The Government's Response to the Health and Social Care Committee and Science and Technology Committee Joint Report: Coronavirus: Lessons Learned to Date

Presented to Parliament
by the Secretary of State for Health and Social Care
by Command of Her Majesty

June 2022

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Introduction

The government welcomes the opportunity to respond to the recommendations made by the House of Commons Health and Social Care Committee and Science and Technology Committee in their joint report 'Coronavirus: Lessons Learned to Date', published on 12 October 2021.[1] As the report recognises, COVID-19 has been the biggest crisis our country has faced in generations, and the greatest peacetime challenge in a century.

The scale and extent of the challenges presented by the COVID-19 pandemic have stretched across government and the government agrees that lessons should be learned. The government has worked relentlessly to respond to the pandemic, taking quick and decisive action to save lives and livelihoods and protect our National Health Service (NHS). This includes, of course, our world-leading vaccine roll-out programme. Throughout, we have adapted and learned lessons from the COVID-19 experience, in order to inform our preparedness for future crises.

The Joint Inquiry investigated six main themes – the country's preparedness for a pandemic; the use of non-pharmaceutical interventions such as border controls, social distancing and lockdowns to control the pandemic; the use of test, trace and isolate strategies; the impact of the pandemic on social care; the impact of the pandemic on specific communities; and the procurement and roll-out of COVID-19 vaccines.

In line with usual practice, the government has limited itself to addressing only the recommendations made by the Committees. However, this does not mean that the government agrees with all their findings, or the wider analysis contained in the Committees' report. The government considers that the report contains a significant number of factual inaccuracies. Since there will be ample opportunity to address questions of fact in the Public Inquiry, we do not do so here.

It should also be noted that, given timings, this response does not fully take into account the government's handling of the Omicron variant. However, we would cite the swift and decisive action taken to safeguard public health and protect our NHS as emblematic of our approach throughout the pandemic.

Ministers and officials from the UK government have, throughout the pandemic, worked closely with the devolved governments to provide a coordinated approach to the response to COVID-19 across the UK, and this approach continues. This work has included joint working on the COVID-19 vaccination programme, National Testing Programme, and the Joint Biosecurity Centre (now part of the UK Health Security Agency (UKHSA). The UK government and the devolved governments have also

[1] **Coronavirus: lessons learned to date** – parliament.uk *(https://committees.parliament.uk/publications/7496/documents/78687/default/)*

worked side by side on the sourcing and supply of personal protective equipment (PPE) and continue to work together on meeting future demand for front line staff, sharing future plans and reflecting on lessons learned. The UK government has also supported the broader UK family of Crown Dependencies and Overseas Territories throughout the pandemic.

Turning to the specific themes of the report, the government understands the need for longer term horizon scanning work across the whole of government to identify future risks relating to security and defence, science and technology, international and domestic issues. The Cabinet Office is in the process of reviewing the National Security Risk Assessment (NSRA) and the Government Office for Science (GO-Science) is actively building futures capability across government, in support of the Integrated Review commitment to improve this, through shared evidence, tools and training.

Non-pharmaceutical interventions have been a key element of the government's response to COVID-19. At the outbreak of the pandemic, the government carefully monitored the data, and our decision-making has always been informed by science and evidence. We took quick and decisive action when we needed to.

As the report points out, public health communications are key to the public's understanding of and compliance with non-pharmaceutical interventions. Messaging from the government early in the pandemic was strong, effective, and undoubtedly contributed to the understanding of and compliance with the regulatory measures taken, including lockdown.

In respect of test, trace and isolate, the government will build on the legacy of the response to this pandemic. As the government has set out in the 'Living with COVID-19' strategy,[2] this includes ensuring that a resilient and scalable infrastructure is in place to protect the public from new and existing threats to health. It will involve working closely with local authorities to ensure they have the knowledge, experience, and capability to support future contact tracing arrangements and to draw down expert advice to deploy for greatest public health benefit; for example the capacity to respond to future public health emergencies. UKHSA, established during the pandemic, will also maintain the well-established relationships with local tracing arrangements within all local authorities.

[2] **COVID-19 Response: Living with COVID-19** – GOV.UK
(https://www.gov.uk/government/publications/covid-19-response-living-with-covid-19)

The government recognises and has responded to the impact of the pandemic on the social care sector. The Prime Minister's announcement of the 'Build Back Better' plan for health and social care in September 2021[3] set out a clear programme of reform as well as proposals for a sustainable funding model and to bring the social care and health sectors closer together which will strengthen the provision of adult social care services. The plan also made a commitment to close working with the devolved governments, laying the foundations for a programme of joint working for the UK to build back better from the pandemic.

Recognising that those from an ethnic minority background have been disproportionately affected, the government has taken action to support these groups at each stage of its COVID-19 response. The government acknowledges that socio-economic factors have an important impact on the overall health and wellbeing of our people and forward proposals have been made in the 'Levelling Up the United Kingdom' white paper.[4]

The government is grateful to the Committees for recognising the success of the vaccines programme, one of the most effective in the world. The UK's vaccination programme, from research and development of vaccines against COVID-19 to the deployment of vaccinations to over 93% of the adult population aged 12+ (as at 7 June 2022), has been one of the most successful and effective initiatives in the history of UK science and public administration.

Overall, however, responding to the demands of the pandemic has been a huge collective national effort and the government would like to thank all those who have been involved, from the scientists who were integral to developing the first COVID-19 vaccines to those who have worked to maintain key services for the public. The government has also benefited from the expertise of its scientific and medical advisers throughout the pandemic and remains deeply grateful for the role they have played in saving lives and protecting the NHS. Above all, we would like to salute the efforts of all those who have worked during the pandemic in our NHS and in adult social care settings to provide care to the ill and the vulnerable.

The government has now set out its 'Living with COVID-19' strategy. 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 Omicron, or during periods of waning immunity, that could again threaten to place the NHS under unsustainable pressure.

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[3] **Build Back Better: Our Plan for Health and Social Care** – GOV.UK *(https://www.gov.uk/government/publications/build-back-better-our-plan-for-health-and-social-care/build-back-better-our-plan-for-health-and-social-care)*

[4] **Levelling Up the United Kingdom** – GOV.UK *(https://www.gov.uk/government/publications/levelling-up-the-united-kingdom)*

The response set out below outlines the government's consideration of each of the 38 recommendations made in the report. It was collated by officials within the Department of Health and Social Care (DHSC) with input from relevant government departments and agencies where necessary. The response has been structured in such a way as to reflect the subheadings in the report’s list of recommendations.

