatic testing was outstripping capacity. The CTF supported DHSC to identify seven priority areas for testing in England as demand continued to increase over the winter months.[188] The priority areas, agreed through COVID-O and published on 21 September 2020, included: supporting clinical care; protecting those in care homes; testing NHS staff; targeting testing to manage outbreaks in high-risk settings; supporting schools by prioritising teachers with symptoms; testing the general public with symptoms in areas of high transmission; and testing symptomatic members of the public in any geographic area.[189] The TPB used the seven priority areas as guardrails for making recommendations on allocations.

3.57. In November 2020, the CTF worked with other government departments to consider how asymptomatic testing capacity created by newly approved LFD technologies should be allocated. The CTF prepared a paper for a COVID-O meeting on 18 November recommending six 'core use cases' for asymptomatic testing (separate to the existing symptomatic testing programme) for the medium-term.[190] The actions from this meeting included for the CTF to work with DHSC/NHST&T to develop a quantified approach to allocating tests objectively based on requests for asymptomatic testing from other sectors.[191]

3.58. Over the winter of 2020/21, the CTF continued to facilitate updates to and decisions on the allocation and prioritisation of testing capacity through COVID-O, based on recommendations from the TPB. See for example updates to COVID-O at meetings on 9 December 2020[192] and 8 January 2021.[193]

3.59. The CTF was involved in considerations about testing prioritisation for critical workers in light of the pingdemic in July/August 2021, and again in December 2021 when there was a potential for testing capacity to be strained due to the Omicron variant. See Section 4 for further details on the pingdemic (paragraph 4.16 - 4.27).

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[186] JO/211 [INQ000089950]
[187] JO/212 [INQ000090237]
[188] JO/213 [INQ000575355]
[189] JO/214 [INQ000575402]
[190] JO/215 [INQ000090921]
[191] JO/216 [INQ000090938]
[192] JO/205 **INQ000066029**
[193] JO/217 [INQ000091617]

Further scaling of contact tracing

3.60. As described above, prior to the launch of the app in September 2020, all contact tracing was conducted using non-app-based tracing methods. At this time, alongside supporting the development of digital contact tracing capabilities, the Cabinet Office worked to understand where further resources could help to bolster the capacity for non-app-based contact tracing.[194] The Cabinet Office also acted as a critical friend to NHST&T by helping to evaluate new options for tracing cases. One option explored was asking businesses to maintain 21-day customer logs to support contact tracing as sectors reopened in 2020.[195] Another was backward contact tracing, which as explained in a note provided to the Cabinet Office by NHST&T[196] was a method which sought 'to identify the source of an infection…identifying chains of transmission that might not otherwise have been identified, and provide additional information that may help to identify links between cases'.[197]

3.61. Although the Cabinet Office supported the ambition for a digital contact tracing app, the department was also keen to manage ministerial expectations around the ability of the app alone to reduce the transmission rate, particularly given the lack of guarantee that people would comply with a digital self-isolation notification. For this reason, the Cabinet Office worked to ensure that plans for complementary non-app-based contact tracing, through which a self-isolation notification could be mandated, were progressed in parallel.[198]

3.62. Ministers were regularly updated on the scaling of contact tracing and any challenges arising at COVID-O meetings. As an example, on 30 June 2020, NHST&T updated ministers on the operational challenges of contact tracing, including the collection of personal contact details from people who were hesitant to share details of those with whom they had been in contact.[199]

3.63. The recruitment processes - including sourcing, training and monitoring - for contact tracing personnel was led by DHSC and NHST&T, with updates provided to ministers and the Cabinet Office as part of progress updates on the wider test and trace programme. On 30 June 2020, NHST&T provided an update to COVID-O which noted low utilisation of NHST&T contact tracing staff - 18,000 staff had been contracted initially based on planning assumptions, but for various reasons including lower reporting rates and fewer non-household contacts due to NPIs, the resourcing demand was lower than expected. The paper

[194] JO/218 [INQ000575382]
[195] JO/219 [INQ000575375], JO/220 [INQ000198115]
[196] JO/170 [INQ000575377]
[197] JO/221 [INQ000575376]
[198] JO/222 [INQ000575386], JO/223 [INQ000575356]
[199] JO/224 [INQ000088856]

provided by NHST&T for this meeting noted the steps being taken to resolve the issue, including redeploying staff who were underutilised and renegotiating contracts to build in flexibility and surge capacity to meet future demand.[200]

3.64. By summer 2020, feedback given to NHST&T/DHSC through engagement with local authorities, national/regional teams, and the public indicated that the centralised, national contact tracing model did not always make best use of local expertise and capabilities, which might have constrained the timely identification and management of local clusters and outbreaks. Recognising the need to build public trust in the NHST&T system in order to maximise engagement with contact tracing, as well as the value of local expertise and capabilities, from summer 2020, NHST&T increased efforts to partner with local authority public health teams. In August 2020, NHST&T decided to reduce the staffing of call centres by approximately 50% with a more local focus to contact tracing - this also helped to resolve the under-utilisation of staff described above. Local level partnerships also supported engagement with harder-to-reach groups.

3.65. Keen to maintain public confidence in the system, the Cabinet Office supported DHSC/NHST&T to shape the public messaging around the shift to more local-level contact tracing. This was presented as a shift from phone-based tracing to a mixture of phone and door-to-door tracing based on learnings about what worked well.[201] The Cabinet Office then worked with NHST&T to review whether the model was working and how challenges, such as local capacity constraints, could be managed.[202] DHSC and UKHSA (the successor to NHST&T) would be best placed to comment in detail on the challenges that persisted following this shift and how they were managed. At a high level, responding to a Cabinet Office commission[203] in September 2020 to understand how the shift was working, NHST&T reported that local authorities were experiencing challenges relating to funding and resourcing for local contact tracing as well as difficulties handling sudden increases in demand. NHST&T also acknowledged a variation in local authorities' readiness, capabilities and day-to-day performance. Further to this, insight from NHST&T fieldwork, shared with the Cabinet Office in November 2020[204], highlighted challenges including: lags in data provision both at the local level and between the local and national level; the granularity of data collected; and, low confidence from local authorities in the national tracing system. For the most part, NHST&T worked directly to support local authorities to overcome such challenges,

[200] JO/204 [INQ000088756], page 11
[201] JO/225 [INQ000575359]
[202] JO/226 [INQ000575394]; JO/227 [INQ000575353]
[203] JO/228 [INQ000593201]
[204] JO/229 [INQ000593204]

with system-wide issues being escalated to COVID-O for discussion (see for example, COVID-O on 16 October 2020, discussed at paragraph 3.67).

3.66. The Cabinet Office also continued its work to review the latest research and approaches to tracing internationally and to test that the approach being taken by NHST&T was informed by the latest developments and opportunities. In September 2020, for example, officials from the CTF and the BIT encouraged NHST&T to trial secondary contact tracing (by requiring primary contacts to identify their contacts), based on insights that it could help to increase compliance and further protect vulnerable groups.[205] NHST&T agreed to pilot the approach.[206]

3.67. The overall progress and operational delivery of the contact tracing system continued to be reviewed through COVID-O, where targets were agreed to drive improvements. On 16 October 2020, for example, COVID-O set NHST&T an ambitious target of tracing 90% of index cases and 85% of contacts by 31 December 2020. At the meeting, NHST&T set out six areas of focus to help drive improvement in contact tracing, which were endorsed by the committee. NHST&T explained at this meeting how the combination of national and local contact tracing was helping to prevent local systems being overwhelmed, as had been seen in other countries which relied entirely on local level tracing.[207]

3.68. The progress on contact tracing was reported in the Government's Winter Plan published on 23 November 2020: "Work to improve contact tracing continues, including the roll-out of tracing partnerships with Local Authorities to ensure a greater proportion of people who have tested positive are reached, help provide the support they and their families need to self-isolate successfully and more quickly, and identify and reach any contacts they have had outside their immediate household. In addition, the NHS COVID-19 app has been downloaded 20 million times, and this is supporting the contact tracing effort, including through use of the QR code check-in capability".[208]

3.69. Throughout the pandemic, target times for testing, contact identification and isolation were based on the latest advice and modelling from scientific and medical experts, including from SAGE and SPI-M, about the speed of transmission. Scientific experts continually reviewed target timeframes and updated recommendations as more was understood about the virus and as new, more transmissible variants emerged. The Cabinet Office did not set the targets,

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[205] JO/230 [INQ000575358]
[206] JO/231 [INQ000575357]
[207] JO/232 **INQ000065313**; JO/233 [INQ000090161], page 3-5; JO/234 [INQ000090099]
[208] JO/021 **INQ000137262**, page 15-16

but instead worked to support the system to deliver in accordance with the expert-informed targets.

Infection Surveillance

3.70. Throughout the pandemic, the Cabinet Office was keen to understand the prevalence of COVID-19 so that transmission could be understood, interventions targeted and strategic decisions taken on restriction measures. A variety of methods were used to monitor levels of infection.

3.71. Prevalence surveys provided a key source of information for decision makers. The Covid-19 Infection Survey (CIS) - led by the ONS - and the REACT Survey - led by Imperial College London and Ipsos Mori[209] - were commissioned in April 2020 by DHSC. Both surveys estimated the level of infection in the UK through questions, nose and throat swabs, and for some participants, blood samples. Although the information was slightly delayed in comparison to other methods of testing and surveillance, rigorous, large-scale surveys of this type provided a "gold standard" of data. Epidemiological analysis therefore continually triangulated the more representative (but lagged) surveillance studies with the more timely (but often biased) testing case data.[210] Data from the CIS was used to support updates to ministers from May 2020[211] and the CIS was also a key data source for the Social Distancing Reviews in spring and summer 2020.[212]

3.72. Wastewater testing, which involved testing sewage water to detect COVID-19, was another means by which the Government sought to better understand the spread of COVID-19 and gain advance warning of outbreaks. Wastewater surveillance was identified as a potential surveillance tool by UKRI, based on its historic utility in tracking polio,[213] and the National COVID-19 Wastewater Epidemiology Surveillance Programme (N-WESP) was rolled out from June 2020.[214] While the Cabinet Office was not directly involved in the N-WESP, data from the programme helped to provide insight on the presence or absence of cases and variants in particular geographic areas or settings and as such was regularly used by the CTF, in conjunction with data from the CIS, to inform updates to ministers and in Spotlight reports summarising the latest intelligence on new and emerging variants.[215] While not

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[209] JO/235 [INQ000575412]
[210] JO/076 **INQ000203933**
[211] JO/236 **INQ000215753** JO/237 [INQ000575432]
[212] For instance: JO/238 [INQ000575290]
[213] JO/239 [INQ000593190]
[214] JO/240 [INQ000575413]
[215] JO/241 [INQ000575301]; JO/242 [INQ000575302]

without limitations,[216] wastewater testing provided a source of data that, unlike data from the testing programme, was not subject to biases based on levels of public compliance or self-reporting. Data from wastewater testing was therefore a helpful addition to the data toolkit to support understanding of transmission.

Variants of Concern and surge testing

3.73. Surge testing refers to increased testing and enhanced contact tracing, including of those without symptoms, in specific locations or environments. Surge testing was used during the COVID-19 pandemic as a way of monitoring and suppressing localised outbreaks and to better understand new variants.

3.74. Departmental responsibility for surge testing, as with other test and trace policy, sat with DHSC. PHE worked to detect and track new variants, with delivery of surge testing managed by NHST&T in close collaboration with local authorities and Incident Management Teams given the localised test and trace effort.

3.75. Given the strategic risk posed by emerging variants of concern, the Cabinet Office worked to understand how surge testing could be used to manage the risk of new variants and what the results of surge tests meant for the Government's strategic response. The Government's Spring 2021 Roadmap noted that surge testing was part of the toolkit of measures being developed by the Government to address variants of concern.[217] CTF officials attended meetings of the Incident Management Team set up in UKHSA to coordinate the response to an emerging variant, as well as the regular meetings of DHSC's Local Action Committee command structure (bronze, silver, gold) which was where local and regional concerns were escalated.[218] The approach to surge testing necessarily adapted in response to new and emerging variants, the practicalities of operational delivery and as lessons were learned both domestically and from international comparators.

3.76. Surge testing was used on various occasions to respond to new emerging variants in 2021, including but not limited to:

3.76.1. the Beta variant, first observed in South Africa in May 2020, and detected in the UK in late December 2020. Surge testing for the Beta variant began on 1 February

[216] Assessment of wastewater monitoring from SAGE meeting on 8 April 2021: "Wastewater monitoring can help to track the presence of SARS-CoV-2 (including new VOCs in the population, alongside clinical testing. It is particularly useful to detect outbreaks when prevalence is low (including in areas where community engagement with testing is low) and also to detect presence and geographical spread of new variants. It is less effective for precise quantification of levels of SARS-CoV-2 (or particular variants) in a population". [JO/243 [INQ000061594]]
[217] JO/022 **INQ000185087**
[218] For example, JO/244 [INQ000575313]. The Local Action Committee structure is described in the Contain Framework, here: JO/245 [INQ000575421]

2021 in specific locations in England. The Beta variant did not become widespread in the UK.

3.76.2. the Gamma variant, first observed in Brazil in December 2020, and detected in the UK in February 2021. Surge testing was used to respond in areas of England where cases of the variant were detected. This variant did not become widespread in the UK.

3.76.3. the Delta variant, first identified in India in October 2020 and detected in the UK in March 2021. Transmission of the Delta variant was high and became the dominant variant by mid-2021.

3.77. The Cabinet Office, as with other policy areas, acted as a critical friend to DHSC, challenging what more could be done and whether any further support for DHSC was required. Updates were provided to ministers at, for example, COVID-O, as required. The CTF worked to collate data from surge testing into the Dashboard so that the spread of new variants could be understood and monitored, and encouraged DHSC to publish data in relation to surge testing to support public understanding of the Government's work in this area. Data reports on surge testing were subsequently published on a weekly basis in the first half of 2021.[219]

3.78. Insight from CTF Field Teams' visits to areas around England to observe the implementation of TTI policies at the local level helped to inform DHSC's understanding of how surge testing was working in practice so that improvements could be made.[220] The CTF also reflected on the use of surge testing as part of evaluating the Government's response to different variants over the first half of 2021.[221]

Exercise Fairlight

3.79. During the course of the pandemic, the Government undertook exercises to help ensure that lessons were learned and to promote preparedness for the next phase of the response. Exercise Fairlight, for example, was a cross-Whitehall forward-looking exercise, commissioned by the Prime Minister, to determine the robustness of the Government's COVID-19 Winter 20/21 plans. Exercise Fairlight, which took place between 1-3 September 2020, produced 90 granular and 13 high-level observations in four categories: Strategy and Communication; Command and Control; Capability and Capacity; and Planning.[222]

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[219] JO/246 [INQ000575403]
[220] JO/247 [INQ000575287]
[221] JO/248 [INQ000575285]
[222] JO/249 [INQ000319854]

3.80. A number of key themes directly relevant to TTI were explored as part of Exercise Fairlight. Exercise Fairlight observed, for example, that testing capacity was, at the time, insufficient and lacked agility, recognising that testing constraints needed to be reflected in departmental planning and prioritisation of testing would be required. The exercise noted that a contingency plan would be required for how to monitor progress of the epidemic if testing was not available to all those with symptoms. Another observation from Exercise Fairlight included the need for clearer articulation of NHST&T priorities, particularly in relation to asymptomatic cases. The report for this exercise is exhibited.[223]

Supporting the development of mass testing

3.81. At the start of the pandemic, based on scientific advice, the focus of test and trace work had been on symptomatic cases of COVID-19 using lab-processed RT-PCR tests. By summer 2020, however, increased understanding of the asymptomatic transmission of COVID-19, as well as advances in rapid testing technologies, prompted new considerations about how testing could continue to protect public health while at the same time enabling those who did not have the virus to participate in economic and social activities. In the absence of an effective vaccine or drug-based treatment, mass testing was viewed as a potential method for avoiding national lockdown and other blanket social distancing measures.

3.82. The Cabinet Office including No.10 was particularly interested in how to accelerate the use of rapid or mass testing to support the Government's overarching objective to control the spread of the virus, balancing the impact of restrictions on health, the economy and wider society.[224] This work primarily took place in the second half of 2020 and early 2021 ahead of the universal testing offer being made available to everyone in England from 9 April 2021. During this time, various options were considered for what a mass testing programme could look like in practice, ranging from one-off whole population testing to regular testing of people in specific parts of England or specific environments (e.g. schools). The ideas and ambition for mass testing adapted in line with the developments of the response, the practicalities of operational delivery and as lessons were learned from pilots and international comparators.