Summary of the Committees' Recommendations

Number	Paragraph number	Recommendation
Pandemic Preparedness		
1.	64	A greater diversity of expertise and challenge – including from practitioners from other countries and a wider range of disciplines – should be included in the framing of the National Risk Register and the plans that emanate from it. Plans for the future should include a substantial and systematic method of learning from international practice during the course of an emergency.
2.	65	A standing capability should be established in government, or reporting to it, to scan the horizon for future threats, with adequate resource and counting on specialists with an independence from short-term political and administrative pressures.
3.	66	The government should ensure comprehensive plans are made for future risks and emergencies. The UK should aim to be a world leader in co-ordinating international resilience planning, including reform of the World Health Organisation to ensure that it is able to play a more effective role in future pandemics.
4.	67	The resourcing and capabilities of the Civil Contingencies Secretariat should be improved. The Civil Contingencies Secretariat should be empowered to 'stress test' plans and to ensure that Departments are able to carry out a contingency plan if required. The details and results of these stress tests should be included in the Cabinet Office's annual report.
5.	68	Arrangements should be established and tested to allow immediate flows of data between bodies relevant to an emergency response with a mechanism to resolve immediately and decisively any disputes.
6.	69	The Armed Forces should have a more central and standing role in preparing for and responding to emergencies like pandemics, given the depth of capability and experience they have in planning, logistics and rapid mobilisation. The Civil Contingencies Secretariat should work with the Armed Forces to improve operational expertise in emergencies in public bodies.
7.	70	The government and the NHS should consider establishing a volunteer reserve database so that volunteers who have had

Number	Paragraph number	Recommendation
		appropriate checks can be rapidly called up and deployed in an emergency rather than needing to begin from scratch.
8.	71	The experience of the demands placed on the NHS during the COVID-19 pandemic should lead to a more explicit, and monitored, surge capacity being part of the long term organisation and funding of the NHS.
9.	72	The NHS should develop and publish new protocols for infection prevention and control in pandemics covering staffing, bed capacity and physical infrastructure. In developing these protocols the NHS should consider the importance of maintaining access for people accompanying some patients such as advocates for people with learning disabilities and birthing partners.
10.	73	Comprehensive analysis should be carried out to assess the safety of running the NHS with the limited latent capacity that it currently has, particularly in Intensive Care Units, critical care units and high dependency units.
11.	74	Building on the experience of staff working more flexibly during the pandemic and to enable more flexible staffing in the NHS, NHS England and Health Education England should develop proposals to better enable NHS staff to change clinical specialty mid-career and train in sub-specialties.
Lockdowns and social distancing		
12.	158	In the early days of a crisis, scientific advice may be necessarily uncertain: data may be unavailable, knowledge limited and time may be required for analysis to be conducted. In these circumstances it may be appropriate to act quickly, on a precautionary basis, rather than wait for more scientific certainty.
13.	159	In future an approach of greater questioning and challenge should characterise the development of policy. Ministers should have the confidence to follow a scientific approach themselves—being prepared to take a more robust approach to questioning and challenging the advice given. The government and SAGE should also facilitate strong external and structured challenge to scientific advice, including from experts in countries around the world, and a wider range of disciplines.
14.	160	In bringing together many of the UK's most accomplished scientists, SAGE became a very UK body. In future, it should include more representation and a wider range of disciplines,

Number	Paragraph number	Recommendation
		from other countries, especially those which have experienced, or are experiencing, the same emergency.
15.	161	In a pandemic, the scientific advice from the SAGE co-chairs to the government should be published within 24 hours of it being given, or the policy being decided, whichever is the later, to ensure the opportunity for rapid scientific challenge and guard against the risk of 'groupthink'. In addition, minutes and SAGE papers should be published within 48 hours of the meeting taking place.
16.	162	The government, via the World Health Organisation, should make the case for an international standard of reporting COVID-19 deaths and a framework for reporting disease related deaths for future pandemics.
Testing and contact tracing		
17.	241	Scientific excellence is not enough in test and trace programmes: the UK must develop greater operational competence in deployment. In particular, the government must ensure that both the new UK Health Security Agency and local authorities have the capability and funding to stand up both central surge capacity and locally driven testing and contact tracing within seven days of a public health emergency being declared.
18.	242	Public Health England and its successor bodies, as well as Ministers and their scientific advisers, should be more willing to study and emulate the practice of other countries with urgency and agility, especially during a crisis. A culture must be established that looks proactively to collaborate with other organisations, rather than to reject assistance.
19.	243	Those responsible for future test and trace programmes should establish a culture and processes to learn rapidly from errors and to act to prevent them being repeated.
20.	244	The reactive, short-term horizon of test and trace for much of the pandemic must be replaced by a capacity for anticipation and preparation—even during the course of an emergency.
21.	245	The organisation of the bodies responsible for testing and tracing should be open and transparent both about their operations and the basis of their decisions.
Social care		
22.	293	Planning for future pandemics should have a more developed and explicit consideration of the intense interaction between the NHS and social care. The prominence of social care within

Number	Paragraph number	Recommendation
		the Department of Health and Social Care should be enhanced and Ministers must address the relative lack of knowledge and experience of social care within the Department and senior levels of the NHS. The Department should ensure that future policy and guidance relating to the sector is well-informed and reflects the diversity of the sector. The Department must also set out how it plans to retain the expertise of the Social Care Taskforce on a more permanent basis.
23.	294	Long term reform of social care is overdue and should be pursued as a matter of urgency. The government's recent announcement on the future of social care is welcome, but the long-term future of the sector remains unresolved. We endorse the Health and Social Care Committee's call for a 10 Year Plan for Social Care to accompany the 10 Year Plan for the NHS. It must ensure that there is parity between the health and care sectors so that social care is given proper priority in a future crisis.
24.	295	We endorse the Health and Social Care Committee's call for additional resources to be directed to social care. That Committee has made the case for an increase of £7 billion a year by 2023/24. We note that despite the government's recent announcement the level of new investment in social care from 2023/24 remains unclear.
25.	296	The government should review the provision of infection prevention and control measures, including infection prevention and control nurses, to social care and ensure that social care providers, particularly care homes, are able to conduct regular pandemic preparedness drills. The government must ensure that care homes have isolation facilities and social care providers are able to provide safe visiting for family and friends of care home residents.
At risk communities		
26.	335	The government should ensure its 'levelling up' agenda includes specific policies to reduce health inequalities, with a particular focus on ensuring that certain groups, including people from Black, Asian and minority ethnic backgrounds, do not continue to face unequal health outcomes.
27.	336	It is essential that in any future crisis, NHS staff from Black, Asian and minority ethnic backgrounds are included in emergency planning and decision-making structures. NHS England should accelerate efforts to ensure that NHS

Number	Paragraph number	Recommendation
		leadership in every trust, foundation trust and Clinical Commissioning Group is representative of the overall Black, Asian and ethnic minority workforce.
28.	337	Leadership in NHS England and Improvement should also increase their engagement with Black, Asian and minority ethnic worker organisations and trade unions to ensure that Black, Asian and minority ethnic members of staff feel valued by the organisation, are involved in decision-making processes and feel able to speak up when they are not being protected.
29.	338	It is unacceptable that staff from Black, Asian and minority ethnic communities did not have equal levels of access to appropriate and useable personal protective equipment as their white colleagues during the pandemic. The government must learn from the initial shortage of appropriate PPE for these staff and set out a strategy to secure a supply chain of PPE that works for all staff in the NHS and care sectors.
30.	339	The NHS, local authorities and the government should ensure that health advice during the remainder of the pandemic and in any future emergencies should be available in a full range of languages, and that outreach programmes should reflect what is most effective in the cultural context of different communities.
31.	340	In planning for future health emergencies, the Department of Health and Social Care and the NHS should consider the specific difficulties faced by people with learning disabilities and their families and recognise the barriers to understanding and communication which, if not overcome, can lead to avoidable deaths of vulnerable people.
32.	341	The NHS should improve the data it holds on people with learning disabilities so that this group of patients can be more appropriately considered for vaccination.
33.	342	The NHS should ensure the guidance on DNACPR notices is clear and properly understood by healthcare professionals and individuals, especially in circumstances where a patient's carer or advocate may not be able to be present in hospital.
Vaccines		
34.	397	It is essential that support for, and investment in, the UK science base is protected and enhanced. This should include delivering the government commitment from Budget 2020 and the 2021 R&D roadmap to invest £22 billion per year in R&D by 2024/25. Science has saved the world from the even greater catastrophe of COVID-19 without the defence of vaccines. The

Number	Paragraph number	Recommendation
		experience should alert us to the risk of unforeseen threats against which a world-class and experienced scientific capability is the best investment.
35.	398	A strategic approach should be taken to manufacturing vaccines. The Life Sciences Industrial Strategy identified vaccine manufacturing as an area in which the UK could and should be stronger and set out deliberately to act on this by creating the Vaccine Manufacturing Innovation Centre. Looking forward and comparing future opportunities and threats against current capability and acting to resolve them is a responsible approach.
36.	399	The Vaccine Taskforce model of forming flexible teams outside of the usual Whitehall administration, but working with it, and comprising people with outside expertise working within it, is a successful one. It should be considered for delivering other government priorities. However, it is concerning to hear that the Vaccine Taskforce model is being eroded by incorporation into "the normal entropy process of Whitehall", and this erosion should be arrested. The procurement model deployed by the Vaccine Taskforce of making decisions at risk, outside conventional procurement procedures, proved highly effective. Lessons from this success should be applied to other areas of government procurement.
37.	400	The UK's regulatory system responded with rigour but flexibility. It could be that the approvals process and the conduct of clinical trials could have proceeded even more quickly, for example by making use of human challenge trials. This may not be appropriate in anything but the most exceptional circumstances – i.e. a deadly pandemic but an assessment of this should be made now before such an occasion might arise.
38.	401	The use of the Armed Forces – as well as civilian volunteer groups – proved effective in advancing the vaccine roll-out quickly and reliably. Protocols should be established to allow the Armed Forces quickly and at scale to participate, and the NHS should consider ways in which it can be more accommodating of volunteer support in normal times building on the experience and enthusiasm demonstrated during the pandemic.

Responses to the Committees' Recommendations

Pandemic preparedness

1. **A greater diversity of expertise and challenge—including from practitioners from other countries and a wider range of disciplines—should be included in the framing of the National Risk Register and the plans that emanate from it. Plans for the future should include a substantial and systematic method of learning from international practice during the course of an emergency.**

The government partially accepts this recommendation.

The government agrees that there is positive learning and engagement to be had with other countries, practitioners, and disciplines, as it has done since the start of the pandemic and continues to do so. The government will do this flexibly, as appropriate and proportionate against other priorities, especially during emergencies. The NSRA process is undertaken by the Cabinet Office and assesses the most significant malicious and non-malicious risks facing the UK and its interests overseas. These risks are presented as reasonable worst-case scenarios and scored by their likelihood and impact. The NSRA is used to inform planning in central and local government and support prioritisation and funding decisions. The NSRA is the basis of the public-facing National Risk Register (NRR).

The Cabinet Office works in collaboration with the lead department for each risk and a range of expert bodies, including industry partners, academics, and subject matter experts, to assess existing and emerging risks in the UK. Sound expert challenge is a key element of the NSRA process, providing a means of ensuring the risk scenarios presented are robust and evidence based, incorporating the latest technical knowledge.

Ahead of every cycle, the Cabinet Office reviews the methodology of the NSRA. For the first time, the Cabinet Office has commissioned an external group, the Royal Academy of Engineering (RAEng), to undertake a review of the NSRA methodology. RAEng has drawn on its extensive network of Fellows as well as academic and industry contacts to review the role of expert challenge in the NSRA and make recommendations for how this can be improved.

As the methodology review concludes, the Cabinet Office is considering ways to substantially increase the accessibility of the NSRA to external experts and increase the diversity of challenge during and after the process.

Learning from and sharing international practice is integral to the UK's preparedness for and response to emergencies. The UK is a forefront Ally in NATO's Civil Preparedness work, including meeting the baselines for national resilience, and the

government is committed to the UN Sendai Framework for Disaster Risk Reduction and the Sustainable Development Goals. Such frameworks and relationships with partners foster learning from international practice to improve the UK's own resilience and enable cooperation to address trans-border challenges.

2. **A standing capability should be established in government, or reporting to it, to scan the horizon for future threats, with adequate resource and counting on specialists with an independence from short-term political and administrative pressures.**

The government does not accept this recommendation for the reason that there exist already a range of complementary standing capabilities that aim to identify and assess current and future malicious and non-malicious risks. These include, but are not limited to:

- Near-term horizon scanning of civil contingencies risks with the potential to seriously disrupt normal activity in the UK or the operation of the UK government (up to six months ahead). This is conducted by the Civil Contingencies Secretariat (CCS) in collaboration with sector specific monitoring in government departments and other organisations.

- The Joint Intelligence Organisation, which provides all-source intelligence assessment and has early warning capabilities focused on a wide range of national security topics.

- The newly formed National Situation Centre (NSC), which brings together data and insights from across government and beyond to support situational awareness on national security, crises, and civil emergency issues.

- The NSRA, which is produced by CCS and looks ahead at the most serious malicious and non-malicious risks facing the UK or its interests overseas in the next two years. The NSRA focuses on understanding significant and common consequences in order to drive planning and is shared across government and with local planners.

- Longer term horizon scanning work across government to identify future risks across security and defence, science and technology, international and domestic issues. GO-Science is actively building futures capability across government, in support of the Cabinet Office and Integrated Review commitment to improve this, through shared evidence, tools and training. GO-Science will also deliver a new Foresight Project on resilience to long-term strategic trends during 2022 that will provide the government with a new risk evidence base and tools to apply this to policy development.

As part of its ongoing work to develop a Resilience Strategy, the government is currently reviewing the way that it assesses risk, focusing in particular on: the nature of the information it gathers and analyses; the means for communicating and sharing that information; and the way in which recipients adapt and apply information to manage risks. In assessing how all of these factors come together, the government will consider whether new structures, specialist staff and processes are required.

The overall objective will be to improve understanding of current and future risks, ensuring that the UK as a whole – the government, businesses, and individuals – can effectively plan, act and adapt.

3. **The government should ensure comprehensive plans are made for future risks and emergencies. The UK should aim to be a world leader in co-ordinating international resilience planning, including reform of the World Health Organisation to ensure that it is able to play a more effective role in future pandemics.**

The government partially accepts this recommendation.

The UK will continue to be a world leader for future responses. The UK supports the World Health Organization's (WHO) unique position in global health as the lynchpin of the global coordination effort during pandemics and other health emergencies. The UK has a strong and committed relationship with WHO working closely with them at country, regional and global levels providing technical expertise.

The UK is also driving progress on organisational and emergency reform. A stronger architecture for preparedness and response to pandemics and other health emergencies includes sustainably financing WHO; supporting improvements to the way outbreaks are investigated; and considering amendments to the International Health Regulations (2005) to improve management of public health emergencies. The UK is working with international partners, bilaterally and in multilateral forums, to address these challenges, including embedding them in a new Pandemic Treaty where appropriate. The government also used the UK's G7 Presidency in 2021 to make progress. The Carbis Bay Declaration set out strong commitments by G7 governments to improve how they prevent, detect, respond to, and recover from pandemics. The UK continues to work closely with the German government on these issues under its G7 Presidency.