3.83. This section will summarise the work conducted by the Cabinet Office in relation to mass testing, which was sometimes referred to with the codenames Operation Moonshot, Project Phoenix or Spitfire. Ultimately the level of mass testing reached in the UK was one of the

[223] JO/250 [INQ000280023]

[224] Dominic Cummings describes in detail his role in accelerating the widespread use of rapid testing in his witness statement for Module 2: JO/064 [INQ000273872], para 370-387

highest in the world per capita and was considered a key tool in supporting the easing of restrictions.

3.84. On 23 July 2020, Professor Keith Godfrey, from the University of Southampton, wrote to the Prime Minister seeking support for the 'Phoenix programme', which he described as a 'national programme to robustly manage COVID-19 without lockdown…by testing whole communities and populations with lower sensitivity, higher scalability tests, as a complement to NHS test and trace'.[225] The letter followed a DHSC-funded pilot study, led by Professor Godfrey, that investigated the effectiveness of weekly saliva testing using RT-LAMP tests in Southampton. Professor Godfrey had met with No.10 officials and advisers, alongside senior scientific members of SAGE (including the CSA, DCMO and others) to discuss the outcomes of the pilot on 22 July 2020, the previous day, where, as the letter notes, there had been "unanimous support for urgent research, development and implementation of the technologies and infrastructure that allow faster, simpler, and more scaled testing for COVID-19".

3.85. On 24 July 2020, the Prime Minister met with Professor Godfrey and others to discuss the next steps to take forward population testing. The agenda[226] and a supporting note provided for this meeting by the CSA[227] are exhibited. At this meeting, the Prime Minister and Health Secretary expressed their support for developing population testing, and the Prime Minister asked Baroness Harding, supported by No.10 and the CTF as needed, to lead NHST&T in taking this programme of work forward. The readout from this meeting also notes that the Prime Minister asked for a "very rapid rollout [of testing] to a specific geographic area with high prevalence", with Leicester and Blackburn suggested as options.[228]

3.86. Piloting of population testing took place in July and August 2020 with the use of RT-PCR and RT-LAMP technologies as set out in Professor Godfrey's proposal.

3.87. From August 2020, the Prime Minister held a regular - typically weekly - meeting on population testing,[229] attended by Baroness Harding and other senior officials, including from the CTF, involved in this work. To support decision-making, NHST&T worked to produce a 'Moonshot SitRep' for these meetings, which detailed the progress on the mass testing programme including the projected trajectory for testing capacity.

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[225] JO/251 [INQ000137242]
[226] JO/252 [INQ000218334]
[227] JO/253 [INQ000137243]
[228] JO/254 **INQ000233914**
[229] The Cabinet Office has identified 23 weekly testing meetings held by the Prime Minister between 24 July 2020 and 21 December 2021 and will provide to the Inquiry separately an index of these meetings and the associated material.

3.88. At the regular testing meeting on 5 August 2020, noting concerns about a resurgence of COVID-19, the Prime Minister said he was keen that the work on mass testing be progressed "as fast as possible", requesting a plan that would "accelerate this work as a project of top national importance" and deliver population testing across the country "by the start of October". To achieve this, the Prime Minister agreed to launch a 'call to arms' to manufacturers, and was clear that the Cabinet Office and HMT should "provide all necessary regulatory approvals to allow this work to proceed urgently", deploying extra staff and "leveraging the wider public sector (including the military) and the private sector to support delivery".[230]

3.89. At the testing meeting on 12 August 2020, the Prime Minister was told that the latest estimate was that testing capacity could be scaled to the levels required for mass population testing by Christmas. The Prime Minister stressed the importance of "moving every possible obstacle…to bring it forward from Christmas by six weeks given the importance of [the mass testing] work to the economy", and agreed that Dominic Cummings and the Cabinet Secretary, Simon Case, should work to remove any obstacles to this posed by Cabinet Office and HMT processes. At this meeting it was also agreed that someone from the CTF should be identified to act with the authority of the Prime Minister to liaise with Baroness Harding and urgently resolve any issues impeding progress on population testing across Whitehall.[231]

3.90. The slidepack prepared by NHST&T for a further meeting on testing with the Prime Minister on 3 September 2020 noted that mass testing had two uses: "testing at-risk groups" (to "achieve a marked impact on R") and "to enable a return to normal life by allowing people to do things they otherwise wouldn't be able to such as going to the theatre or the football".[232]

3.91. On 9 September 2020, Operation Moonshot was announced publicly by the Prime Minister at a No.10 press conference.[233] The Prime Minister described how testing would continue to be used to identify and isolate positive cases to protect high risk groups, but that in the near future, the ambition was to also use testing to identify people who *did not have* COVID-19 and could therefore "lead more normal lives, without the need for social distancing": "We are hopeful this approach will be widespread by the spring and, if everything comes together, it may be possible even for challenging sectors like theatres to have life much closer to normal before Christmas". Moonshot was to run within the existing NHST&T infrastructure, under the leadership of the SRO, Alex Cooper (DHSC).

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[230] JO/255 [INQ000471024]
[231] JO/256 [INQ000498301]
[232] JO/257 [INQ000137254]
[233] JO/258 [INQ000086845]

3.92. Slides presented by NHST&T to the Prime Minister on 10 September 2020 are exhibited.[234] They show that while testing capacity was at the time very tight, a range of activity was underway to build up mass testing over the coming months.

3.93. Through autumn 2020, the CTF worked as a 'critical friend' to support NHST&T to explore different options for a mass testing programme.[235] This included considering where the UK could learn from approaches to mass testing being taken internationally, with officials visiting Slovakia in November 2020 to learn lessons from their whole population test event.[236] The CTF also worked to support the design of pilots, considering how and where in the country mass testing could best be trialled based on transmission data, levels of local preparedness and learnings from other approaches in other countries.[237] As a result, a mass testing pilot was carried out in Liverpool in November 2020, which offered rapid, on-site LFDs to all residents, regardless of symptoms.[238]

3.94. The CTF monitored the progress of pilots and wider mass testing work, working with NHST&T to provide advice to the Prime Minister to help shape the overall strategy on how restrictions could continue to be lifted safely as schools reopened and the country headed into the winter months when demand on the NHS was likely to increase.

3.95. Following the Prime Minister's testing meeting on 18 November 2020,[239] No.10 sent a letter, agreed by the Prime Minister, to DHSC Second Permanent Secretary, Shona Dunn, setting out the Prime Minister's expectations for the mass testing programme.[240] The letter emphasised the importance of the programme in managing the virus and enabling an exit strategy from the November lockdown. It set out the parameters for the programme and asked DHSC to produce a detailed plan.

The development of community testing

3.96. Ministers discussed mass testing at a COVID-O meeting on 21 November 2020.[241] The paper for the meeting, prepared by the CTF, set out the proposal to roll out asymptomatic testing for people in the areas of highest prevalence in England. This built on the concept of the city-wide testing pilot in Liverpool in November 2020 and would seek to reduce prevalence of

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[234] JO/259 [INQ000137259], JO/260 [INQ000137258]
[235] JO/261 [INQ000575354], JO/262 [INQ000575397], JO/263 [INQ000575395]
[236] JO/264 [INQ000575396]
[237] See for instance: JO/265 [INQ000575312]
[238] JO/266 **INQ000496277**
[239] JO/267 [INQ000585869]
[240] JO/268 [INQ000575392]
[241] JO/269 **INQ000136695**

COVID-19 by identifying positive cases of COVID-19, including among asymptomatic persons.

3.97. Recognising the pressure that this could put on systems which were already preparing to roll out the vaccine, the CTF was asked to consider the deliverability, trade-offs and local authority buy-in around mass testing. An amended version of the proposal was considered by Cabinet at a meeting on 22 November 2020,[242] which would give local Directors of Public Health the opportunity to use mass testing in their areas, based on their knowledge of how mass testing could help drive down the virus in their locality.

3.98. Following agreement at Cabinet, the Community Testing Programme (CTP) was announced in the Winter Plan[243], which described how developments in testing technologies and the availability of rapid turnaround tests were enabling the use of testing to be broadened: "To date, testing has focused on symptomatic testing, testing in areas with outbreaks and protecting those most at risk, for example in care homes. Those efforts will continue but the use of testing is now being broadened to identify those showing no symptoms who can infect people unknowingly".

3.99. Initially, the CTP offered "Local Authorities in tier 3 areas the opportunity to participate in a six week testing surge". The Government indicated that it would also continue piloting further rapid testing in schools, colleges and universities, and would deploy rapid testing for specific one-off events. This included testing university students before they travel home for Christmas, starting from 30 November 2020, as well as supporting universities to establish sustained testing regimes.[244]

3.100. The CTP was led by DHSC, working closely with NHST&T and with the CTF to develop the strategy, policy and operational delivery model. DHSC worked with the CTF to develop guidance for local authorities explaining how the CTP would work and what it meant for the local level in practice. The guidance was published on 30 November 2020.[245] This guidance was updated at various points as the CTP adapted and was expanded in line with the changing demands of the pandemic response, including an increase in numbers of local authority areas falling under higher restrictions, the emergence of new strains of COVID-19, periods of national lockdown and progress on the vaccine programme. Throughout, the

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[242] JO/270 [INQ000089062]
[243] JO/021 **INQ000137262** page 17
[244] To mitigate the risk that students travelling home from higher education institutions (HEIs) for the winter break would transmit infection to their relatives, some of whom may be more vulnerable, HEIs became the first-use case for LFD-based COVID-19 mass asymptomatic testing. UKHSA published an evaluation [JO/271 **INQ000496282**] of this testing.
[245] JO/272 [INQ000223465]

guidance contained a section outlining the support available to local authorities from central government. DHSC would be best placed to provide further detail on the support available, but as the guidance outlines, this included but was not limited to the following:

3.100.1. funding to cover the costs of delivering the CTP;

3.100.2. communications support, tailored to local need, decisions on testing priorities and key audiences to engage;

3.100.3. relationships via NHST&T Regional Convenors and CTP Liaison Teams to support local areas with "planning, logistics, set-up and communication…draw[ing] on the lessons from other town and use case pilots…elevat[ing] queries and concerns to the national level";

3.100.4. provision of Standard Operating Procedures and a LFT guidebook to support local authorities to, for example, identify test sites, use digital software, order tests and design workforces;

3.100.5. centrally-provided tools such as: training; national sourcing of staff (from commercial suppliers, volunteer programmes, furloughed individuals etc.); workforce modelling; commercial support; and organisational design;

3.100.6. and, military support, where appropriate.

3.101. The Prime Minister was updated on progress on the CTP by the CTF,[246] including at weekly testing meetings,[247] at which he stressed the need to have ambitious plans and to push local authorities to increase the numbers being tested where possible, offering to facilitate support across government to deliver this ambition if required.[248] Updates were also regularly provided to COVID-O meetings, at which ministers worked to scrutinise delivery plans for the programme.

3.102. At a COVID-O meeting on 9 December 2020, ministers discussed the need for the CTP to be dynamic and able to respond to changing prevalence rates. The committee agreed that the CTP should focus not only on the areas with highest prevalence but also on areas with rising case rates, where community testing could prevent further case rises, with decision-

[246] JO/273 [INQ000575307]

[247] The Cabinet Office has identified 23 weekly testing meetings held by the Prime Minister between 24 July 2020 and 21 December 2021 and will provide to the Inquiry separately an index of these meetings and the associated material.

[248] JO/274 **INQ000062993**

making via the Gold Local Action Committee on where targeted support should be prioritised.[249]

3.103. For the weekly testing meeting on 17 December 2020, DHSC provided a paper on 'The role of testing in advance of Christmas and building testing for January and beyond'.[250] The readout records that "Given the ambitious current work programme, and risk of creating unmanageable demand pressures, the PM agreed that it would not be right for major population testing above current plans pre-Xmas. The Health Secretary set out initial thinking on mailshot testing across the country towards the end of January, subject to MHRA approvals and technological solutions. The PM was very attracted to this proposal".[251]

3.104. As infection and hospitalisation rates continued to rise in the meantime, the CTF worked with DHSC and NHST&T to explore what more could be done through the CTP to reduce transmission while enabling critical sectors to operate. The proposal to expand the CTP to all local authorities across England for those who had to leave home for work was discussed with the Prime Minister at a regular testing meeting on 7 January 2021. At this meeting, consideration was given as to whether the testing offer should be expanded even further, but this was decided against given the risk that tests could lead to more risk-taking behaviour which needed to be balanced against the national lockdown messaging.[252] Following the Prime Minister's agreement, the proposal to expand the CTP was reviewed and agreed by ministers at a COVID-O meeting the following day. The expansion of the CTP was announced on 10 January 2021.[253]

3.105. Once expanded, the CTF worked to maximise engagement with the programme, collaborating with MHCLG to optimise local authority engagement and with NHST&T to consider ways to incentivise public participation. The CTF and Equality Hub also supported DHSC to consider how the CTP could best engage and support disproportionately impacted groups. The CTF also supported engagement with the devolved administrations in relation to the CTP, including the sharing of lessons learned, as part of regular meetings led by the CDL.

3.106. The January 2021 announcement of the CTP expansion also explained that "In addition to local authorities, NHS Test and Trace will also work closely with other government departments to scale up workforce testing".[254] By the end of March 2021, over 60,000 businesses across the country had registered their interest to provide rapid tests to key

[249] JO/275 [INQ000091241]
[250] JO/276 [INQ000575305]; JO/277 [INQ000575306]
[251] JO/278 [INQ000498321]
[252] JO/279 [INQ000575374]
[253] JO/280 [INQ000086661]
[254] JO/281 [INQ000086661]

workers. From 6 April 2021, the workplace testing programme supplied home test kits to companies with over 10 workers where it was not possible to set up testing on-site.[255]

The development of the universal testing offer

3.107. On 3 February 2021, in advice sent to the Prime Minister, the CTF set out the costs and benefits of two options for increasing asymptomatic testing as lockdown was eased. A 'one-off test event' would seek to test a high proportion of the adult population over 7-10 days, whereas DHSC proposed a series of national targeted testing surges as cohorts were released from lockdown, through a combination of Community Testing, employer-led testing and home testing.[256]

3.108. The Prime Minister held a meeting to discuss these options on 4 February 2021 - slides for this meeting are exhibited.[257] The readout records that "The Health Secretary and Dido Harding set out the proposed plan to develop testing surges of targeted population groups to align with roadmap easing. Shona Dunn stressed the importance of each surge then being sustained with repeated testing for these groups. In their view, and that of CDL, this approach was preferable for disease management than a one-off national test. CMO noted the importance of establishing testing as a routine. If we proceeded with opening all schools on 8 March [2021], this would involve communicating out testing plans at the very start of March [2021] and encouraging testing the weekend before schools open. Schools already had much of the infrastructure in place, with 2m tests undertaken so far. Dido [Harding] committed to reviewing when surge testing might be available for other cohorts, such as non-essential retail and hospitality, and how we would tackle the question of shoppers or patrons of hospitality, as well as employees. The PM agreed that this was a good plan, and asked for it to be further developed".[258]

3.109. The Spring 2021 Roadmap published on 22 February 2021 confirmed that, as part of Step 1, pupils and students in all schools and Further Education settings would return to face-to-face education from 8 March 2021, supported by a range of testing measures.[259]

3.110. On 5 April 2021, the CTF prepared a paper for COVID-O recommending that ministers agree to proceed to Step 2 of the Spring 2021 Roadmap on 12 April 2021 on the basis that the tests for lifting restrictions had been met. Alongside the announcement, the paper recommended

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[255] JO/281 **INQ000520772**
[256] The paper at JO/282 [INQ000575366] is incorrectly dated as 3 January 2020. JO/283 [INQ000575365] confirms it was submitted to the Prime Minister on 3 February 2021.
[257] JO/284 **INQ000063360**
[258] JO/285 [INQ000575310]
[259] JO/286 [INQ000236463]

that ministers also agree for NHST&T to launch a 'simplified universal asymptomatic testing offer where anyone is eligible to access regular testing', which would be launched with a national communications campaign promoting the benefits of regular testing, alongside a renewed focus on 'tackling areas of stubborn transmission and disproportionately impacted groups'.[260] The paper noted that the CTF was working with NHST&T and HMT on a review of the role, funding and delivery channels for asymptomatic testing for when the universal offer was initially set to expire in June 2021.[261] Ministers agreed with the recommendation and the universal testing offer was announced by the Government later the same day: "In a significant step forward, which paves the way for businesses and society reopening, anyone will be able to access free, rapid lateral flow tests (LFDs) for themselves and their families to use twice a week, in line with clinical guidance".[262]

3.111. In the Autumn and Winter Plan 2021, published on 9 November 2021, the Government confirmed that it would "continue to provide the public with access to free lateral flow tests in the coming months. People may wish to use regular rapid testing to help manage periods of risk such as after close contact with others in a higher risk environment, or before spending prolonged time with a more vulnerable person. At a later stage, as the Government's response to the virus changes, universal free provision of LFDs will end, and individuals and businesses using the tests will bear the cost".[263] Prior to this announcement, the CTF had provided advice to the Prime Minister on 1 September 2021,[264] CDL had chaired a Small Ministerial Group on 6 September 2021[265] and COVID-O had agreed the Autumn and Winter Plan on 13 September 2021.[266]

3.112. In the Living with COVID-19 strategy, published in February 2022, the Government announced that, from 1 April 2022, the Government would no longer provide free universal symptomatic and asymptomatic testing for the general public in England. It was working with retailers and pharmacies to help establish the private market in testing, alongside some limited ongoing free testing.[267]

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[260] JO/287 [INQ000091855], page 3-4
[261] In the event, the universal testing offer was extended several times and was withdrawn from 1 April 2022.
[262] JO/288 [INQ000237346]
[263] JO/023 [INQ000480678]
[264] JO/289 [INQ000575339]
[265] Papers from DHSC: JO/290 [INQ000575324], JO/291 **INQ000119866** Readout: JO/292 [INQ000354852]
[266] JO/293 [INQ000092120]
[267] JO/005 [INQ000086652]

4.SECTION 4: Isolation

4.1. This section begins with a focus on domestic policy regarding isolation and then turns to policy relating to international travel. Throughout the pandemic, self-isolation policymaking was informed by expert scientific advice. Public compliance and enforcement in relation to self-isolation is covered in Section 5.