For each major risk identified in the NSRA, a designated lead government department (LGD) or arms-length body is responsible for its overall management. Guidance on

the roles and responsibilities for LGDs was agreed and published by CCS in 2011.[5] These responsibilities include conducting capability assessments and contingency and emergency planning, including with local responders and partner organisations.

The Resilience Capabilities Programme (RCP) uses the risks and reasonable worst-case scenarios in the NSRA to model the different facets of a response through a series of generic and risk agnostic capabilities. Each capability is owned by a LGD which is responsible for developing plans to ensure it can be flexibly deployed to respond to a range of scenarios. Any civil emergency may call upon a number of different capabilities (sometimes several at a time), requiring them to work together effectively. By using the RCP to assess the ability of departments to address these common consequences of emergencies, the government is able to draw upon a broad evidence base, enabling informed cross-government decisions to be made about risk tolerance, and allowing it to identify gaps in preparedness and strengthen plans accordingly. The RCP will continue to assess departmental capability, adapting the selection of generic capabilities where necessary to reflect updates to the NSRA.

The government intends to set up a catastrophic emergencies programme to focus on 10 risks which may give rise to whole-system emergencies, including pandemics. The programme will seek to address the challenges posed by the breadth of impact of catastrophic emergencies and provide support for departments' planning for catastrophic risks.

As part of ongoing work to develop a Resilience Strategy, the government will review how it leverages its international relationships – including its contributions to multilateral organisations – in order to build greater resilience to global-scale risks.

4. **The resourcing and capabilities of the Civil Contingencies Secretariat should be improved. The Civil Contingencies Secretariat should be empowered to 'stress test' plans and to ensure that Departments are able to carry out a contingency plan if required. The details and results of these stress tests should be included in the Cabinet Office's annual report.**

The government partially accepts this recommendation.

CCS has a key role to play in driving UK resilience and is considering the appropriate role, resourcing, and capabilities as part of reviews and the development of the Resilience Strategy. As part of enhancing capability, the government also launched

[5] **List of lead government departments' responsibilities for planning, response, and recovery from emergencies** – GOV.UK *(https://www.gov.uk/government/publications/list-of-lead-government-departments-responsibilities-for-planning-response-and-recovery-from-emergencies)*

the new NSC in 2021 to improve situational awareness of all risks, from civil contingencies to national security. It will provide additional capabilities to bring together data and expertise that supports decision-making.

As set out above, LGDs are responsible for the overall management of risks in their area of responsibility, including the assurance of relevant plans, and the RCP assesses the capabilities of departments and coordinates cross-departmental work as required. CCS supports the assurance of resilience capabilities and preparedness through a variety of means, including wargaming and red teaming to stress test plans, and rehearsals and exercises to confirm and validate command, control and coordination arrangements. CCS is committed to establishing a National Resilience Exercising Programme, with a clear role in both building and assuring preparedness for risks in the NSRA.

The government is aware of the benefits of transparency but also the sensitivities of some readiness assessments for national security. The matter of what is appropriate to include in the Cabinet Office's annual report or those of LGDs will be kept under review.

5. Arrangements should be established and tested to allow immediate flows of data between bodies relevant to an emergency response with a mechanism to resolve immediately and decisively any disputes.

The government accepts this recommendation.

The newly formed NSC within the Cabinet Office is applying lessons learned from the COVID-19 pandemic and accelerating the government's modernisation of the use of data. The NSC draws upon data and insights from across government and beyond to support situational awareness and response on national security, crises, and civil emergency issues.

The development of the Resilience Strategy will seek to improve communication and information sharing during emergencies. CCS is undertaking its five-year review of the Civil Contingencies Act and supporting regulations. The review will consider if the information sharing duties for Category 1 and 2 responders remain fit for purpose.

6. **The Armed Forces should have a more central and standing role in preparing for and responding to emergencies like pandemics, given the depth of capability and experience they have in planning, logistics and rapid mobilisation. The Civil Contingencies Secretariat should work with the Armed Forces to improve operational expertise in emergencies in public bodies.**

The government does not accept this recommendation.

The government already has strong central functions dedicated to planning for and managing crises. Further, the government already makes use of the Ministry of Defence's (MoD) planning capabilities in a crisis where required, and considers that having a standing capability dedicated solely to resilience is not necessary. From MoD's perspective it is also not desirable, as it would reduce Defence's ability to conduct its own tasks.

For the majority of emergencies requiring a response at the national level, there is a pre-nominated LGD which is responsible for both the planning and activation of central government response arrangements. In discharging these responsibilities, departments are already able to request the support of MoD and the Armed Forces in preparing for and responding to emergencies. The Armed Forces also provide considerable planning expertise on a regular basis to both CCS and other government departments for major events and crises, a process governed by the Military Aid to the Civil Authorities (MACA) process.

This was seen in the preparations for leaving the European Union, Winter Response and in the early days of the pandemic, when MoD provided a network of Strategic Liaison Officers (SLOs). Spanning across the Cabinet Office, key departments and the NHS, they were able to not only assist departments to develop plans, but also to provide advice on the use of military capabilities, facilitate the MACA process and to track potential and emerging demand for military capabilities. Some existing military planning capabilities with deep expertise not easily found in government (for example Reserve Officers with the Engineer and Logistic Staff Corps) have contributed to central planning and response work. MoD, additionally, has an existing network of 18 full-time, staff-trained, Joint Regional Liaison Officers (JRLOs) to provide civil authorities with advice at the operational level.

Generic planning capabilities, while invaluable, are also dependent on thorough knowledge of civilian capabilities, organisational structures, legal frameworks and working practices. These can also be provided through adherence to the UK government's Crisis Management doctrine, rather than through the standing provision of military planners and uniform application of military planning techniques.

7. **The government and the NHS should consider establishing a volunteer reserve database so that volunteers who have had appropriate checks can be rapidly called up and deployed in an emergency rather than needing to begin from scratch.**

The government accepts this recommendation.

The NHS Volunteer Responders programme has already established a database of over 400,000 active volunteers who have offered to help the NHS during the current pandemic and options for developing a refreshed operating model for the programme are being developed. This will enable those who wish to continue to volunteer through the programme in a business-as-usual (BAU) environment to do so, whilst retaining a list of those who are prepared to step forward in emergency situations to support in non-clinical roles.

In addition to working directly with volunteers, the response of the voluntary sector to support the NHS during the pandemic has significantly reduced pressure on NHS services. For example, the British Red Cross, Age UK, and Royal Voluntary Services have all provided additional surge capacity to support hospital discharge, speeding up the discharge process and other organisations such as Re:Act have also provided volunteers to support in mortuaries, in intensive care units and other settings. Local voluntary sector organisations have also been invaluable in providing support.

St John Ambulance has focused its BAU operations to provide significant levels of support to the NHS. This includes providing an auxiliary ambulance service, volunteers in emergency departments, provision of over 26,000 volunteer vaccinators and much more. It has, therefore, provided a service akin to an NHS Reserve, especially for the ambulance service, but also within other areas of the NHS. They are able to rapidly flex and provide clinically trained volunteers where they are needed most.

In January, NHS England established the NHS Volunteering Taskforce which aims to create and sustain a lasting legacy for volunteering, both directly with the NHS, and with other organisations acting on behalf of the health and social care system, to build on the huge efforts of the public to support the NHS during the pandemic.

8. **The experience of the demands placed on the NHS during the COVID-19 pandemic should lead to a more explicit, and monitored, surge capacity being part of the long-term organisation and funding of the NHS.**

The government partially accepts this recommendation. The NHS has robust systems and processes in place to plan for and proactively manage and mitigate risks associated with increased demand which have been tested through the pandemic.

As part of its emergency preparedness arrangements, NHS England works with UKHSA and NHS organisations to understand its response to a range of threats and hazards including a series of major incident and surge exercises. Those exercises are used to inform the development of policies, guidance, and standard operating procedures that are used nationally, regionally, and locally to assess the response to surges in activity. Those exercises and lessons identified are reported to NHS Boards to inform future plans and practice.

NHS England works closely with voluntary agencies and independent sector providers to ensure that the health and social care response to an incident is as robust as practicable and that it works with key partners to address the needs of the population.

The NHS has been effective at redeploying capacity to meet the needs of COVID-19 patients. To manage demand and meet patient need, NHS England established a Critical Care Capacity Panel. The Panel reviewed capacity in the most pressured systems daily and coordinated safe patient transfers to facilitate mutual aid and load levelling between regions. Further plans to maintain NHS and social care resilience are set out in the government's 'Living with COVID-19' strategy.

9. **The NHS should develop and publish new protocols for infection prevention and control in pandemics covering staffing, bed capacity and physical infrastructure. In developing these protocols, the NHS should consider the importance of maintaining access for people accompanying some patients such as advocates for people with learning disabilities and birthing partners.**

The government partially accepts this recommendation.

UKHSA produces infection prevention and control (IPC) guidance to support all healthcare organisations in protecting NHS staff, visitors, and patients in the event of a pandemic. This guidance is based on the latest scientific knowledge of pathogens causing the pandemic and will therefore vary depending on the nature of that pandemic. NHS England's role is to support the implementation of and adherence to IPC guidance in healthcare settings in England. Individual healthcare providers are responsible for implementing IPC guidance in their settings, taking into account their

own individual circumstances, including staffing, estate, and infrastructure, which will also vary.

It is, however, not advisable to have a fixed infection control plan for all possible pandemics – it has to be adapted to the infection that occurs. For example, previous infectious disease outbreaks include HIV (predominantly sexually transmitted) and Ebola (transmitted by close contact) had very different infection control issues and using COVID-optimised infection controls would not have led to optimal outcomes.

The government is working to develop pandemic preparedness plans that cover a wider range of infectious disease scenarios, including respiratory, contact and vector-borne scenarios. Issues of staffing, bed capacity and physical infrastructure must adapt and align appropriately with the IPC guidance relevant to the nature of the pathogen in question and the latest scientific information available during an outbreak. Work on infrastructure issues that would be relevant to any infectious disease or pandemic management is built in as part of the new hospitals programme, which is looking at designing an estate which can support IPC practice, including greater use of single rooms to manage patients with infectious diseases.

In terms of maintaining access for specific individuals in hospital, visiting guidance for the pandemic made clear that healthcare providers should enable a carer (or someone else) able to support the patient with communication needs to accompany them. In addition, NHS England's guidance for maternity services made clear that women should have access to support at all times during their maternity journey and Trusts should facilitate this.

In both these cases, good IPC practice should be used as an enabler and any guidance developed should reflect the specific nature of the pandemic, with particular importance placed on quickly building testing capacity to safely enable visiting.

10. Comprehensive analysis should be carried out to assess the safety of running the NHS with the limited latent capacity that it currently has, particularly in Intensive Care Units, critical care units and high dependency units.

The government partially accepts this recommendation.

NHS England has set up a national programme responsible for improvement and innovations within adult critical care. It has completed a stocktake of the critical care workforce across England to understand the pressure that NHS providers are under and has established a data system with daily returns from all critical care units reporting patient numbers, interventions, and staff availability. Work is continuing with

colleagues around the country to continue to review and support critical care services and to ensure that there is equitable access.

11. Building on the experience of staff working more flexibly during the pandemic and to enable more flexible staffing in the NHS, NHS England and Health Education England should develop proposals to better enable NHS staff to change clinical specialty mid-career and train in sub-specialties.

The government accepts this recommendation and agrees that doctors should be able to train in a different clinical specialty part way through their career and training, and to train in different sub-specialties.

The General Medical Council (GMC) is responsible for setting the standards and expected outcomes for medical education and training in the UK. In 2017, the GMC commissioned the Academy of Medical Royal Colleges to carry out a review of flexibility within postgraduate medical education. The Academy published guidance in June 2020 describing how doctors in training who wish to train in another specialty can receive recognition towards the Certificate of Completion of Training in the new specialty of capabilities gained in their existing specialty.[6]

The GMC has introduced a framework for regulated credentials for doctors, which focus on discrete areas of practice where consistent clinical standards recognised across the UK are necessary to support patient care.[7] Credentials are designed to support increased flexibility for doctors who may wish to accredit areas of practice beyond their initial or current specialty training. These credentials are mainly in areas where the capacity to train doctors is insufficient to meet patient or service need.

To date, early adopter credentials have been approved to cover the following areas:

- Cosmetic Surgery led by the Royal College of Surgeons
- Interventional Neuroradiology (Acute Stroke) led by the Royal College of Radiologists
- Liaison Psychiatry led by the Royal College of Psychiatrists
- Pain Medicine led by the Faculty of Pain Medicine
- Remote and Rural led by NHS Education Scotland

[6] **Guidance for flexibility in postgraduate training and changing specialities** – Academy of Royal Medical Colleges (*https://www.aomrc.org.uk/reports-guidance/guidance-for-flexibility-in-postgraduate-training-and-changing-specialties/*)
[7] **GMC credentials for doctors** – General Medical Council (*https://www.gmc-uk.org/-/media/documents/gmc-credentialing-framework-2021_pdf-78983531.pdf*)

In addition, Health Education England (HEE) has funded curriculum development and successful pilots in England of credentials in the following areas:

- Breast clinicians in partnership with the Royal College of Radiologists
- Obstetric physicians in partnership with the Royal College of Physicians
- Perinatal mental health (initially medical only) in partnership with the Royal College of Psychiatrists

Lockdowns and social distancing

12. **In the early days of a crisis, scientific advice may be necessarily uncertain: data may be unavailable, knowledge limited, and time may be required for analysis to be conducted. In these circumstances it may be appropriate to act quickly, on a precautionary basis, rather than wait for more scientific certainty.**

The government partially accepts this recommendation.

Throughout the pandemic the government has been informed by the evidence, including public health and scientific advice, and has taken quick and decisive action using the evidence available. The government is already adapting and learning lessons from COVID-19 to inform its preparedness for future crises. Decisions are taken by Ministers following advice from officials including scientific advice. However, decisions on where the balance of public interest lies have remained with the Ministers throughout, as they do in all policy making.

13. **In future an approach of greater questioning and challenge should characterise the development of policy. Ministers should have the confidence to follow a scientific approach themselves—being prepared to take a more robust approach to questioning and challenging the advice given. The government and SAGE should also facilitate strong external and structured challenge to scientific advice, including from experts in countries around the world, and a wider range of disciplines.**

The government partially accepts this recommendation.