4.2. To understand the guidance and rules on isolation it is worth bearing in mind the distinction between index cases (who may be symptomatic and/or had tested positive for the virus), their household contacts and their non-household contacts.

4.3. In the early 'contain' phase of January to March 2020, there were relatively small numbers of known index cases and the focus for PHE/DHSC was on tracing and isolating cases and their household and non-household contacts using existing structures to delay the establishment of community transmission. The Cabinet Office was not involved in decisions relating to isolation in this period, which were necessarily taken by the relevant clinical and scientific experts. DHSC would be better placed to comment on how existing systems and learnings from other diseases were utilised and what, if any, new measures were developed during this period.

4.4. At a press conference on 12 March 2020, on the basis of clinical and scientific advice at a COBR meeting earlier that day,[268] the Prime Minister announced a move from the 'contain' to the 'delay' phase of DHSC's 'Coronavirus action plan'.[269] Later that day, nationwide guidance was introduced and index cases were required to stay at home for at least 7 days if they had coronavirus symptoms, however mild – either a new continuous cough or a high temperature.[270] On 16 March 2020, this guidance was expanded to include household contacts (i.e. those in the same household as a person with symptoms).[271] The following week, on 23 March 2020, the UK Government announced the first national lockdown, at which point everyone was asked to stay at home.[272]

4.5. As described in Section 3, a nationwide contact tracing system was launched in England with the establishment of NHST&T on 28 May 2020, and the Government proceeded with a phased lifting of national lockdown restrictions in June and July 2020. From this point, where

[268] JO/294 [INQ000056209]; JO/295 [INQ000056221]
[269] JO/296 **INQ000057508**
[270] JO/297 [INQ000593209]
[271] JO/298 [INQ000086753]
[272] JO/299 [INQ000052715]

possible, testing and tracing was used as a way of helping to target isolation requirements and avoid blanket restrictions.

4.6. Over the course of the pandemic, changes in the epidemiology of COVID-19 and the arrival of new and more transmissible variants meant that the self-isolation guidance was necessarily amended multiple times. The CTF worked with DHSC and the scientific community to understand the latest evidence and provide timely advice to ministers at COVID-O and COVID-S on recommended changes to the self-isolation guidance. This included, for example, changes to the duration of the isolation period, changes to the guidance based on developments in understanding of the symptoms of COVID-19 and the introduction of any exemptions from self-isolation. Changes to the isolation guidance were, throughout the pandemic, made on the basis of expert scientific and expert advice.

4.7. Another key area of the Cabinet Office's work in relation to self-isolation was in monitoring levels of adherence with the guidance, understanding the barriers preventing people from following the guidance (see Section 5, notably paragraph 5.15) and working with experts across government to consider what could be done, whether it be financial support or legislative measures, to help maximise public compliance with self-isolation. Learning from isolation approaches being taken internationally was a key part of this work and is detailed further in Section 5 (paragraph 5.12, 5.14-5).

4.8. From 28 September 2020, the Government introduced in England a legal requirement to self-isolate for people testing positive for COVID-19 or contacted by NHST&T. The Health Protection (Coronavirus, Restrictions) (Self-Isolation) (England) Regulations 2020 ('the Self Isolation Regulations') made provision for mandatory periods of self-isolation, as well as providing for enforcement and prosecution of breaches of the Regulations. The legal requirement to self-isolate remained in place until February 2022.[273]

Test to Release

4.9. In line with its effort to help ensure that the policy response to COVID-19 balanced the impacts across public health, society and the economy, the CTF acted as a critical friend to challenge what could be done to enable those who did not have the virus to return to work and social activities, including, for example, by shortening self-isolation periods and using testing to enable them to resume normal activities. Decisions in relation to such measures were taken in collaboration with clinical and scientific advice.

[273] JO/300 [INQ000086653]

4.10. In October 2020, for example, the CTF challenged DHSC to review whether the earlier scientific advice from the CMO and GCSA on the 14-day isolation period for contacts remained unchanged, or whether the duration could be reduced.[274] The CTF worked with DHSC and HMT, in particular, to understand the trade-offs of maintaining and reducing the isolation period to develop a proposal for ministerial consideration at COVID-O meetings on 2 and 3 November 2020.[275] The proposal sought to improve compliance by introducing a simplified policy with a clearer ask. COVID-O agreed to allow contacts in England to 'test to release' on day eight to ensure no one needed to isolate for more than 10 days.[276]

4.11. The Winter Plan, published on 23 November 2020, noted that alongside the test-to-release approach for close contacts, the Government was planning to introduce mass testing as an alternative to the need for self-isolation for people who had been in close contact with someone with COVID-19. Mass testing is described in detail in Section 3 (paragraph 3.81-3.95).

4.12. Again, in December 2020, ministers raised whether the period of self-isolation for contacts could be shortened owing to concerns about compliance and the impact on the economy. Following discussion at a COVID-O meeting on 9 December 2020,[277] on 11 December 2020, a statement from the UK CMOs noted: "After reviewing the evidence, we are now confident that we can reduce the number of days that contacts self-isolate from 14 days to 10 days".[278] This change was reflected in amendments to the regulations and took effect in Wales from 10 December 2020 and in England, Scotland and Northern Ireland from 14 December 2020.

4.13. The Alpha variant was announced shortly afterwards and the UK entered another national lockdown in January 2021. The Spring 2021 Roadmap for exiting that lockdown, published in February 2021, noted that "In time, it is possible that testing becomes a viable alternative to self-isolation for contacts of infected people. The emergence of new variants has meant this is not yet feasible, but the testing programme is being primed to deliver this when the time is right".[279]

4.14. As per the policy paper published by UKHSA in August 2021 to explain the workplace daily contact testing pilots, two randomised controlled independent research studies were initiated to provide further evidence of the impact that daily contact testing could have on public health. The studies allowed comparison of onwards transmission between those participating

[274] JO/301 [INQ000198162]
[275] **JO/174 INQ000054050** JO/302 **INQ000062856**
[276] JO/303 [INQ000090866], JO/304 [INQ000091159]
[277] JO/275 [INQ000091241]
[278] JO/305 [INQ000054307]
[279] JO/306 [INQ000072888]

in daily contact testing and those self-isolating. One of the trials involved the general public and the other secondary schools and colleges.[280]

4.15. The statutory instrument which gave effect to the lifting of lockdown in steps - the Health Protection (Coronavirus, Restrictions) (Steps) (England) Regulations 2021, laid on 29 March 2021 - clarified the territorial application of the Self Isolation Regulations, and created new exceptions from the requirement to self-isolate, or remain in the place where a person is self-isolating, including for participants in serial testing schemes.

Pingdemic

4.16. In summer 2021, there was a high prevalence of COVID-19 and large numbers of people were being notified to self-isolate through the NHS app. This became known as the 'pingdemic'. The rise in infections followed the easing of restrictions as part of Step 3 of the Spring 2021 Roadmap, in mid-May 2021, as well as increased rates of testing and reporting of infection through the NHS app.

4.17. From a health perspective, the pingdemic showed that the app was working broadly as intended by tracing and notifying those in close contact with the virus. While a 'ping' (i.e. a notification) from the app was not a legal obligation to self-isolate, increased levels of staff absences began to impact the ability of businesses and public sector organisations to operate as usual, potentially causing disruption to critical services and economic activity.

4.18. On 12 July 2021, the Government announced that Step 4 of the Spring 2021 Roadmap would go ahead on 19 July 2021, and that an exemption from isolation for contacts of positive cases for under 18s and for double vaccinated adults would take effect on 16 August 2021.[281] This had been discussed and agreed by COVID-O on 1 and 2 July 2021.[282]

4.19. While the exemption to self-isolation was expected to mitigate the effects of the 'pingdemic' from 16 August 2021, the CTF worked with other departments to consider the impact of staff absences in the intervening period, and the policy options, in order to advise ministers on how the Government could respond, balancing the impacts across health, society and the economy. As well as changes to the 'logic' of the app announced by the Health Secretary,[283] two cross-government schemes were implemented in short order: critical worker exemptions and daily contact testing.

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[280] JO/307 [INQ000049230]
[281] JO/308 [INQ000075760]
[282] JO/309 [INQ000092002], JO/310 **INQ000063951**
[283] JO/311 [INQ000593205]

4.20. Following discussions about the impact of workforce absences at a COVID-O meeting on 12 July 2021,[284] the CTF commissioned DHSC to consider the policy options for making exemptions to the self-isolation policy for named critical workers, including in which sectors exemptions should apply and how they would work in practice.[285] The CTF worked with DHSC and No.10 officials to review the options available ahead of providing advice to ministers. As an example, the exhibited email chain shows official-level consideration of whether a decentralised process for agreeing exemptions (with sign off of agency/sector exemption requests by nominated individuals in government departments) or a centralised process (with sign off by a single department e.g. DHSC or Cabinet Office) should be implemented.[286] The CTF also recommended bringing CCS colleagues into the discussions given their responsibility for overseeing disruption to the operation of critical national infrastructure (e.g. energy and food supply).

4.21. On 15 July 2021, the CTF provided an update to the Prime Minister on the pressures arising from the number of people self-isolating, recommending that a targeted approach should be introduced to ensure the ongoing delivery of critical services, with communications to support businesses to protect themselves from disruption.[287] The issue was discussed at a Dashboard meeting the following day, the readout for which notes the Prime Minister's steer not to "weaken language on the app to emphasise that it is only advisory, as this would reduce self-isolation and contradict the wider message of caution" but instead to establish exemptions as soon as possible for workers where critical safety situations could arise due to absence.[288]

4.22. At a COVID-O meeting on 19 July 2021, ministers agreed with the recommended approach set out in the exhibited paper[289] provided by DHSC for the meeting, which would give, in 'very limited and specific circumstances, the ability for departments to identify named fully vaccinated contacts who may have a reasonable excuse to leave self-isolation to carry out critical roles ahead of 16 August [2021] when the exemption for fully vaccinated contacts [would come] into force'.[290] All departments were to exercise discretion when defining sectors in which the exceptions should apply and that any arrangement should apply only where there would be (a) a major detrimental impact on the availability, integrity or delivery of essential services, or (b) significant impact on national security, national defence or the

[284] JO/178 [INQ000092214]
[285] JO/312 [INQ000575347]
[286] JO/313 [INQ000575350]
[287] JO/314 [INQ000575369]
[288] JO/315 [INQ000575371]
[289] JO/316 **INQ000182294**
[290] JO/317 [INQ000092225], page 2

functioning of the state. The actions indicated that the DHSC should work with all departments to finalise a list of sectors to match the specific criteria outlined in the papers and the CTF would work with all departments to rapidly assess where absences in staff numbers in specific sectors may cause future issues.[291]

4.23. As agreed by COVID-O on 19 July 2021, departments were responsible for approving applications for exemptions from self-isolation within their respective sectors, but could only do so for specific types of roles and workforces agreed in advance by the Cabinet Office and DHSC. This was to ensure that exceptions were being applied consistently across government and not overused.

4.24. The CTF, with support from CCS, continued to monitor the data and impact of increased rates of COVID-19, considering what further steps could be taken to manage pressures on workforces. Alongside the critical worker scheme, the CTF worked with NHST&T and other government departments to recommend daily contact testing - whereby critical workers would take daily LFDs for 10 days rather than self-isolating - as a way of mitigating disruption to key sectors. The proposal for daily contact testing was reviewed by ministers at a COVID-O meeting on 22 July 2021. At the meeting, ministers acknowledged the pressures across all sectors, with food and logistics recognised as the biggest concerns, but discussed the need for decisions around exemptions to be driven by NHS capacity which was already under strain.[292] Ministers agreed to expand daily contact testing and to prioritise the food sector, but noted that assurances on testing capacity would be needed prior to roll out.[293]

4.25. On 23 July 2021, the Prime Minister met with CDL, the GCSA, Jenny Harries, and officials from the CTF to be updated on the challenges of workforce absences and potential mitigations. In addition to the critical worker exemptions and daily contact testing underway, the CTF presented options for further interventions.[294] The readout notes a discussion about allowing fully-vaccinated self-isolating people to go to work in all sectors, but not to do other activities, before 16 August 2021. The Prime Minister concluded that it was not necessary or beneficial to change the policy at that time. Self-isolation was one of the main mitigations to encourage caution at a time of rising cases, and wider public compliance with self-isolation would be reduced if exemptions were made which were ostensibly for work only.[295] The CTF was actioned to prepare regulations for this option as a contingency.

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[291] JO/180 [INQ000092056]
[292] JO/318 [INQ000092219]
[293] JO/319 [INQ000092071]
[294] JO/320 **INQ000064043**
[295] JO/321 [INQ000575373]

4.26. The CTF worked with CCS and other government departments to collate data in relation to the critical worker scheme and daily contact testing so that the impact of the pingdemic could be measured and the need for further mitigation measures reviewed. CCS and the CTF worked with departments to review the risk of staff absences in their areas of responsibility, the contingency plans in place for managing disruption and any potential vulnerabilities, providing regular updates to senior officials and working to scope potential ways to mitigate disruption, for example by using military resource and/or relaxing legislation should the need materialise.[296] An example of these data summaries, provided to No.10 on a daily basis over late July/August 2021 is exhibited.[297] The CTF also worked to consider amendments to the exemption policy in response to departmental concerns in relation to critical workforces, as can be seen in the exhibited email chain.[298]

4.27. On 16 August 2021, the exemption from isolation for contacts of positive cases for under 18s and for double vaccinated adults came into force.[299] This exemption, in conjunction with a decline in case rates, essentially ended the pingdemic. However, the measures introduced to combat it - critical worker exemptions and daily contact testing - remained in place for those contacts who were not yet double-vaccinated.

Omicron

4.28. The Government acted quickly to amend TTI policy in response to the risk posed by the Omicron variant, starting from a position of caution and relaxing measures as the risk of the variant was better understood and becoming the dominant strain in the UK.

4.29. On 30 November 2021, as concerns grew in relation to the new Omicron variant, self-isolation regulations were amended to legally require all close contacts of confirmed or suspected Omicron cases to self-isolate, regardless of vaccination status. The isolation mandate for close contacts was later removed from 14 December 2021, and replaced with advice for close contacts to take a daily LFD test for seven days to help identify asymptomatic cases and break chains of transmission.[300]

4.30. In light of lessons learned from the pingdemic earlier that summer, the CTF also took early action to consider how to mitigate potential pressures on workforces. The CTF worked with UKHSA to put in place a critical workers testing scheme to help identify asymptomatic cases and limit the risk of outbreaks in workplaces in critical national infrastructure, national

[296] JO/322 [INQ000575349], JO/323 [INQ000593217]
[297] JO/324 [INQ000575338]
[298] JO/325 [INQ000575337]
[299] JO/326 [INQ000237473]
[300] JO/327 [INQ000575405]

security, transport, and food distribution and processing. While UKHSA was responsible for delivery of the scheme, the CTF ran a cross-government prioritisation process, overseen by COVID-O, to allocate the available tests to departmental sectors. Ministers agreed[301] to the contingency prioritisation of testing supply set out in a paper[302] provided by the CTF for a COVID-O meeting on 23 December 2021.

4.31. As per earlier stages of the response, the CTF worked to test that TTI policies were proportionate to the public health risk and that relaxations were introduced where it was safe to do so in order to manage the economic and societal impacts of more stringent measures. Following a COVID-O meeting on 17 December 2021, for example, the CTF was asked to work with DHSC and the CMO to consider the existing 10-day isolation period and the impacts of any changes.[303] On 22 December 2021, the self-isolation period for index cases and their fully vaccinated contacts was reduced from ten to seven days provided they tested negative on days six and seven. The 10-day period remained for contacts who were not fully vaccinated.[304]

4.32. The CTF continued to ensure that the policy on self-isolation was proportionate given the latest data available and, on 12 January 2022, COVID-O was asked to consider a further reduction in the self-isolation period requirement for index cases.[305] The CTF produced an evidence pack for the meeting which aimed to demonstrate the trade offs and operational considerations for different response options.[306] From 17 January 2022, people with COVID-19 in England could end their self-isolation after five full days, as long as they tested negative on days five and six, regardless of vaccination status.

4.33. From 24 February 2022, the legal requirement to self-isolate was removed and replaced with a recommendation to self-isolate if symptomatic.[307]

Borders and travel

4.34. On 27 January 2020, the Health Secretary announced that anyone in the UK who had returned from Wuhan in the last 14 days needed to self-isolate.[308] Guidance relating to inbound international travel was adapted and expanded over the subsequent weeks. On 25 February 2020, the Government published two categories of guidance for inbound travellers

[301] JO/328 [INQ000104522]; JO/329 [INQ000104597]
[302] JO/330 [INQ000104620]
[303] JO/331 [INQ000104480]
[304] JO/332 [INQ000114475]
[305] JO/333 [INQ000091551]
[306] JO/334 [INQ000091523]
[307] JO/300 [INQ000086653]
[308] JO/335 [INQ000237587]

to the UK.[309] This guidance was withdrawn on 12 March 2020 and was superseded by 'Stay at home' guidance for all those with confirmed or possible coronavirus (COVID-19) infection.[310]

4.35. As restrictions were eased following the first lockdown and international travel opened up, it was important to ensure that policies were in place to manage the risk of new variants or increased transmission caused by people arriving into the UK from overseas. The CTF (which included a specific Transport, Borders and International Team) worked closely with other government departments including DHSC, DfT, HMT and the Home Office, to convene and broker cross-Whitehall analysis and develop policy advice for decision through COVID-O.[311] The CTF also worked to consider options for testing international arrivals[312] and to oversee discussion and implementation of agreed measures, as well as working closely with other government departments to commission and support work to amend travel restrictions where needed.[313]

4.36. In the first roadmap published on 11 May 2020, the Government announced that it would introduce two measures as soon as possible.[314] First, all international arrivals would be required to complete a passenger locator form (and be strongly encouraged to use the app). And second, all international arrivals not on a short list of exemptions would be required to self-isolate in their accommodation for 14 days on arrival in the UK.

4.37. On 8 June 2020, the Health Protection (Coronavirus, International Travel) (England) Regulations 2020 ('The International Travel Regulations') came into force, making provision for mandatory 14-day self-isolation and testing requirements for those returning to England from non-exempt countries. At a COVID-O meeting on 11 June 2020,[315] it was agreed that the CTF would work with the Home Office, DHSC, JBC, DfT and FCDO to create a robust, flexible set of criteria to determine a country's status and risk level.

4.38. The International Travel Regulations were amended over 50 times during the pandemic as the Government sought to monitor global transmission rates of COVID-19 and enable safe international travel while at the same time controlling the spread of COVID-19, including new variants, within the UK. The majority of amendments made changes to the countries/territories on the exemption list and to the list of individuals exempt from complying

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[309] JO/336 [INQ000052487]
[310] JO/337 [INQ000223375]
[311] JO/338 [INQ000198185]
[312] For instance: JO/339 [INQ000575300]
[313] For instance: JO/340 [INQ000575303]; JO/341 [INQ000198179]
[314] JO/342 **INQ000198892**
[315] JO/343 [INQ000088844]

with the regulations by reason of their employment. The Government also made changes to the restrictions on international arrivals as the pandemic progressed.

Measures for travellers entering the UK

4.39. On 6 July 2020, the Transport Secretary announced a list of countries from which people arriving in England would be exempt from self-isolation on arrival.[316] These were known as 'travel corridors' and the list was updated over time.

4.40. In October 2020, the Prime Minister asked the Transport and Health Secretaries to establish a Global Travel Taskforce to finalise plans for rapid implementation of a "test to release" (TTR) regime for international arrivals, and to explore other measures to restart international travel and tourism.[317] The Global Travel Taskforce was led by DfT, working closely with other departments including the CTF team, the Home Office and HMT and provided a mechanism for industry and other key stakeholders to engage with issues on international travel and to consider ways to manage the risks while maintaining as much stability for the industry as possible. The proposals for a TTR scheme were discussed and agreed by COVID-O on 19 November 2020,[318] with the TTR scheme implemented from 15 December 2020,[319] allowing international arrivals to shorten their isolation period to five days on the basis of a negative test result.

4.41. In January 2021, the CTF's work on borders was undertaken against the backdrop of new and emerging variants domestically and across the globe. CTF officials worked with DHSC, other government departments and the TPB to assess and develop options.[320]

4.42. In light of the risks posed by new variants, on 8 January 2021, the Transport Secretary announced that from the following week people due to arrive in England from all international destinations would be required to present a negative COVID-19 test result before departing for England to help protect against new variants circulating internationally.[321] Corresponding amendments to the International Travel Regulations came into force on 15 January 2021.

4.43. Following further work by the CTF and other government departments, on 27 January 2021, the Prime Minister announced a package of further measures to control transmission.[322] This included a 10-day managed quarantine for international arrivals from so-called 'red-list

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[316] JO/344 [INQ000237315]
[317] JO/345 [INQ000049273]
[318] JO/346 [INQ000091200]
[319] JO/347 [INQ000575406]
[320] JO/348 **INQ000054512**
[321] JO/349 [INQ000086667]
[322] JO/350 [INQ000575416]

countries', which were assessed as posing a high risk to UK public health due to the potential for new and emerging variants. Two COVID-O meetings[323] on 4 February 2021 approved the proposals for implementation of the Managed Quarantine Service (MQS), and a COVID-O Managed Quarantine Sub-Committee (MQSC) was stood up. The CTF formed the secretariat for the newly established MQSC, a role which included advising on what discussions should take place at the MQSC.[324] The MQSC met on 5 February 2021 and again on 8 February 2021 (discussed at paragraph 5.42).[325]

4.44. The necessary amendments to the Regulations came into force on 15 February 2021, introducing a mandatory self-isolation requirement consisting of a 10-day hotel quarantine with tests on days two and eight for individuals travelling from specified red-list countries. [326] Any passengers travelling back to England from countries not on the list were required to quarantine at home for the same period and abide by the same testing regime.[327] The Home Office awarded a contract to Mitie to carry out (on behalf of NHST&T) visits to those quarantining at home, in addition to the work by the Isolation Assurance and Compliance Service.[328]

4.45. The Spring 2021 Roadmap published in February 2021 announced that DfT would lead a successor to the Global Travel Taskforce, "with an ambition to develop a framework that can facilitate greater inbound and outbound travel as soon as the time is right, while still managing the risk from imported cases and variants".[329] The Global Travel Taskforce published a report on 9 April 2021, which recommended implementing a traffic light system which would identify countries as red, amber or green based on the level of risk posed to UK public health - testing and quarantine requirements would vary according to the traffic light system.[330] The traffic light system came into effect from May 2021.[331]

4.46. Over the course of the rest of 2021, the CTF supported the refining and simplification of the system and brought in more open travel for people who were vaccinated based on some criteria. For example, exemptions were introduced for vaccinated arrivals from amber countries as well as arrivals from green countries from 19 July 2021. From 4 October 2021, the framework was simplified to a red list with travellers from all other countries facing

[323] JO/351 [INQ000091872]; JO/352 [INQ000092337]; JO/353 [INQ000091713]
[324] JO/354 [INQ000198183]
[325] JO/355 [INQ000177565]
[326] JO/356 [INQ000575409]
[327] JO/357 **INQ000237376**
[328] JO/358 [INQ000575418]
[329] JO/022 **INQ000185087**, page 41
[330] JO/359 [INQ000223605]
[331] JO/360 [INQ000237361]

restrictions based on vaccination status, reducing testing requirements for vaccinated arrivals after 24 October 2021. Additional measures were also brought in during the Omicron wave before the Government announced, on 14 March 2022, that all managed quarantine capacity was to be stood down from the end of March 2022, and travel restriction regulations were revoked in full on 18 March 2022.[332]

UK/France border closure and testing of hauliers

4.47. On 20 December 2020, in response to the detection of the new Kent/Alpha variant in the UK, France announced a 48-hour closure of its UK border for all travellers including accompanied freight, to come into force from 23:00 that evening.[333]

4.48. The CTF worked with CCS to convene two COBR meetings on 21 December 2020, first at official level and later at ministerial level, to coordinate and agree cross-government actions to monitor the impact of the border closure on critical supply chains and to explore ways in which testing at the border could support the resumption of vehicle movements.[334] Officials from CCS and the CTF worked with DfT, NHST&T and FCDO, among others, to develop options for testing hauliers at the border to mitigate the disruption to supply chains.[335]

4.49. On 22 December 2020, the Government announced an agreement with the French Government to allow accompanied freight services and some passenger services to resume between the UK and France subject to the provision of a recent negative LFD test result.[336]

4.50. Once the agreement was in place, CCS and the CTF continued to support DfT to address challenges arising from the border testing programme. This included monitoring and helping to resolve congestion issues, designing public communications to clarify testing requirements, and addressing translation issues in the testing process following reports that this was hindering testing takeup.[337]

[332] JO/361 [INQ000055832]
[333] JO/362 [INQ000054366]
[334] JO/363 **INQ000254825**; JO/364 [INQ000575316]; JO/365 [INQ000063076]
[335] JO/366 [INQ000575400]
[336] JO/367 [INQ000049245]
[337] JO/368 [INQ000063101]

5.SECTION 5: Communications, compliance and enforcement

5.1. In the absence of a vaccine or effective therapeutic, maximising adherence with TTI was a key way that the Government could seek to reduce the transmission of COVID-19 and protect lives. This was emphasised in public messaging and published strategic plans throughout the pandemic. The 'Next chapter in our plan to rebuild' strategy published on 24 July 2020, for example, explicitly noted that the efforts of NHST&T to limit transmission and reduce the likelihood of needing national-level interventions could 'only work with the full cooperation of COVID-19 positive individuals and their close contacts'.[338]

Communications

5.2. Communications were an important part of helping to maximise public engagement with TTI guidance and the work of NHST&T. Within the Cabinet Office, communications were led by the COVID-19 Communications Hub (Comms Hub). The Cabinet Office established the Comms Hub in March 2020, bringing together a broad range of communications professionals, including behavioural scientists, from across government to ensure efficient and effective delivery of cross-government public communications. The Comms Hub worked closely with a range of teams throughout the pandemic, including behavioural science experts and the Equality Hub, to help ensure COVID-19 communications were inclusive and accessible.

5.3. The Comms Hub led the Government's overall public communication strategy in relation to COVID-19, working closely with No.10 and other government departments to shape and strategically align government campaign activity so that, collectively, messaging helped to drive public behaviour in line with the Government's strategic objectives. Public messaging in relation to the NHST&T programme was led by a dedicated NHST&T communications team. The Comms Hub supported NHST&T by sharing expertise, providing insight from polling and qualitative research and supporting where coordination was needed with other parts of government to deliver campaigns.

5.4. Using data from polling, advice from behavioural experts, and insight from regional and local networks, the Comms Hub helped NHST&T to maximise the reach of its public messaging and tailor communications to specific target audiences. Target audiences varied over time but included, for example, people in specific parts of the UK where transmission was particularly high, and communities where there were lower levels of engagement with NHST&T. The Equality Hub supported this work by helping departments to increase the

[338] JO/369 [INQ000086693], page 8

accessibility of public messaging relating to the pandemic - this included, supporting the Department for Environment, Food and Rural Affairs (Defra) to develop accessible communications material for local authorities to reach non-shielded vulnerable people and helping to ensure British Sign Language interpreters were present for No.10 press conferences.[339] The Comms Hub also supported NHST&T to review the end-to-end customer journey of the test and trace programme to identify the points at which people were most likely to disengage and where more could be done through public messaging to retain public engagement.[340]

5.5. An important part of the Comms Hub's role in relation to communications on TTI was helping to coordinate and ensure collaboration between different departments where campaigns brought together different policy areas. One example of this was the Back to School Testing campaign in autumn 2021 where the CTF worked closely with NHST&T (and later UKHSA), DHSC and DfE to coordinate public messaging that would seek to deliver on the steer from No.10 to increase asymptomatic testing and reporting of test results among schoolchildren and their households.[341]

5.6. As part of its work to help ensure that policy changes were communicated clearly, the Comms Hub worked to anticipate and monitor the effectiveness of both the Government's overall communications approach and specific campaigns to strengthen the design of public messaging, including in relation to TTI. Assessment methods included quantitative campaign tracking and qualitative focus groups, which were used both prior to the launch of campaigns and, once campaigns were live, to assess audience response and inform improvements to communications. This work involved, for example, testing public understanding of the key messages within government campaigns and evaluating whether the behaviours being taken among different cohorts in response to messaging were as intended. The Comms Hub's Insight and Evaluation team provided daily and weekly assessments of public sentiment and behaviours using quantitative tracking, which directly informed communications activity, as well as wider policy and strategy formulation. Where necessary, additional ad-hoc evaluations were conducted to address immediate challenges. Examples of the weekly insight reports, which contain data relating to public perceptions on government communications, are exhibited.[342]

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[339] JO/370 [INQ000083928]; JO/371 [INQ000083862]
[340] JO/372 [INQ000575289]
[341] JO/373 [INQ000575336]
[342] JO/374 [INQ000593200] (16 October 2020); JO/375 [INQ000593203] (4 December 2020); JO/376 [INQ000593202] (10 February 2021)

5.7. The Director of National Resilience Communications, who led Comms Hub during the pandemic response, held weekly calls with local authorities to communications at a local level. This engagement was also an opportunity for local authorities to provide feedback on how local communities were interpreting and responding to national-level public messaging. Feedback from these meetings was used to inform and refine government communications and to support policy and strategy development.

Compliance

5.8. A wide range of government departments and organisations were involved in work to consider, design and monitor compliance relating to TTI policies. The range of bodies included but was not limited to: NHST&T, DHSC, Home Office, HMT, MHCLG/DLUHC, BEIS, DCMS and DfT. As with other policy issues described in this statement, the Cabinet Office worked to coordinate the efforts of these different organisations, joining up relevant parts of government, facilitating ministerial decision-making, acting as a critical friend in the development of policies on compliance and enforcement, and working to formulate advice to ministers based on the latest data and evidence.

5.9. The Cabinet Office also supported DHSC with the development of regulations where it was deemed necessary that restrictions, such as self-isolation, be mandated to control transmission.