Decisions made by Ministers were, and continue to be, informed by the available scientific and clinical advice to facilitate robust policy development. Advice from the scientific and clinical community has formed a key part of the policy development process, which is structured around questioning and challenge, together with additional considerations including economic and social impacts, and overall deliverability. Decisions are taken by Ministers following advice from officials including scientific advice. However, decisions on where the balance of public interest lies have remained with the Ministers throughout, as they do in all policy making.

During the COVID-19 response, scientific advice has been drawn from a pool of over 240 Scientific Advisory Group for Emergencies (SAGE) participants across academic disciplines, with the intention of building in a diversity of views and challenge. Of course, it also comes from government bodies such as UKHSA, and incorporates clinical and public health advice. SAGE COVID-19 meetings have also benefited from the expertise of the wider academic community, through groups and network

representatives, such as the National Academies, which have often included academics from outside the UK.

Learning from the experience of COVID-19, the government is strengthening the ways in which it engages with scientists both during crisis and non-crisis moments and in how expert advice is sought and used, as well as how it docks into policy and operational decision-making. The government has been clear throughout the pandemic that it has adapted its response and will continue to do so as it learns more about the virus and how to tackle it. There will always be lessons to be learned, which is why the government is launching a Public Inquiry.

14. In bringing together many of the UK's most accomplished scientists, SAGE became a very UK body. In future, it should include more representation and a wider range of disciplines, from other countries, especially those which have experienced, or are experiencing, the same emergency.

The government partially accepts this recommendation.

The government engages with other nations and international experts through a range of fora, such as the G7, the G20, and via WHO. With respect to the provision of scientific advice, much engagement with international experts occurred from the outset of the pandemic, and this is an important principle to keep for future emergencies.

SAGE has drawn international perspectives from SAGE participants' wider international academic networks. Science is an international endeavour and most if not all of the contributing national academies are in collaboration, or at least discussions, with international counterparts.

Effective international collaboration and responsive coordination between national public health institutes (NPHIs), or equivalent public health bodies, is also crucial for sharing data, evidence, and research as the COVID-19 pandemic progresses, as well as for learning from each other. A strong network of NPHIs is needed to strengthen existing networks of Emergency Operation Centres and to build laboratory network capability. Public Health England (PHE) and UKHSA's active membership in the International Association of National Public Health Institutes (IANPHI), comprising 110 members in 95 countries, has been essential for the exchange of information and joint actions. It has also drawn on the network to learn from other countries in their response to the COVID-19 pandemic and continues to do so.

In addition, through bilateral engagement, DHSC collaborates internationally to exchange knowledge with other countries on matters such as effective future pandemic preparedness. The Department will continue to engage bilaterally with countries from around the world to learn from the breadth of global activity on

prevention and detection of infectious diseases, and inform UK thinking where lessons could be learned. This has been reinforced through engagement in the margins of G7 and G20 Health Ministers' meetings (specifically with the United States, India, Germany, Italy, Singapore, Argentina, Netherlands, Brazil, and Saudi Arabia), as well as through the World Health Assembly and other multilateral fora. The Department will continue to take advantage of bilateral opportunities to learn from international experience and share the UK's expertise, to improve future pandemic preparedness.

It is vital that the work to prepare for the next pandemic is a collaborative global effort by governments, international organisations, and industry partners. The Pandemic Preparedness Partnership's '100 Days Mission' report,[8] which was welcomed by G7 leaders, includes recommendations to guide governments, international organisations, and industry partners on steps which can be taken now and over the longer-term to ensure the mission is achieved. The UK government will work with other nations across the globe to implement these recommendations.

15. In a pandemic, the scientific advice from the SAGE co-chairs to the government should be published within 24 hours of it being given, or the policy being decided, whichever is the later, to ensure the opportunity for rapid scientific challenge and guard against the risk of 'groupthink'. In addition, minutes and SAGE papers should be published within 48 hours of the meeting taking place.

The government does not accept this recommendation.

During the COVID-19 response, over 1,200 papers tabled at the 105 COVID-19 SAGE meetings have been released in a routine rhythm since May 2020. This is the first time it has been done during a SAGE activation. As of 8 April 2022, 95% of all papers tabled at SAGE have been released.

Papers that come to SAGE are very often prepared to tight timescales. The risk of aiming for a rule that publication must occur within 24-48 hours of a SAGE meeting is that it may lead to groups only providing papers to SAGE once they are content they are ready for release. This could have unintended consequences; a delay to the provision of up-to-date information would delay the discussion of papers at SAGE, and ultimately delay the provision of science advice to Ministers.

SAGE minutes and papers are, therefore, released on a weekly cycle, which the government considers to be as soon as reasonably possible. However, in some

[8] **100 Days Mission to respond to future pandemic threats** – G7 *(https://www.gov.uk/government/publications/100-days-mission-to-respond-to-future-pandemic-threats)*

instances, it may not be feasible to stick to a defined timescale of paper release for reasons of national security, because the paper is concerned with policy still in development and/or for practical reasons; Cabinet Office (with Number 10) have an important role to play in decisions regarding the release of such papers.

The default continues to be that the government will always aim for full transparency and release the SAGE minutes and papers in a regular and timely manner where it is possible to do so.

16. The government, via the World Health Organisation, should make the case for an international standard of reporting COVID-19 deaths and a framework for reporting disease related deaths for future pandemics.

The government partially accepts this recommendation.

The Office for National Statistics (ONS) and NHS Digital, which together represent the UK on matters relating to the classification of diseases and deaths, have been closely involved in helping WHO formulate international standards on the reporting of COVID-19 deaths. WHO issued international guidelines for certification and classification (coding) of COVID-19 as cause of death[9] in April 2020 and subsequently updated these[10] in the light of emerging knowledge and public health needs. ONS and NHS Digital will continue to engage actively with WHO to ensure robust international classifications and standards are in place and to support WHO's readiness to respond to any future pandemics or other emerging health problems.

ONS reports deaths involving or due to COVID-19 based on the contents of the death certificate. The numbers of deaths reported on the coronavirus data website[11] follow a different methodology based on death within either 28 or 60 days of a laboratory-confirmed positive COVID-19 test, in the latter case with COVID-19 being mentioned on the death certificate. This approach was developed during the pandemic by PHE and other responsible organisations to permit rapid reporting of newly identified deaths without waiting for the process of death certification to be completed. It was not designed to produce definitive figures on deaths caused by COVID-19 in the long term, or to be internationally comparable. The Office for Statistics Regulation published a

[9] **International Guidelines for Certification and Classification (Coding) of COVID-19 as Cause of Death** – WHO
(https://www.who.int/publications/m/item/international-guidelines-for-certification-and-classification-%28coding%29-of-covid-19-as-cause-of-death)
[10] **Updates 3 & 4 in relation to COVID-19 coding in ICD-10** – WHO
(https://www.who.int/publications/m/item/updates-3-4-in-relation-to-covid-19-coding-in-icd-10)
[11] **COVID-19 Death Data** – GOV.UK
(https://coronavirus.data.gov.uk/details/deaths)

blog, 'The challenges of counting COVID deaths' [12] in August 2020 on the differences between these ways of counting COVID-19 deaths.