5.10. The Cabinet Office was involved in discussions to consider compliance with and enforcement of TTI policy from an early stage of TTI policy development, including prior to the establishment of NHST&T. At a deep-dive meeting on test and trace with the Prime Minister on 30 April 2020, for example, ministers and senior officials discussed the anticipated levels of compliance with the new contact tracing app. At this meeting, it was noted that while the public could be expected to comply initially, compliance would likely decline over time if people received multiple self-isolation notifications. The papers provided by DHSC for this meeting noted that although in principle the Government could consider mandatory measures to increase participation with the testing programme, there would be 'significant legal, ethical, equality and operational issues to consider and overcome'.[343] The Prime Minister acknowledged at the meeting that 'a balance had to be found between authoritarianism and consent, but that there was a desire for the Government to be emphatic about compliance'.[344]

[343] JO/377 [INQ000575361]; JO/126 **INQ000062075**
[344] JO/127 [INQ000088694]

5.11. At the point that NHST&T was launched on 27 May 2020 - and in general throughout the response to COVID-19 - the Government's starting position was to expect public compliance with TTI policies introduced to reduce the spread of COVID-19 as a 'matter of social duty'.[345] This position was, however, kept under close review, and while voluntary compliance with TTI policy was preferential, it was important that stronger measures to mandate compliance were not ruled out if non-compliance increased the risk to public health. Issues relating to compliance and enforcement were regularly a focus of discussion at COVID-O meetings.

5.12. Once established in May 2020, the CTF included a small team focused on compliance and enforcement. As part of its role it worked with other government departments to monitor compliance with TTI policies and provide updates and advice to ministers. Broadly, during the initial periods where self-isolation policies were implemented on a voluntary basis, the CTF's work involved supporting the monitoring of adherence to TTI rules/guidance to see where further intervention might be needed, understanding any barriers to compliance (e.g. financial, practical, social), identifying learnings from other countries and providing advice to ministers on interventions to help maximise engagement with TTI policies. At the point that mandatory self-isolation measures were introduced to control transmission, the CTF's work shifted to monitoring the impact of the new measures and helping to ensure that appropriate support was available to enable compliance.

5.13. Measuring levels of compliance with TTI policies was challenging as much of the data relied on self-reporting which was inevitably subject to biases. In the absence of an accurate, objective data picture, compliance levels were suspected to be lower than available data suggested, based on the assumption that some people were unlikely to admit a lack of adherence to the rules.[346] To build confidence in the data picture on compliance, the Government worked to obtain and compare data from a range of different sources including polling, surveys, and observations from on-the-ground visits by CTF Field Teams. NHST&T also employed different methods to gauge levels of compliance, including by contacting individuals who had tested positive and their close contacts to ascertain adherence with self-isolation requirements.

5.14. Behavioural and scientific insights, as well as learning from other countries, helped to supplement the data picture on levels of compliance with TTI policy. The CTF commissioned expert advice and modelling from scientific and behavioural experts to understand how likely the public were to be compliant with TTI policies, how different levels of compliance would impact overall transmission and what impact different interventions could be expected to have

[345] JO/378 **INQ000062288**
[346] JO/379 [INQ000120558], page 3

on compliance and transmission rates. The CTF worked closely with, for example, No.10 data scientists and the BIT, to formulate advice to ministers which reflected the latest scientific insight, including from forums such as SAGE and the Scientific Pandemic Influenza Group on Behaviour (SPI-B).

5.15. Maximising compliance with the NHST&T programme was a priority for the Cabinet Office throughout the response to COVID-19. It was therefore important for the CTF to understand and address where possible the barriers preventing people from engaging with TTI policies. Using the data and expert advice available, as well as insight from CTF Field Teams and the local level, and international comparators, the CTF worked to understand the range of financial, social and practical barriers to compliance with TTI policies, as well as any demographic and geographic disparities in compliance, in order to advise ministers. Barriers to adherence with TTI policies were understood to be wide-ranging and included, but were not limited to: lack of awareness or misunderstanding of TTI guidance and the public health risks associated with not complying; practical concerns relating to, for example, needing to leave home to buy essential supplies or perform caring responsibilities; concerns about loneliness and the mental health impact of self-isolating; financial disincentives of self-isolation for those unable to work from home or not entitled to sick pay; scepticism or distrust of scientific evidence and/or government communications, particularly among more deprived communities and ethnic minorities; poor awareness or dismissal of symptoms; and, reluctance to isolate if asymptomatic.[347] Some of the steps taken to overcome these barriers are explained in the remainder of this section.

5.16. Issues of compliance were regularly discussed at COVID-O, where ministers determined where further intervention was needed to reduce rates of transmission. At a COVID-O meeting on 30 June 2020, the Chair of NHST&T told ministers that there had been "a significant drop in compliance from the initial onset of symptoms to the end of the 14 day isolation period" with insight from public engagement attributing this to a range of emotional, mental, practical and financial reasons.[348] The paper provided by NHST&T outlined the measures being taken to improve compliance (including improved communications and calls and texts from NHST&T to those self-isolating), and highlighted further actions that could be considered (e.g. financial compensation and out-of-home isolation in secure accommodation). The paper recommended that existing measures continue to be pursued in the first instance while further work was undertaken to understand the extent of non-compliance, factors driving low cooperation and the likely response to mandatory measures

[347] See for instance, summaries of barriers to engagement in: JO/380 [INQ000091673] and JO/068 [INQ000575314]
[348] JO/224 [INQ000088856], page 1

before any decision was taken on going further.[349] Ministers agreed with the recommended approach.[350] The Chair's brief, provided to CDL by the CTF, is exhibited.[351] Following this meeting, the CTF continued working with other government departments, notably DHSC and HMT, to develop options for further intervention, including the provision of financial support, should the need arise.[352]

5.17. In the absence of mandatory requirements, public messaging was a key way through which the Government sought to maximise compliance with TTI guidance. The Comms Hub worked closely with the CTF and NHST&T to design communications which were informed by behavioural insight and understanding of the barriers to compliance. For example, when confusion about the rules was understood to be driving a lack of compliance and increasing transmission rates, communications were designed that sought to clarify who was eligible for a test and what the guidelines were for self-isolation. National-level campaigns were supported by bespoke campaigns designed at the local level with local authorities and community representatives to reach vulnerable and harder-to-reach groups.[353]

5.18. By mid-September 2020, with infections rising and evidence suggesting only a very low percentage (circa 20%) of those with COVID-19 symptoms in England fully complied with self-isolation guidance, and that rates of self-isolation by other household members and contacts were likely to be even lower, the CTF prepared advice for the Prime Minister recommending a carrot-and-stick approach to increasing compliance.[354] The advice was prepared in close collaboration with behavioural experts, and through consideration of international comparators and modelling, to understand the levels of compliance needed to reduce transmission. The recommended approach sought to alleviate the financial burden of self-isolation for the lowest-income households through a £500 Test and Trace Support Payment.[355] At the same time, a legal duty to self-isolate if instructed to do so would be introduced, as well as financial penalties both for non-compliant individuals and for any employers who forced staff to break self-isolation rules. Following the Prime Minister's approval,[356] the proposal was formally agreed by ministers at a COVID-O meeting on 18

[349] JO/204 [INQ000088756], page 7-8
[350] JO/224 [INQ000088856], page 9
[351] JO/381 [INQ000146707]
[352] See for instance JO/382 [INQ000575428], which highlights the work being undertaken by the CTF in this period to negotiate an agreed position between DHSC and HMT in relation to financial support to increase compliance with TTI policies.
[353] JO/383 [INQ000575430]
[354] JO/384 [INQ000575390]
[355] Local authorities in England were asked to set up the payment schemes by 12 October 2020 (with people due to receive payments in the meantime to receive them backdated). The committee agreed that the Barnet Consequentials should be offered proactively to the devolved administrations who could decide whether to implement the Support Payment scheme and how to direct the funding.
[356] See Prime Minister's response to the CTF's recommendation paper at JO/385 [INQ000575391]

September 2020[357] and announced on 20 September 2020.[358] Mandatory self-isolation came into effect on 28 September 2020.[359]

5.19. Also in September 2020, No.10 asked the CTF to lead a cross-government Compliance and Enforcement Initiative, the aim of which was to bring greater coordination to cross-department efforts for increasing compliance and enforcement of COVID-19 measures and to improve the reliability, regularity and coordination of data through the development of a cross-government Compliance and Enforcement Tracker.[360] This work was overseen at official level by an Enforcement Board Steering committee, chaired by Simon Ridley, with updates regularly provided to ministers at COVID-O. The first update which was provided to a COVID-O meeting on 2 October 2020[361] summarised the cross-departmental work underway to encourage compliance with COVID-19 rules, including in relation to TTI, and the metrics which would be used to measure their effectiveness.

5.20. Local authorities played an important role in supporting the Government's ambitions to increase compliance. It was therefore important for the Cabinet Office to help ensure they were supported with the necessary resources and powers to be able to take action at the local level. On 22 September 2020, the Prime Minister announced an extra £60 million for local authorities and the police to support compliance and enforcement activities.[362] Between 13 October and 18 November 2020, CTF Field Teams conducted eight in-person or virtual visits to places across England to understand local authorities' experience in implementing and administering COVID-19 guidance. The report from these visits is exhibited.[363] The CTF used this insight, working with other departments, in particular MHCLG, to help formulate advice to ministers.

5.21. At a COVID-O meeting on 2 December 2020, ministers agreed with the CTF's recommended strategic approach to achieving the level of public compliance necessary to fulfil the Government's Winter Plan for managing COVID-19.[364] Recognising the added challenges of public fatigue, confusion over rules and reduced concern about the virus particularly in light of progress on a vaccine, the paper recommended maintaining public confidence through

[357] JO/386 [INQ000090196]
[358] JO/387 **INQ000517400**
[359] The legal duty for individuals who tested positive for COVID-19 remained in place until 24 February 2022, while close contacts reached by NHST&T were legally required to self-isolate up until 16 August 2021.
[360] JO/388 [INQ000575327]
[361] JO/389 [INQ000090067]
[362] JO/390 [INQ000137285]
[363] JO/391 [INQ000575284]
[364] JO/392 [INQ000090985]

simple, targeted and evidence-driven policies which were communicated to the public effectively and had clear ownership within government.

5.22. Through December 2020, based on evidence[365] that financial concerns were continuing to drive lower levels of compliance with self-isolation, the CTF worked to develop options for expanding the eligibility of Test and Trace Support Payment. The CTF worked to negotiate a way forward between DHSC, which favoured a maximal approach whereby all those testing positive could receive financial support, and HMT, which did not want to expand the existing eligibility criteria. A note to the Prime Minister from the CTF on 18 December 2020 recommended he engage with the Chancellor to unblock the issue, suggesting a compromise could be to extend the eligibility of the scheme to those who could not work from home and who were earning less than the median income.[366]

5.23. By January 2021, in the context of the Alpha variant, there was a renewed focus on improving adherence to self-isolation rules, as well as efforts to increase and promote the existing support for self-isolation so that individuals were not deterred from testing in the first place. DHSC prepared a paper with options for ministers to consider at a COVID-O meeting on 22 January 2021.[367] Options included increased communications, working with local authorities to provide further practical, social and emotional support for people self-isolating, increased financial support, and further enforcement measures. As per the meeting minutes, the CDL told the committee that the Prime Minister would want to see that "all options had been explored" and that "if options had been discounted, it would be important to be able to show the Prime Minister why they would not have worked".[368] Ministers agreed in principle to expand the eligibility for the £500 Test and Trace Support Payment to parents of children who had tested positive. Agreement was then sought from the Prime Minister[369] and Chancellor[370] before the expansion was announced as part of the Spring 2021 Roadmap published on 22 February 2021[371] and came into effect from 8 March 2021.

5.24. With heightened concern about new variants and increased transmission rates, ministers reviewed what more could be done to maximise levels of compliance with TTI policy among

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[365] As explained at paragraphs 5.13-4, insight on compliance came from a variety of sources. Examples of evidence used to underpin the advice to ministers on expanding the Test and Trace Support Payment are cited in the paper prepared for COVID-O on 22 January 2021 (JO/381 [INQ000091673]) and include YouGov polling and academic research, such as: *Smith LE, Potts HWW, Amlot R, Fear NT, Michie S, Rubin GJ. Adherence to the test, trace and isolate system: results from a time series of 21 nationally representative surveys in the UK (the COVID-19 Rapid Survey of Adherence to Interventions and Responses [CORSAIR] study). BMJ (submitted)*

[366] JO/393 [INQ000575293]

[367] JO/394 [INQ000054525]

[368] JO/395 [INQ000575322], page 10

[369] JO/396 [INQ000575292]; JO/397 **INQ000564720** JO/398 **INQ000234306**

[370] JO/399 [INQ000575401]

[371] JO/022 **INQ000185087**

international arrivals at COVID-O meetings on 26 January and 4 February 2021. The paper[372] provided by DHSC for the latter meeting asked ministers to consider a package of stronger measures for international arrivals including mandatory hotel quarantine for arrivals from 'red list' countries, tougher sanctions for non-compliance, and mandatory testing. Strengthened enforcement measures were announced by the Health Secretary in an oral statement to Parliament on 9 February 2021.[373]

5.25. Throughout 2021, the CTF continued to review the latest scientific and behavioural research to consider what more could be done to improve compliance. The CTF's Analysis and Data team compiled evidence from different expert and analytical sources into a number of Spotlight reports which were used to inform policymaking. Examples of Spotlight reports focused specifically on testing and self-isolation compliance in February and May 2021 respectively are exhibited.[374]

Enforcement

5.26. Maximising public compliance with COVID-19 measures, including but not limited to guidance and policies relating to TTI, was a priority for the Cabinet Office in order to minimise the transmission of COVID-19. The Government's starting position on TTI was to expect compliance, with enforcement considered a last resort option to mandate compliance in order to protect public health.

5.27. Within government, the Home Office was the lead department in relation to enforcement. Home Office officials helped to advise on whether, for example, a regulation could be considered "proportionate", taking into account whether it would be comprehensible to the public, practical to enforce, contribute to community tensions, or could cause a breakdown in the policing by consent model.

5.28. Within the Cabinet Office, as set out above, a small team within the CTF was focused on compliance and enforcement. The CTF supported the monitoring of adherence to relevant requirements and helped to make sure that support and guidance were in place for organisations responsible for enforcing the regulations. The CTF worked closely in this area with MHCLG/DLUHC and the Home Office, as well as: DHSC; BEIS; the Health and Safety Executive (HSE); MoJ; the BIT and operational colleagues (for example, in the police and local authorities).

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[372] JO/400 [INQ000091715]
[373] JO/401 [INQ000147702]
[374] JO/068 [INQ000575314]; JO/071 [INQ000575309]

5.29. Individual police forces are operationally independent of government, and were therefore responsible for their own response during the pandemic. All guidance pertaining to police enforcement of COVID-19 legislation and regulations was developed by the College of Policing for dissemination to police forces. The College of Policing is an operationally independent non-departmental public body and its guidance was a policing product, independent of government.

5.30. Throughout the pandemic, the Cabinet Office recognised the importance of consulting with the bodies responsible for enforcing mandatory restrictions, including those in relation to isolation and testing. For this reason, from March 2020, the Chair of the National Police Chiefs' Council (NPCC), Martin Hewitt, was regularly invited to attend COBR, and later COVID-O meetings, to discuss issues including the operational challenges of enforcement and the requisite police resourcing.[375]

5.31. As the former Home Secretary explained in her statement for Module 2 of the Inquiry, throughout the pandemic the advice provided to the Prime Minister and Cabinet Office by the Home Office in relation to enforcement was that the policy should focus enforcement activity only on egregious breaches of the regulations.[376] In the event, the vast majority of issues relating to public non-compliance with the regulations were resolved without the use of enforcement which the Police and Home Office considered to be a last resort for achieving compliance with the regulations.

5.32. In April 2020, slides were produced for a meeting with the Prime Minister looking specifically at the policing response to COVID-19, including the enforcement of new restrictions (including mandatory self-isolation).[377] The risk register contained within the slidepack listed as its top "red rated" risk "maintaining public trust and legitimacy despite the breadth and scope of new powers and restrictions", with mitigation measures including: the collection of data on enforcement; following the 4Es approach (explaining, engaging, encouraging, and only resorting to enforcement after the others have not succeeded); and, ensuring that the Home Office and NPCC were engaged ahead of decisions on measures so that timely, clear and consistent guidance could be provided to police forces.

5.33. As the second wave of COVID-19 took hold, enforcement activity became an area of significant interest to No.10, and the focus of several COVID-O meetings, between September and November 2020. This coincided with the implementation of new regulatory

[375] For instance: JO/402 [INQ000007807]

[376] Witness statement of Dame Priti Patel JO/403 [INQ000279975]. For examples of advice to the Prime Minister, see: JO/404 [INQ000054268]; JO/405 [INQ000054533].

[377] JO/406 [INQ000575288]

requirements which, among other things, significantly increased the enforcement powers granted under the regulatory framework and increased the maximum penalties for non-compliance with isolation and quarantine requirements.

5.34. On 2 September 2020, the Prime Minister hosted a policing roundtable on COVID-19 enforcement, organised by the Cabinet Office.[378] This meeting was an opportunity for the Prime Minister to speak directly to senior representatives from the Police to "[e]mphasise the need for further and more visible enforcement action, to ensure that the public is clear we will enforce the law…[and to] invite policing representatives to advise on what more they need from Government to enhance their approach".[379] Issues relating to the enforcement of TTI policies, including border quarantine, and low compliance with self-isolation rules were discussed at the roundtable.

5.35. In setting out the policy objectives for the new regulations around self-isolation and managed quarantine, the steer from No.10 was that the enforcement powers, specifically fines for non-compliance, should be significantly increased.

5.36. On 22 September 2020 (i.e. a week before the Self Isolation Regulations came into force), the Prime Minister announced that police enforcement of isolation rules would be stepped up, with £60 million in additional funding being allocated to the police and local authorities in order to increase enforcement activity.[380]

5.37. Enforcement activity remained a focus throughout this period, with discussions on enforcement and compliance taking place at a number of COVID-O meetings,[381] notably on 21 October 2020 where the committee discussed further steps to allow local authorities to carry out enforcement where needed, especially in relation to businesses. The committee agreed to strengthen local authority enforcement powers and the CTF was asked to work with departments to support the enactment and delivery of the changes.[382]

5.38. Aside from regular discussion at COVID-O, the Prime Minister also held meetings with Martin Hewitt (the Chair of the NPCC) and the Home Secretary during this period to discuss issues around enforcement.[383]

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[378] JO/407 [INQ000575427]; JO/408 [INQ000575326]
[379] JO/407 [INQ000575427]
[380] JO/409 [INQ000220404]
[381] For instance: JO/233 [INQ000090161], JO/410 [INQ000090162], JO/411 [INQ000091753]
[382] JO/412 **INQ000065389**
[383] For instance: JO/413 [INQ000575294]; JO/414 [INQ000575295]; JO/415 [INQ000575298]

5.39. Additionally, from 23 October 2020, the Home Secretary wrote weekly to the Prime Minister with an update on the work of the Home Office and its partner agencies in support of the Government's approach to tackling COVID-19. These updates contained specific statistics on enforcement activity.[384] Over time these updates were adjusted in frequency to fortnightly, until January 2021 when the implementation of further national restrictions led to an increased interest in enforcement activity.[385]

5.40. On 8 December 2020, the Prime Minister met with the Home Secretary and Martin Hewitt, among others, to discuss enforcement relating to COVID-19 measures. The Prime Minister's briefing[386] for the meeting advised that he "underline [that] robust enforcement activity remains crucial to our response" and use the meeting as an opportunity to: "(i) listen to feedback on enforcement over lockdown", (ii) "test the police's plans ahead of travel between tiers over Christmas and (iii) understand any barriers to enforcement". The briefing also noted: "on 2 December [2020], we strengthened regulations following police concerns that the evidential basis they required to issue FPNs was weak. The police are continuing to issue fines, however they still have two main concerns: whether Test and Trace can supply relevant evidence so that they can successfully identify those who breached the regulations; and whether the appeals process allows for individuals to fairly dispute the directive to self-isolate. We are working with departments and the police to scope policy options to resolve the issue".

5.41. On 15 January 2021, the Home Office presented a paper to COVID-O entitled Police Enforcement of Covid Measures.[387] Specifically on self-isolation it said: "We are working with DHSC and the police to change the operating model around self-isolation enforcement to ensure people can be prosecuted where necessary. The current system does not effectively enable sufficient evidence to be collected or made available to the police, and we will therefore be proposing legislative and operational amendments so as to support more effective police action". The COVID-O committee agreed with the approach set out in the paper and the Home Office, DHSC and CTF took forward joint work to agree a mechanism to share pertinent data with the police.[388] On 28 January 2021, the Health Secretary announced new measures[389] including a new protocol for NHST&T to more efficiently share data on reported self-isolation breaches with the police.

[384] For instance: JO/416 [INQ000575296]; JO/417 **INQ000054100** JO/418 [INQ000575425]; JO/419 [INQ000575426]
[385] JO/420 [INQ000575299]
[386] JO/421 [INQ000575364]
[387] JO/422 [INQ000091654]
[388] JO/423 [INQ000092281]
[389] JO/424 [INQ000575404]

5.42. As per paragraph 4.43, on 8 February 2021, COVID-O looked specifically at managed quarantine and mandatory testing in the context of those returning to England from non-exempt foreign countries (in accordance with the International Travel Regulations set out above). Changes to those regulations were discussed, in particular the proposed new enforcement powers which included the police having powers of entry to reach those who were suspected of having absconded from mandatory isolation/hotel quarantine.[390] In the event, these powers were introduced through amendments to the International Travel Regulations which came into force from 15 February 2021.

5.43. This level of engagement with the departments and agencies leading on enforcement allowed the regulatory framework to be strengthened and adapted to deal with enforcement challenges as they arose.

[390] JO/425 [INQ000108604]; JO/426 [INQ000108600]

6.SECTION 6: Inequalities and Disproportionately Impacted Groups

Inequalities in relation to TTI

6.1. Individual government departments are responsible for understanding the equality impacts of the policies for which they are responsible through compliance with the Public Sector Equality Duty (PSED). In line with this, DHSC had overall responsibility for ensuring that equality impacts were taken into account in the design and delivery of TTI policies.

6.2. Throughout the COVID-19 response, the Cabinet Office worked with DHSC, and other government departments as necessary, to understand, monitor and promote action to combat disproportionate impacts experienced by certain groups in relation to TTI.

6.3. Within the Cabinet Office, work to address inequalities in relation to the TTI programme was primarily led by the CTF (which included a small team focused on disproportionately impacted groups) and the Equality Hub,[391] which together worked closely with the Comms Hub where public messaging was used to help combat disproportionate impacts of TTI policies. Officials from the Equality Hub and CTF regularly attended meetings of the SAGE Ethnicity Subgroup which provided advice to ministers to ensure equalities considerations were factored into planning. The BIT also contributed research and advice to help shape and maximise engagement with TTI policies.

6.4. At ministerial level, discussions pertaining to inequalities in relation to TTI regularly took place at COVID-O meetings, as well as at Dashboard and other meetings with the Prime Minister on the testing programme. The Minister for Equalities, the Rt Hon Kemi Badenoch MP, was also closely involved with the work of the Equality Hub and Comms Hub in this regard.

6.5. The Cabinet Office's involvement in work to address inequalities in relation to TTI began early in the pandemic, prior to the establishment of the CTF and NHST&T. In April 2020, for example, officials from the Government Equalities Office (GEO) (a predecessor unit to the Equality Hub), supported DHSC to consider the potential impacts of TTI policies as they were developed. This included providing guidance on PSED as well as equalities insights from an earlier review of social distancing measures, feedback from equalities stakeholders and advice on equality risks.[392]

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[391] The Equality Hub was created in September 2020, merging the former Race Disparity Unit (RDU), Disability Unit (DU) and Government Equalities Office (GEO). The Social Mobility Commission (SMC) secretariat joined the Equality Hub in April 2021. The Equality Hub was renamed the Office for Equality and Opportunity (OEO) in October 2024.

[392] JO/427 [INQ000083955]

6.6. In this early period, GEO also worked to coordinate cross-government reviews of the social distancing measures (including isolation policies) introduced to ensure departments were fulfilling PSED requirements. GEO collated assessments from different departments to produce a single assessment document to support a review by ministers. The first of these assessments was provided to ministers at a COBR meeting on 16 April 2020.[393] GEO coordinated PSED assessments to inform ministerial reviews every three weeks of social distancing measures[394] until August 2020.[395] As work on test and trace increased over the course of 2020, TTI policies became a greater focus of this work.

6.7. Alongside coordinating the reviews of social distancing measures, GEO supported officials responsible for PSED in other government departments, including through the Cross-Government PSED Network which was used to share knowledge and expertise. GEO ran a session on 9 June 2020[396] for the PSED Network and helped to advise departments on how to carry out effective impact assessments in emergency response situations.[397] GEO shared guidance with departments, and the CTF once established, on how to factor equalities considerations into policy making.[398]

6.8. Work to ensure that the relevant data was being collected and monitored to identify disproportionate impacts of the pandemic also began in the early period. The DU asked the ONS to collect and analyse data by disability or impairment status. Disability analysts continued to work closely with the ONS to improve available data throughout the pandemic. The DU also worked to update ministers on the known impacts of the pandemic on disproportionately impacted groups, including through the GPSMIG. An action from a GPSMIG meeting on 21 May 2020[399] was for all departments to consider data gaps in relation to disabled people and to ensure that public messaging relating to the pandemic was fully accessible.

6.9. Once the CTF was established in May 2020, it worked with GEO (and later the Equality Hub) to ensure that disparities and vulnerabilities continued to be considered as part of

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[393] JO/428 [INQ000083790]; JO/429 [INQ000083934]

[394] Agreed at the 20 March 2020 COBR meeting JO/430 [INQ000056212]

[395] Between April and August 2020, three regulation reviews and two proposed easement analyses were conducted, coordinated by GEO. **First review**: 15 April JO/429 [INQ000083934], **Second review:** 12 May JO/431 [INQ000083943], **Third review**: 8 June JO/432 [INQ000083944], **Analysis of easements:** July 2020 JO/433 [INQ000083867], **Analysis of easements:** August 2020 JO/434 [INQ000083868].

[396] JO/435 [INQ000083886]

[397] JO/436 [INQ000083887]

[398] JO/437 [INQ000083914]

[399] JO/438 **INQ000083584**

departments' policymaking and reflected within the Government's overarching strategies. In relation to TTI, specifically, work of this kind included, but was not limited to, the following.

6.9.1. *NHS app:* GEO worked to ensure NHST&T and DHSC were considering implications of the app for victims of domestic abuse and stalking, collaborating with experts in the Home Office, the Victims Commissioner and relevant charities (e.g. Refuge and Women's Aid) as appropriate. The DU and CTF also worked to ensure that disabilities were considered as part of app development, including the need for a non-digital route to engagement with NHST&T services,[400] as well as supporting the design of exemption criteria, processes and guidance.[401]

6.9.2. *Support for those self-isolating:* As described in Section 5, the CTF worked to help ensure that those required to self-isolate had access to the necessary support. In September 2020, the CTF worked to agree through COVID-O the introduction of a Test and Trace Support Payment scheme to provide financial support to the lowest income households asked to self-isolate as well as an additional discretionary fund for local authorities to support those facing specific hardship and ensure all needs were catered for (see Section 4, paragraph 5.18). In January 2021, the CTF worked to agree through COVID-O the extension of support payments for parents/guardians required to miss work to care for a child required to isolate with the aim of further reducing inequalities related to isolation.[402]

6.9.3. *Community Testing Programme (CTP)*: As described in Section 3 (paragraph 3.98-3.106), the CTP provided national-level support and funding for testing that could then be prioritised and targeted locally with directors of public health and local authorities developing approaches that worked best for their citizens. The CTF and Equality Hub supported DHSC to consider and produce guidance for local leaders on how the CTP could best engage and support disproportionately impacted groups.[403]

6.9.4. *Certification:* As part of the Spring 2021 Roadmap, the Government committed to reviewing whether COVID-19-status certification (through proof of vaccination or a negative test) could play a role in reopening the economy, reducing restrictions on social contact and improving safety.[404] The CTF led the review, part of which

[400] JO/439 [INQ000187647]
[401] JO/440 [INQ000083923]; JO/441 [INQ000083921]; JO/442 [INQ000083895]
[402] JO/443 [INQ000092295]
[403] JO/272 [INQ000223465]
[404] JO/022; **INQ000185087**, page 40

focused on considering issues related to ethics and equalities. The Equality Hub held a roundtable with disability stakeholders on 23 March 2021, at which a range of issues were identified including the potential distress that regular testing could cause for some individuals and the need to make the process fully accessible for people with disabilities.[405] With support from the Equality Hub, the CTF conducted an equality impact assessment as part of a review of COVID-19-status certification in April 2021.[406] The Minister for Equalities also helped to promote issues relating to inequalities at ministerial discussions on certification and the testing programme more broadly.[407] The CTF worked to help ensure people with disabilities could access a different testing route where they were required to undertake a test and could not do so at home.

6.9.5. *Mitigating disruption to services supporting vulnerable groups:* The Cabinet Office worked to help monitor and mitigate disruption to sectors providing services to vulnerable and disproportionately impacted groups. On 1 June 2020, for example, CCS raised concerns to NHST&T about the potential impact of staffing reductions due to self-isolation in workplaces such as prisons, homeless shelters and children's homes, encouraging the provision of sector-specific guidance and clear processes to escalate concerns to support the continued functioning of critical sectors such as these.[408]

6.9.6. *Priority testing for vulnerable groups and high-risk settings*: Further to the detail on prioritisation provided in Section 3 (paragraph 3.18-3.20 and 3.54-3.59), the CTF worked to ensure that vulnerable groups and those in high-risk work environments were considered in discussions around testing prioritisation. For example, for a COVID-O meeting on 18 November 2020, DHSC provided a list of prioritisation proposals[409] including recommendations to include homeless shelter and outreach workers, prison visitors and court staff on the priority list for test allocations. COVID-O agreed to the recommendations and the CTF was tasked with working cross-departmentally to provide an objective basis for prioritising requests for tests from new additions to the priority list.

[405] JO/444 [INQ000575286]
[406] JO/445 [INQ000086706]
[407] JO/117 [INQ000091937]; JO/446 [INQ000185176]; JO/176 **INQ000083897**
[408] JO/447 [INQ000575436]
[409] JO/215 [INQ000090921]

6.10. In addition to involvement with the specific workstreams identified above, a key focus for the Cabinet Office throughout the pandemic was maximising engagement with and ensuring equal access to NHST&T services.

6.11. From early on in the pandemic response, the Cabinet Office worked to challenge what more could be done to increase the accessibility of NHST&T services. At a 9:15 C-19 Strategy meeting on 22 April 2020, for example, issues were raised about the inaccessibility of some testing sites across the country, especially in remote areas. DHSC was asked to work with MHCLG and LRFs to address the issue and support getting people access to testing, including through increased communications, mobile testing and testing at home.[410] Further detail on the Cabinet Office's work to increase engagement of disproportionately impacted groups through communications is described in Section 5 (paragraph 5.2-5.7).

6.12. Understanding the latest data and qualitative insight and research in relation to disproportionately impacted groups was important in helping the Cabinet Office to understand where further intervention was needed to reduce unequal access and engagement with NHST&T services. The CTF worked to collate and monitor data through the Dashboard, which was supplemented by insight and analysis from the Equality Hub.

6.13. Data in relation to TTI and disproportionately impacted groups was regularly reviewed at ministerial forums such as Dashboard meetings and COVID-O, where the Cabinet Office continued to challenge where more could be done. At a COVID-O meeting on 24 September 2020, for example, ministers were updated on the impacts of the pandemic on disproportionately impacted and vulnerable groups, with the CDL noting that 'there was a need to improve the data gathering and analysis…to encourage trust with the Test and Trace programme'.[411] DHSC & NHST&T were asked to consider options for improving testing provision and uptake among these groups as a result of this meeting.[412]

6.14. A further COVID-O meeting on 29 October 2020 agreed a supplementary package of measures to prevent disproportionate healthcare outcomes for groups or people with particular backgrounds or characteristics.[413] HMT and relevant departments were tasked with determining how to align the funding for the new package of measures with existing commitments. The augmented package focused on five key areas: increasing testing;

[410] JO/121 [INQ000088458]
[411] JO/448 [INQ000090183], page 4
[412] JO/449 **INQ000065388**
[413] JO/039 [INQ000090185]

tackling transmission and underlying comorbidities; and investigating and mitigating known risk factors.