Methods for rapid reporting of deaths not based on death certificates necessarily differ between countries because of numerous differences in the organisation of health and social care systems, availability and quality of diagnostic facilities, data collection capabilities, and ability to use multiple reporting routes to overcome the limitations of individual sources. Comparison of all-cause mortality is considerably easier than comparison of disease-specific mortality, as the fact of death is often collected more quickly than diagnostic details, and all-cause mortality avoids confusion caused by national differences in clinical practice, diagnostic criteria and availability of laboratory testing. When comparing across countries there is therefore a strong case for total deaths from all causes as the most reliable measure of the impact of a pandemic. While ONS has published comparisons of all-cause excess mortality in European countries[13] during the pandemic, not all countries produce sufficiently timely or reliable data for similar comparisons to be feasible on a global basis.

The government will continue to work with WHO and other international stakeholders to support effective international reporting of COVID-19 deaths and those caused by other health conditions, including future pandemics, on the most appropriate basis for each situation, recognising that appropriate methodologies may vary as outlined above. ONS and other UK statistics providers have developed substantial expertise in monitoring the pandemic and estimating incidence, symptom prevalence and other measures in addition to deaths and this knowledge will also be made available to promote internationally comparable standards and methods.

[12] **The challenges of counting COVID deaths** – OSR *(https://osr.statisticsauthority.gov.uk/the-challenges-of-counting-covid-deaths/)*

[13] **Comparisons of all-cause mortality between European countries and regions** – ONS *(https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/comparisonsofallcausemortalitybetweeneuropeancountriesandregions/datauptoweekending3september2021)*

Testing and contact tracing

17. **Scientific excellence is not enough in test and trace programmes: the UK must develop greater operational competence in deployment. In particular, the government must ensure that both the new UK Health Security Agency and local authorities have the capability and funding to stand up both central surge capacity and locally driven testing and contact tracing within seven days of a public health emergency being declared.**

The government partially accepts this recommendation.

UKHSA and local authorities need robust contingency plans to respond to wider public health emergencies that extend beyond the response to the COVID-19 pandemic. The timeframe within which testing or tracing arrangements can be put in place to respond to future public health emergencies, where they are needed, will depend on the nature of the emergency and be subject to available investment in the usual way.

For its COVID-19 response, UKHSA has had oversight of a network of regional test sites, local test sites, mobile testing units and home distribution for polymerase chain reaction (PCR) testing – and a range of distribution systems for lateral flow tests – which have been designed to provide the flexibility to respond to changes in demand while ensuring fast turnaround times, and ran a national trace service and supported local authorities in local-level responses to the pandemic. This network will be reduced in the coming months in accordance with the plans set out in the government's strategy for living with COVID-19, with UKHSA retaining a mix of capabilities including mobile testing and a scaled back national tracing function. UKHSA will continue to work closely with local authorities to enable appropriate test and trace arrangements to be deployed efficiently and effectively in response to future outbreaks. This includes wider public health emergencies.

UKHSA will build on the legacy of the response to this pandemic. This includes ensuring a resilient and scalable infrastructure is in place to protect the public from new and existing threats to health. UKHSA will provide system leadership on health security and will work closely with local authorities, the NHS, local Directors of Public Health, professional bodies and associated local partners to co-design policies, responses on health security and the future of the local health protection system so that there is capacity to respond to future public health emergencies across England.

18. **Public Health England and its successor bodies, as well as Ministers and their scientific advisers, should be more willing to study and emulate the practice of other countries with urgency and agility, especially during a crisis. A culture must be established that looks proactively to collaborate with other organisations, rather than to reject assistance**

The government partially accepts this recommendation, whilst recognising the very strong existing international relationships which have been employed from the beginning and continued through the pandemic.

Future collaboration with other countries will build on a strong foundation of joint learning and working that has already been established and demonstrated in previous incidents (for example, the West African Ebola outbreak or through the UK Rapid Public Health Support Team). UKHSA is actively committed to collaborating with other organisations and countries and will continue to both contribute to and learn from global experience, while recognising that cross-country comparisons are notoriously difficult given differing population profiles and other factors. The government also notes that countries quoted publicly as having adopted successful responses have in some cases followed very divergent policies, and also that perspectives on which countries are responding effectively have shifted somewhat.

PHE/UKHSA has been an active member of IANPHI, which facilitates peer review and learning between 110 institutions in 95 countries. The IANPHI forum has been actively engaged in sharing learning and insights into COVID-19 and on broader aspects of public health capacity development. PHE/UKHSA has actively contributed to and benefitted from such learning. PHE/UKHSA has also been an active participant of the WHO Evidence Collaborative for COVID-19 Network, which has been supporting systematic reviews and the sharing of evidence to inform global practice.

In addition to these formal networks, strong partnerships exist allowing informal linkages with a number of NPHIs for rapid idea exchange. There is regular dialogue between experts in different countries, sharing experiences and approaches, for example the National Institute for Public Health and the Environment in the Netherlands, and the Robert Koch Institute in Germany. These meetings can be convened rapidly, focus on specific issues and foster strong collaboration with other countries and organisations. The UK has hosted a number of sessions throughout the pandemic in response to requests from international partners to learn from its experience and these continue on a regular basis. The UK is also co-chairing work on the proposed WHO international pathogen surveillance network.

19. Those responsible for future test and trace programmes should establish a culture and processes to learn rapidly from errors and to act to prevent them being repeated.

The government accepts this recommendation.

UKHSA has a vital role to play in helping to identify and implement lessons learned from the management of this pandemic, both during the remaining stages and beyond, including assessing and responding to the longer-term public health impacts.

While there will be further lessons to be learned from the pandemic, the drive for continuous improvement has already led to significant advances and improvements being adopted.

20. The reactive, short-term horizon of test and trace for much of the pandemic must be replaced by a capacity for anticipation and preparation—even during the course of an emergency.

The government partially accepts this recommendation, while recognising that responding to unexpected events will remain a critical part of the pandemic response.

Subject to securing sufficient resources, UKHSA will utilise strong surveillance capabilities, rooted in the highest quality data systems, data architecture and analytics to anticipate, prepare for, and respond to health risks. UKHSA will exploit the potential of new techniques and technologies across a range of disciplines.

UKHSA will work in professional surveillance networks with partners across government, such as the Food Standards Agency, Animal and Plant Health Agency and the Department for Environment, Food and Rural Affairs, as well as in collaboration with international partners, to ensure that health threats, including those from zoonotic diseases and antimicrobial resistance (AMR), are detected earlier and responded to more effectively.

As a Category 1 responder under the Civil Contingencies Act, UKHSA will work with DHSC to provide effective emergency preparedness, resilience, and response to all public health emergencies. This includes surveillance, analysis, risk assessment, management of and response to infectious disease incidents and outbreaks. UKHSA will build on the advice from its expert advisory committees where appropriate.

UKHSA will also work alongside DHSC and other partners to lead a refreshed approach to pandemic preparedness (aligned to the One Health agenda), as well as contribute to a review of emergency and clinical countermeasures, and the re-procurement of the Pandemic Specific Vaccine Advance Purchase Agreement.

21. The organisation of the bodies responsible for testing and tracing should be open and transparent both about their operations and the basis of their decisions.

The government accepts this recommendation.

Transparency is a key element of how the NHS Test and Trace service has operated and how UKHSA will operate in future. UKHSA will publish an annual report, strategic plan and business plan and accounts, as well as information on areas including pay, diversity of the workforce, performance, the way it manages public money and the public benefits achieved through its activities. This will include how it protects those groups most at risk, whether in relation to geography, socio-economic characteristics, or clinical conditions.