Quarterly reports on progress to address inequalities in relation to COVID-19

6.15. The progress of the Government's work to address COVID-19 health inequalities, including in relation to TTI, was monitored and findings published as part of four Quarterly Equality Reports. This work responded to a review by PHE in June 2020 into 'Disparities in the risks and outcomes of COVID-19'.[414] Following this publication, the Prime Minister and Health Secretary asked the Minister for Equalities to lead cross-government work to address the findings. The resulting 4 reports included recommendations to reduce inequalities, including in relation to TTI.

6.16. In October 2020, the Equalities Minister appointed two independent advisers to: assist with the review of Covid-19 health disparities for ethnic minorities; provide medical and epidemiological expertise; review and advise on the Covid-19 disparities project;[415] and, quality-assure the Quarterly Reports.

6.17. The First Quarterly Report[416] published on 22 October 2020 noted several improvements by NHST&T, including: the collection of data on ethnicity as part of contact tracing; the introduction of translation services to improve the accessibility of virtual and in-person NHST&T services; and the promotion of NHST&T through regional press partnerships, including community ethnic minority radio stations, as well as social media campaigns targeted towards ethnic minority audiences. The report made 13 recommendations, including further improvements in communications to engage hard-to-reach groups and build confidence among ethnic minority people.

6.18. The Second Quarterly Report, published on 6 February 2021,[417] recognised successful efforts by DHSC and MHCLG to remove some of the main identified barriers to engaging with NHST&T by running pilots of community-led, localised, asymptomatic testing at places of worship in ethnically diverse areas such as Wolverhampton and the London Borough of Brent. The report noted that testing rates in those areas had increased significantly. The report also cited partnerships with respected community figures and organisations to help build trust in NHST&T services and community-volunteer-led testing, to dispel myths, to learn and address the barriers to engagement and to increase take up of testing.

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[414] JO/450 **INQ000101218**
[415] JO/451 [INQ000083926]
[416] JO/452 [INQ000086832]
[417] JO/453 [INQ000086650]

6.19. The Third Quarterly Report,[418] published on 25 May 2021, recognised the correlation between, on the one hand, financial hardship, deprivation, lower socio-economic status and having a dependent child in the household, and on the other hand, lower adherence to full self-isolation, not requesting a test, and poorer symptom recognition. The report made a number of recommendations, including in relation to encouraging asymptomatic testing - particularly for those within higher risk occupations - as sectors of the economy reopened.

6.20. The Fourth Quarterly Report was published on 3 December 2021.[419] The report recognised that further measures had been taken to improve the accessibility of NHST&T services, including the Pharmacy Collect service which had enabled 80% of the population in England to be within a 20-minute walk of testing at a community pharmacy and enabled more testing in deprived areas. Such measures, together with local partnerships and improved engagement and communications, had coincided with a 53% increase in the uptake of testing services by ethnic minorities after June 2020. The report made recommendations including ensuring that communications remained diverse and inclusive, maintaining community partnerships to improve understanding and tailor communications, and recruiting trusted voices to land messaging where necessary.

[418] JO/454 [INQ000086794]
[419] JO/455 [INQ000089747]

7.SECTION 7: Learning lessons and living with COVID-19

7.1. The Government sought to learn lessons and identify opportunities for improvement throughout the pandemic.[420] As detailed in this statement, the structures and processes through which the Government operated evolved over time as lessons were learned and the focus of the response evolved. One example of governance structures specific to TTI evolving as lessons were learned was the creation of the UKHSA, which brought together NHST&T, the JBC and the health protection functions formerly in PHE, into a single health agency responsible for health security. The Cabinet Office, working with DHSC, helped to equip the Prime Minister with advice in relation to the creation of the UKHSA, as can be seen from the exhibits provided.[421]

7.2. I set out below some of the broader and overarching COVID-19 internal review exercises which the Cabinet Office carried out or was involved in during the relevant period. It is important to note, by way of introduction:

7.2.1. In June 2021, the Prime Minister and the Cabinet Secretary signed the Declaration on Government Reform. They said: "The COVID-19 pandemic has strained our country's resilience like nothing we have seen out of wartime…There have been successes - the speedy introduction of furlough, the delivery of universal credit, the vaccination programme - which attest to the brilliance, imagination and dedication of public servants. But as with any crisis, the pandemic has also exposed shortcomings in how the Government works. Some processes have been too cumbersome. Accountability for delivery of services has at points been confused. The speed with which good practice in one department or area of government has been adopted by others has not always been rapid enough. If we are to power the recovery we need, it is imperative we both learn from our successes and are honest about where improvements must come".[422] This kick-started a government-wide reform programme, which included improvements on data sharing, capabilities, and work to be more representative of the country.

7.2.2. In September 2021, the National Situation Centre (SitCen) became operational within the Cabinet Office. The SitCen brings together data and expertise from across government, and externally where appropriate, to support crisis management and response. The creation and design of the SitCen drew upon

[420] As an example, in August 2021, the CTF reflected on the ways in which the UK Government had responded to new variants since the start of the pandemic JO/248 [INQ000575285]
[421] JO/456 [INQ000137240]; JO/457 [INQ000137241]
[422] Declaration on Government Reform JO/458 [INQ000137267]

lessons learned from the COVID-19 pandemic, including in relation to data sharing on test and trace, and has helped to accelerate the UK Government's modernisation and use of data and wider information and insight. The SitCen has also improved the Government's ability to identify the disproportionate impact of different risks on different communities across the UK.

7.2.3. It was the responsibility of DHSC as LGD for public health to ensure that specific lessons on TTI were identified and learned.

Innovation and Lessons Learned from the Government's response to COVID-19

7.3. In spring 2022, the Cabinet Office carried out an Innovation and Lessons Learned project, reflecting on the Government's response to COVID-19 to identify changes in the Civil Service approach with the potential to improve productivity or service delivery outside of crises, and at scale. This work covered three strands: a review of external literature; a review of lessons learned material completed by government departments; and a review of lessons learned material from the CTF. The final report for the Innovation and Lesson Learned project is exhibited.[423] The findings from the final report were summarised in a slide pack,[424] and in a note to the Cabinet Secretary and the Permanent Secretary, Alex Chisholm.[425] The findings of the Innovations and Lessons Learned project have since contributed to work on Civil Service reform led by what is now called the Civil Service Strategy Unit. .

7.4. 'Data and Analysis' was one thematic area reviewed as part of the Innovation and Lessons Learned project. A reflection from the final report was that the Government had sometimes been 'constrained by what was possible using existing systems and databases', and that 'setting up new systems to do new things', as was the case with NHST&T, was much harder than delivering in areas where government had existing systems (e.g. universal credit, patient records, etc.). The report acknowledged that 'more interoperability between digital systems across government would improve the ability of the state to rapidly introduce new digital services'.[426]

7.5. Whilst primarily conducted to identify innovations for use outside of crisis response, some of the evidence gathered through the Innovation and Lessons Learned project, particularly from the CTF strand of the review, produced useful lessons about the effective operation of a crisis team. The findings from the CTF strand of this work[427] were primarily drawn from a range of

[423] JO/459 [INQ000180306]
[424] JO/460 [INQ000180305]
[425] JO/461 [INQ000180304]
[426] JO/459 [INQ000180306]
[427] JO/462 [INQ000280034]

lessons learned exercises completed by the CTF at key points in the pandemic, and from engagement with former CTF teams and staff members.

7.6. A number of recommendations were made by the CTF strand of the project. One recommendation was to ensure equalities considerations were central to decision making from the start, and to identify those who may be disproportionately impacted as early as possible (e.g. multi-generational households), whilst recognising that disproportionately impacted groups will not always be the same cohort of people. Another recommendation was to create and maintain an overview of all pressures on local authorities and key delivery agencies related to the policies and decisions in question to ensure effective allocation of resources.

Other notable exercises and related reports

7.7. The Cabinet Office contributed to DHSC's December 2022 'Technical report on the COVID-19 pandemic in the UK',[428] produced to support future UK CMOs, GCSAs, National Medical Directors, and UK public health leaders in the event of a pandemic or major epidemic. Chapters 6 and 7 of this report, entitled 'Testing' and 'Contact Tracing and Isolation' respectively, may be of particular interest to the Inquiry, and cover areas which the Inquiry has noted interest in, including but not limited to: the utilisation of data; national and local level engagement; public communication; and collaboration with the devolved administrations.

7.8. Further, the Cabinet Office has provided evidence to support a range of Parliamentary Select Committee investigations and reports relating to lessons learned from the COVID-19 pandemic, including on TTI, for example the Government's response to the Health and Social Care and the Science and Technology Committees' Joint Report on lessons from the COVID-19 pandemic.

7.9. The Cabinet Office also contributed to a wider UK Government response to lessons learned work led by the Independent Panel for Pandemic Preparedness and Response. The Independent Panel was established by the Director General of the WHO in 2020 to initiate an independent review of the international health response to COVID-19 and of experiences gained and lessons learned. The final report from the Panel is exhibited.[429]

Living with COVID-19

[428] JO/076 **INQ000203933**
[429] JO/463 [INQ000183545]

7.10. In September 2021, the CTF produced a note for No. 10[430] which listed the following strategic aims of TTI from October 2021 to March 2022:

7.10.1. "Identify and isolate COVID-positive individuals through an updated and proportionate test, trace, and isolate programme".

7.10.2. "Maintain surveillance for dangerous variants through appropriately comprehensive PCR testing, sequencing and tracing".

7.10.3. "Retain capability to surge response to respond to outbreaks, very high or increasing prevalence or where a variant is detected".

7.10.4. The note explained that "These are transitional aims that will take us to an expected much smaller TTI offer for 2022/3 onwards, by which time we will expect to have (for example) no widespread asymptomatic testing or large-scale contact tracing, subject to the path of the virus."

7.11. On 18 February 2022, CDL, the Chancellor, the Health Secretary, CMO and CSA met to discuss the approach to 'Living with Covid'.[431] Following this trilateral discussion, No.10 fed back that the Prime Minister was strongly of the view that the Living with Covid strategy should include: the removal of outstanding legal restrictions; a significant reduction in ongoing COVID-19 response costs (including testing); and, the necessary contingency infrastructure to enable response structures to stand back up quickly at the lowest possible cost. This strategy was to be funded from within DHSC's existing budgets.[432]

7.12. Following this discussion, DHSC proposed a package of ongoing testing and surveillance which would have required around £3 billion funding to be reprioritised from other areas.[433] A joint reply from No.10, HMT and the CTF set out a package which was consistent with the steers from the trilateral meeting but reduced the necessary reprioritisation to £795 million.[434] There was further correspondence from DHSC on 20 February 2022.[435] On 21 February 2022, the Prime Minister discussed this with the Chancellor and the CDL, and then with the Health Secretary (readouts of these meetings are exhibited[436]). While the size and cost of the package was later revised somewhat (see paragraph 7.16), these discussions paved the way for the announcement of the Living with Covid strategy later that day.

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[430] JO/464 [INQ000575304]
[431] JO/465 **INQ000064430** JO/466 **INQ000064431** JO/467 **INQ000064432**
[432] JO/468 [INQ000198240]
[433] JO/469 [INQ000593197]
[434] JO/470 [INQ000593192]
[435] JO/471 [INQ000593196]
[436] JO/472 [INQ000593187]

7.13. The Living with Covid strategy[437] stated as follows:

7.13.1. "The Government's objective in the next phase of the COVID-19 response is to enable the country to manage COVID-19 like other respiratory illnesses, while minimising mortality and retaining the ability to respond if a new variant emerges with more dangerous properties than the Omicron variant, or during periods of waning immunity, that could again threaten to place the NHS under unsustainable pressure".

7.13.2. "To meet this objective, the Government will structure its ongoing response around four principles":

7.13.2.1. "Living with COVID-19: removing domestic restrictions while encouraging safer behaviours through public health advice, in common with longstanding ways of managing most other respiratory illnesses";

7.13.2.2. "Protecting people most vulnerable to COVID-19: vaccination guided by Joint Committee on Vaccination and Immunisation (JCVI) advice, and deploying targeted testing";

7.13.2.3. "Maintaining resilience: ongoing surveillance, contingency planning and the ability to reintroduce key capabilities such as mass vaccination and testing in an emergency"; and,

7.13.2.4. "Securing innovations and opportunities from the COVID-19 response, including investment in life sciences."

7.14. The strategy recognised that TTI had played an important role throughout the pandemic but the free provision of testing at scale had come at a very significant cost to the taxpayer. The TTI budget in the financial year 2020-21 exceeded that of the Home Office, and the programme cost £15.7 billion in the financial year 2021-22.[438] This level of spending was considered necessary due to the severe risk posed by COVID-19 when the population did not have a high level of protection.

7.15. As immunity levels increased, it was agreed that testing and isolation would play a less important role in preventing serious illness.

[437] JO/005 [INQ000086652], page 7-8
[438] ibid., page 17

7.15.1. From 21 February 2022, the Government would remove the guidance for staff and students in most education and childcare settings to undertake twice weekly asymptomatic testing. From 1 April 2022, the Government would no longer provide free universal symptomatic and asymptomatic testing for the general public in England. Instead, there would be limited symptomatic testing available for a small number of at-risk groups and free symptomatic testing would remain available to social care staff.

7.15.2. From 24 February 2022, routine contact tracing would end. Contacts would no longer be required to self-isolate or be advised to take daily tests. Instead, guidance would set out precautions that contacts could take to reduce risk to themselves and other people - and those testing positive for COVID-19 would be encouraged to inform their close contacts so that they could follow that guidance. Local health teams would continue to use contact tracing and provide context-specific advice where they assessed this to be necessary as part of their role in managing infectious diseases.

7.15.3. From 24 February 2022, all remaining legal requirements relating to self-isolation were removed, and replaced with guidance where applicable. Self-isolation support payments and national funding for practical support were ended. The Health Protection (Coronavirus, Restrictions) (England) (No. 3) Regulations were revoked. Local authorities were to continue to manage local outbreaks of COVID-19 in high risk settings as they do with other infectious diseases.

7.16. Work was continuing in DHSC and UKHSA on the funding package for Living with Covid and the steady state, core functions of UKHSA. There were further negotiations and correspondence with HMT, No10 and the CTF[439], and consideration by the Prime Minister and the Chancellor.[440] Final confirmation of the package was provided on 28 March 2022 and meant that £1,206 million of funding needed to be reprioritised.[441] Following this agreement, there was a COVID-O on 29 March 2022 which agreed that, while the public channels for free testing would close, there would continue to be free symptomatic and asymptomatic testing for higher-risk patients and settings.[442]

[439] JO/473 [INQ000593186]; JO/474 [INQ000593193]; JO/475 [INQ000593185]
[440] JO/476 [INQ000575372]
[441] JO/477 [INQ000593188]
[442] JO/478 [INQ000091571]; JO/479 [INQ000091607]; Public announcement available on gov.uk JO/480 [INQ000257324]

7.17. Looking beyond COVID-19, also in March 2022, the UK Government and CEPI hosted the Global Pandemic Preparedness Summit, building on the 100 Days Mission ambition championed by Prime Minister Boris Johnson during the UK's 2021 G7 Presidency to develop capabilities to scale up the discovery and development of effective diagnostics within the first 100 days of a pandemic. The Summit raised $1.5 billion to support this work.

7.18. In April 2022, the cross-government official-level Pandemic Disease Capabilities Board (PDCB) - co-chaired by DHSC and the Cabinet Office, and which considers pandemic preparedness in-the-round - completed a cross-government review of how emergency response capabilities built for the acute-phase of the COVID-19 pandemic were being transitioned into longer-term mechanisms to support preparedness for future emergencies. A summary of the report and recommendations - some of which related to TTI - from this review is exhibited.[443] First, recognising the importance of specialist testing capabilities for different sectors and settings (e.g. education, justice, environment, and farming), a recommendation was made for UKHSA to work with NHSE, DfE, BEIS, DfT, DLHUC, Defra, MoJ and MoD to develop options for a scalable domestic pandemic diagnostics and surveillance system. After reviewing NPIs and social distancing measures established for COVID-19, the report also made recommendations for DHSC and UKHSA to conduct further work to explore potential public behaviour changes expected during a pandemic and the impact of these on rates of disease transmission.

7.19. In June 2023, the UK Government published the Biological Security Strategy (BSS) which outlined the Government's commitment to developing capabilities to scale up the discovery and development of effective diagnostics within the first 100 days of a pandemic.[444] This commitment, underpinned by targeted research and development programmes across the range of biological threats, included the development of solutions that could be rapidly repurposed towards a future Disease X. This work is being led by DHSC and UKHSA, in collaboration with industry and academia.

[443] JO/481 [INQ000196446]
[444] JO/482 [INQ000208910]

Statement of Truth

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

Signed:

Personal Data

Dated:15 April 2025

8.ANNEX A: CABINET OFFICE DECISION MAKING STRUCTURES

Governance structures: The first stage (up to 15 March 2020)

8.1. When the novel coronavirus was identified and began to spread globally, the first collective ministerial decisions about the response, as distinct from those decisions within the responsibility of a single department, were taken at ministerial COBR meetings. The Cabinet Manual explains that COBR, run by CCS during the relevant period, is "the mechanism for agreeing the central government response to major emergencies which have international, national, or multi-regional impact. Meetings at COBR are in effect Cabinet committee meetings, although there is no fixed membership, and they can meet at ministerial or official level depending on the issue under consideration."[445]

8.2. The CCS Director chaired the first cross-government ad hoc senior officials meeting on the novel coronavirus on 17 January 2020.[446] The first ministerial COBR meeting was on 24 January 2020.

8.3. The first discussion of the novel coronavirus at a formal Cabinet meeting was on 31 January 2020. COVID-19 was considered at further Cabinet meetings during the first stage. The Cabinet Secretary (Mark Sedwill at the time) was the senior official for Cabinet.

8.4. Testing, tracing and isolating those thought to have been in contact with the virus was considered at COBR and Cabinet meetings. In line with the LGD model, work was led within the relevant government departments.

8.5. Ministers continued to meet in COBR and Cabinet structures throughout the relevant period for Module 7, though neither was the primary forum for decision-making in relation to TTI.

Governance structures: The second stage (Mid-March - 27 May 2020)

8.6. As described, as the scale of the crisis grew, the volume and scale of decisions that needed to be taken within a whole-of-government response demanded a bespoke architecture, which became the principal way by which decisions were made (alongside COBR meetings and Cabinet).

8.7. During this stage, a daily 9:15 C-19 Strategy meeting of key ministers, officials and advisers chaired by the Prime Minister was the key forum for oversight of all issues and strategy.[447] At each 9:15 C-19 Strategy meeting: the COVID-19 Dashboard was presented; there were

[445] See Cabinet Manual JO/007 [INQ000182315], page 32]
[446] The minutes and actions are at JO/483 [INQ000097687], JO/484 [INQ000097689] and JO/485 [INQ000097688]
[447] From 6 April until 25 April 2020 (inclusive) the Rt. Hon. Dominic Raab MP, in his position as the First Secretary of State, deputised for the Prime Minister as Chair of the 9:15 C-19 Strategy meetings and the Quads.

discussions of priority issues; and, a standing item covered the daily communications narrative and press conference. The Senior Secretary was Mark Sweeney.[448]

8.8. Following advice to the Prime Minister,[449] four new Ministerial Implementation Groups (MIGs) were established to lead the Government's key lines of operation during this stage. These Implementation Groups had the status of Cabinet committees and took collective decisions. The MIGs reported into the 9:15 C-19 Strategy meetings and were each chaired by a different Cabinet minister. These structures were announced to the public via a press notice published on gov.uk[450] on 17 March 2020. The MIGs remained in place until late May 2020.

8.9. The four MIGs were: the Health Ministerial Implementation Group (HMIG);[451] the General Public Services Ministerial Implementation Group (GPSMIG);[452] the Economic and Business Response Ministerial Implementation Group (EBRMIG);[453] and, the International Ministerial Implementation Group (IMIG).[454] The ToR for each MIG is exhibited and explains:[455]

8.9.1. The HMIG was set up to "focus on: policy interventions to protect public health, including monitoring and implementation of current interventions, and consideration of any future interventions; oversight of NHS capacity; social care preparedness, notably ensuring capacity in the critical care system for those worst affected; and medical and social support for those to whom we will be providing the shielding intervention". The Chair was the Health Secretary. The Deputy Chair was the Secretary of State (SoS) for Housing, Communities, and Local Government. Relevant ministers from the devolved administrations were invited to HMIG meetings as required. The Senior Secretary for the HMIG was Simon Ridley.

8.9.2. The GPSMIG was set up to "coordinate and advise on public sector issues relating to the C-19 pandemic across the UK, excluding the NHS and social care". The Chair was the CDL. The Senior Secretary for the GPSMIG was Jessica Glover.

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[448] Other Directors General in the Cabinet Secretariat - Jonathan Black, Jessica Glover and Simon Ridley - would sometimes cover this meeting, to allow for resilience and illness.
[449] JO/486 [INQ000087166]
[450] See New government structures to coordinate response to coronavirus: 17 March 2020, available at: JO/487 [INQ000086849]
[451] Chronologies of HMIG meetings over the relevant period: [JO/488 [INQ000113577]; JO/489 [INQ000176782]
[452] Chronologies of GPSMIG meetings over the relevant period: JO/490 [INQ000113576]; JO/491 [INQ000177567]
[453] Chronologies of EBRMIG meetings over the relevant period: JO/492 [INQ000176784]; JO/493 [INQ000113575]
[454] Chronologies of IMIG meetings over the relevant period: JO/494 [INQ000113578]; JO/495 [INQ000176783]
[455] See ToR for each MIG JO/496 [INQ000087167]

8.9.3. The IMIG was set up, according to its ToR, to "coordinate and advise on UK's role in the coordination and delivery of the international health and economic response to the C-19 pandemic, bilaterally and through multilateral (e.g. G7/20) and international (e.g. WHO, IMF, World Bank) organisations. Setting the UK's strategic approach to the threats and opportunities arising from the pandemic and setting the course for the longer term strategic national recovery". The Chair was the Foreign Secretary. The Senior Secretary was David Quarrey (the Prime Minister's adviser on International Affairs and Deputy National Security Adviser).

8.9.4. The EBRMIG, was set up to "coordinate and advise on business-related regional, sectoral and corporate-level issues relating to the C-19 pandemic". The Chair was the Chancellor of the Exchequer. The Deputy Chair was the Secretary of State for Business, Energy and Industrial Strategy. The Senior Secretary was Jonathan Black.

8.10. Test, trace and isolate work was primarily discussed in the HMIG. Some ministerial discussion also took place in the GPSMIG in relation to testing for public sector workforces, and other cohorts, including rough sleepers.

Governance structures: The third stage (from 28 May 2020)

8.11. By early May 2020, the UK had passed the initial peak of the COVID-19 pandemic. The Government published the first roadmap out of lockdown on 11 May 2020.[456] Consideration was given to how best to manage ministerial governance and decision-making structures given the likely longevity of the pandemic and government response.

8.12. On 22 May 2020, Simon Case, then Permanent Secretary in No.10 responsible for COVID-19, and Helen MacNamara, the Deputy Cabinet Secretary, submitted advice[457] to the Prime Minister recommending more sustainable and streamlined governance structures, with clearer and more focused lines of accountability. These changes were agreed by the Prime Minister and communicated to Heads of Department across government on 28 May 2020. I now briefly summarise each aspect of this third stage of governance.

[456] Our plan to rebuild: The UK Government's COVID-19 recovery strategy; 11 May 2020; JO/497 [INQ000089917], page 22-29

[457] In May 2020, an internal review by Helen MacNamara identified "a need to plan further ahead; build greater resilience in structures; reduce parallel chains of command and tasking; increase understanding of organisational roles and responsibilities; and improve openness to diversity of backgrounds, views and styles of leadership" JO/498 [INQ000137221]; JO/499 [INQ000137222].

8.13. COBR continued to meet periodically during this stage, particularly where issues required cross-UK action. An update on COVID-19 also continued to be taken at each weekly meeting of Cabinet. Neither of these fora routinely discussed or made decisions relating to TTI.

8.14. The MIGs were stood down at the beginning of this stage and two new Cabinet committees were established resembling the governance structure for managing EU Exit which had enabled discussions on both strategy and on driving delivery and assurance of implementation.

8.15. The COVID Strategy committee (COVID-S) was chaired by the Prime Minister. The core membership of COVID-S comprised the Chancellor of the Exchequer, the Foreign Secretary, Home Secretary, the CDL, the Health Secretary, and the SoS for BEIS. According to its ToR[458], COVID-S was set up "to drive government's strategic response to COVID-19, considering the impact of both the virus and the response to it, and setting the direction for the recovery strategy". The meetings ran between 4 June 2020 and 21 February 2022, setting in place the overarching COVID-19 strategy, and meeting at key strategic junctures in the response to the pandemic.

8.16. The COVID Operations committee (COVID-O) was usually chaired by the CDL. On occasion, meetings were chaired by the Prime Minister or delegated to the Paymaster General or the Minister for the Cabinet Office. The core membership was the Chancellor of the Exchequer and the Health Secretary (other departments would be invited according to the agenda of a particular meeting). According to its ToR,[459] COVID-O was set up "to deliver the policy and operational response to COVID-19." The meetings ran between 29 May 2020 and 29 March 2022. Meetings often started with data and science briefings either from the Dashboard team or key experts. The devolved administrations were invited to meetings where a UK-wide approach was needed, for example on border measures and vaccination.

The COVID-19 Taskforce (CTF)

8.17. It was clear within the Cabinet Office during April 2020 that the Government needed to establish a dedicated, single unit focussed on COVID-19 and that this needed to be resourced appropriately. Some duplication had emerged between the Cabinet Office and No.10 operations on the COVID-19 response, which had necessarily been built at speed. It

[458] JO/500 **INQ000147649** page 3

[459] Prior to the first meeting, the secretariat provided two documents to the Chair in addition to the Chair's brief and papers. These set out the ToR for COVID-O JO/501 [INQ000087168], and also the process for managing and running the committee JO/502 [INQ000087169].

made sense to streamline these operations as the Government moved from the acute to the chronic phase of the crisis.[460]

8.18. The new CTF was formed in May 2020 and operated until March 2022. The Cabinet Office has provided a dedicated statement for Module 2 of the Inquiry covering the role of the CTF, which details its structures and senior leadership. I now provide a short summary based on that.

8.19. The CTF led the official advice in the centre of government to the Prime Minister, CDL and other ministers on the development and delivery of the COVID-19 strategy, across the full range of policy issues and at all key decision-making moments, informed by a single analytical picture of the pandemic. The CTF also ran the government's COVID-19 Cabinet committees. Officials in the CTF worked very closely with No.10 colleagues and with other government departments, most particularly DHSC and HMT, and experts, such as the CMO and GCSA.

8.20. The Cabinet Office's Module 2 corporate statement[461] described at a high level the subsequent evolution of the CTF to March 2022, when it was stood down:

8.20.1. "The Taskforce initially reported to [Simon Case] as the Permanent Secretary at No.10 responsible for COVID-19. Its first incarnation brought together the No.10 team (led by Tom Shinner) and a Cabinet Office team (led by Simon Ridley)".

8.20.2. "The Taskforce coalesced over the summer of 2020. To meet the challenges of developing the Government's ongoing response and enabling the decision making required, the Taskforce had to bring in resource from around the Government, beginning this process in May and June 2020. Its size, having begun in the tens, reached hundreds within six months".

8.20.3. "After Tom Shinner left in July 2020, Kate Josephs joined the Taskforce to replace him. At this point all the staff in the Taskforce formed a single team in the Cabinet Office, which worked closely with No.10".

8.20.4. "[Simon Case] was appointed the Cabinet Secretary in September 2020. Simon Ridley and Kate Josephs led the Taskforce until James Bowler was appointed

[460] The 'End of Phase I Review' JO/503 [INQ000136763] conducted by Helen Macnamara and Martin Reynolds in May 2020, made recommendations on how the Cabinet Office and No.10 structures could be set up to best serve the Prime Minister in the next phase of the pandemic. The report highlighted some of the duplication that had emerged between Cabinet Office and No.10 teams and the need to streamline relevant structures. This was, however, in relation to the COVID-19 response on the whole, rather than referring specifically to TTI work.
[461] JO/008 [INQ000092893], page 39-41

Second Permanent Secretary in the Cabinet Office with responsibility for leading the Taskforce from October 2020. Kathy Hall joined the Taskforce in October 2020 ahead of Kate Josephs leaving in December 2020 for a new role. Rob Harrison joined the Taskforce in October 2020 to lead the analysis and data team and to continue building these capabilities. James Bowler, Kathy Hall, Simon Ridley and Rob Harrison remained the Taskforce senior leadership until July 2021".

8.20.5. "Around the time that delivery of the [COVID-19 Response - Spring 2021] roadmap concluded, James Bowler was appointed as Permanent Secretary to the Department for International Trade with effect from August 2021. Simon Ridley led the Taskforce from this point until March 2022, supported by Kathy Hall (who remained in post until January 2022) and Rob Harrison (who remained in post until February 2022)".

Strategic leadership and coordination

8.21. The CTF coordinated and advised on strategy for the COVID-19 response, working with HMT, medical and health experts including the CMO and GCSA and other departments to ensure the strategy reflected a wide range of inputs and considerations. This included preparing a number of strategies throughout the pandemic which steered the overarching government response.[462]

8.22. The CTF provided a coordination function to deliver a number of key announcements through the pandemic, working closely with the cross-government COVID-19 communications hub. The CTF also coordinated and published guidance to the public and businesses across the breadth of the pandemic response.

8.23. The CTF also led coordination and engagement across government and with the devolved administrations.

Data and Analysis

8.24. During the summer and autumn of 2020, the relevant data and analysis teams in the Cabinet Office were progressively merged into a single entity within the CTF. This worked especially closely with DHSC, the JBC, the ONS, HMT and the secretariats of SAGE and its sub-groups. This sought to ensure that the analytical effort across government and commissions to SAGE

[462] Examples of government strategies supported by the CTF include: the November 2020 'COVID-19 Winter Plan' (JO/021 **INQ000137262**), 'COVID-19 Response - Spring 2021 (Roadmap)' (JO/022 **INQ000185087** and 'COVID-19 Response: Autumn and Winter Plan 2021' (JO/023 [INQ000480678]).

and its sub-groups were coordinated and aligned to the needs of policy development and decision-making. As part of this, in the summer of 2020, the CTF took on responsibility for running the Dashboard.

8.25. The CTF equipped decision makers with a single analytical picture that included the health, economic and societal impacts of COVID-19, as well as considering international comparators. Much (though not all) of the primary analysis was done by others; the unique contribution of the CTF was to commission and integrate the inputs into a single analytical picture.

8.26. Regular (often daily) Dashboard briefings to the Prime Minister had originally been led by the CCS from mid-March 2020 and were continued by the CTF. The meeting would typically also involve other senior ministers (CDL, Chancellor, Health Secretary and others as required) along with the CMO, GCSA, Head of NHST&T and JBC, and senior officials and advisers from No.10, the CTF, HMT and DHSC. These meetings complemented the policy-making process by developing a shared understanding of the data picture as it developed and building familiarity with the key indicators and trends. The Prime Minister also used dashboard meetings to ask questions and request follow-up briefing.

Delivery and development of policy

8.27. The Government's response to COVID-19 was a whole-of-government effort which evolved over time according to the path of the pandemic and continuously weighed the pandemic's health, economic and social impacts. The unique role of the CTF was to ensure the Prime Minister and other ministers were equipped with rounded advice on the balance of these impacts. The CTF coordinated across departments to join up the response, bring stakeholders together, manage collective agreement and apply lessons learnt from each event to the next.

8.28. The CTF had a number of focused teams - including on TTI - that worked with other departments on a range of areas in response to the pandemic. These teams provided advice to the Prime Minister and CDL, supported cross-government ministerial and officials meetings, and worked with lead departments and experts, bringing together a range of interests. While responsibility for delivery in these areas lay with departments and other relevant bodies, the focused teams in the CTF contributed to policy development and helped ensure that collectively agreed policies were delivered effectively. This was an important way in which the CTF helped to ensure that the different components of the COVID-19 response balanced the health, economic and social impacts, and aligned with the wider government strategy.

8.29. The areas covered by these teams changed over time according to the nature of the Government's response. Areas covered for significant periods of the response include the following (listed alphabetically): business and the economy; compliance and enforcement; disproportionately impacted groups; education and wider public services; health and adult social care; local action; regulations; social contact; TTI; travel and borders; and, vaccines and therapeutics.