UKHSA publishes regular data on operational performance areas for COVID-19, notably the fortnightly NHS Test and Trace statistics[14] and epidemiological data such as the national flu and COVID-19 surveillance reports.[15]

UKHSA will remain transparent and open in its reporting through the established governance processes that exist for executive agencies across government. DHSC sets out the government's priorities for the organisation in the annual remit letter. UKHSA is then accountable for its performance to the Secretary of State for Health and Social Care, who, in turn, is responsible for accounting to Parliament for the Agency's performance.

[14] **Weekly statistics for NHS Test and Trace (England)** – GOV.UK *(https://www.gov.uk/government/collections/nhs-test-and-trace-statistics-england-weekly-reports)*
[15] **National flu and COVID-19 surveillance reports: 2021 to 2022 season** – GOV.UK *(https://www.gov.uk/government/statistics/national-flu-and-covid-19-surveillance-reports-2021-to-2022-season)*

Social care

22. **Planning for future pandemics should have a more developed and explicit consideration of the intense interaction between the NHS and social care. The prominence of social care within the Department of Health and Social Care should be enhanced and Ministers must address the relative lack of knowledge and experience of social care within the Department and senior levels of the NHS. The Department should ensure that future policy and guidance relating to the sector is well-informed and reflects the diversity of the sector. The Department must also set out how it plans to retain the expertise of the Social Care Taskforce on a more permanent basis.**

The government partially accepts this recommendation.

Preparations within adult social care have been, and will continue to be, an integral component of the government's pandemic preparedness agenda.

The capability and capacity of the Social Care Group within DHSC has grown since early 2020, now having a dedicated Director General to lead its work. A Chief Nurse for Adult Social Care was also appointed in December 2020 to provide professional leadership to the workforce as well as providing professional advice across the sector and raising the status and standards of social care nursing. The COVID-19 Social Care dashboard was launched on 22 October 2020 as a single point of information to support local, regional, and national government to understand where infection is taking place and to ascertain rapidly the measures being implemented to reduce it. As part of the 'Adult Social Care Winter Plan 2020 to 2021'[16] the Department set up a Regional Assurance Team, comprising people with significant experience within the adult social care sector, who provide direct engagement between DHSC and regional stakeholders.

COVID-19 guidance for adult social care is reviewed in consultation with UKHSA, and other partners and providers to ensure guidance for the sector is clear, understandable, and well-informed by sector partners. As guidance is updated, DHSC will continue to test it with end-users to ensure it better equips care providers, care workers, commissioners, and care recipients.

The Social Care Sector COVID-19 Taskforce, chaired by Sir David Pearson, formed an important part of DHSC's response to COVID-19 in the social care sector. Its remit was to ensure the delivery of the measures outlined in the government's 'Social Care

[16] **Adult social care: our COVID-19 winter plan 2020 to 2021** – GOV.UK *(https://www.gov.uk/government/publications/adult-social-care-coronavirus-covid-19-winter-plan-2020-to-2021/adult-social-care-our-covid-19-winter-plan-2020-to-2021)*

Action Plan'[17] (April 2020) and 'Care Home Support Package'[18] (May 2020); the latter was supported by the £600 million Infection Control Fund.

The Taskforce played an important part in ensuring DHSC did all it could to reduce the risk of transmission of COVID-19 in the sector, both for those who rely on care and support and for the social care workforce, and it ensured preparedness for the second wave of COVID-19. The Taskforce ran until the end of August 2020 and reported on its findings and recommendations[19] in September 2020, which helped shape the 'Adult Social Care Winter Plan 2020 to 2021'.

The Taskforce's successor, the Social Care COVID-19 Stakeholder Group also chaired by Sir David Pearson, undertook a review of the 2020 to 2021 winter plan, and made 33 recommendations, which were incorporated by the Department in the subsequent Adult Social Care Winter Plan 2021 to 2022,[20] which provided a response to each of the recommendations in its annex. Those findings and recommendations that the Taskforce and subsequent Stakeholder Group made that were not fully reflected in the Winter Plan 2021 to 2022 have helped shape DHSC's planning for the future.

DHSC worked closely with the NHS to ensure that its 'Adult Social Care Winter Plan 2021 to 2022' was co-ordinated and integrated. The plan, published on 3 November 2021, focused not just on COVID-19, but also on other viruses such as flu and norovirus, to ensure that those who receive social care were protected over the winter.

DHSC does not currently plan to re-instate the Taskforce. However, DHSC continues to work with all organisations represented on the Taskforce, who advise and support delivery of DHSC policy. DHSC's stakeholders have been instrumental in shaping guidance that seeks to enable people to live as safely as possible, whilst maintaining contacts and activity that enhance the health and wellbeing of service users and their family carers.

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[17] **Coronavirus (COVID-19): adult social care action plan** – GOV.UK *(https://www.gov.uk/government/publications/coronavirus-covid-19-adult-social-care-action-plan)*

[18] **Care home support package** – GOV.UK *(https://www.gov.uk/government/publications/coronavirus-covid-19-support-for-care-homes/coronavirus-covid-19-care-home-support-package)*

[19] **Social care sector Covid-19 support taskforce report on first phase of the pandemic** – GOV.UK *(https://www.gov.uk/government/publications/social-care-sector-covid-19-support-taskforce-report-on-first-phase-of-covid-19-pandemic)*

[20] **Adult social care: COVID-19 winter plan 2021 to 2022** – GOV.UK *(https://www.gov.uk/government/publications/adult-social-care-coronavirus-covid-19-winter-plan-2021-to-2022/adult-social-care-covid-19-winter-plan-2021-to-2022)*

23. Long term reform of social care is overdue and should be pursued as a matter of urgency. The government's recent announcement on the future of social care is welcome, but the long-term future of the sector remains unresolved. We endorse the Health and Social Care Committee's call for a 10 Year Plan for Social Care to accompany the 10 Year Plan for the NHS. It must ensure that there is parity between the health and care sectors so that social care is given proper priority in a future crisis.

The government accepts this recommendation.

In September 2021, the government announced that it would be investing an additional £5.4 billion over three years to begin a comprehensive programme of reform for adult social care. Then, in December 2021, it published its adult social care reform white paper, 'People at the Heart of Care',[21] which set out its 10-year vision for adult social care and outlined its priorities for investment over the next three years.

The £5.4 billion investment over three years – building on measures in the Health and Care Act – includes £3.6 billion to reform the social care charging system and enable all local authorities to move towards paying providers a fair cost of care; and a further £1.7 billion to begin major improvements across adult social care in England.

The government's ten-year reform vision puts people at the centre of social care and will ensure that people have choice, control, and support to live independent lives; can access outstanding quality and tailored care and support, and find adult social care fair and accessible. The measures set out in the white paper will bring tangible benefit to the lives of people who draw on care, their families, and their carers. Over the three years from April 2022, there is funding for: a new £300 million investment in housing; £150 million of additional funding to improve technology and increase digitisation across social care; a £500 million investment in the workforce; a £5 million investment to pilot new ways to help people understand and access the care and support available; a £25 million investment to work with the sector to kickstart a change in the services provided to support unpaid carers; and more than £70 million to increase the support offer across adult social care to improve the delivery of care and support services.

[21] **People at the Heart of Care: adult social care reform white paper** – GOV.UK *(https://www.gov.uk/government/publications/people-at-the-heart-of-care-adult-social-care-reform-white-paper)*

Implementation of the government's 'Health and social care integration' white paper, published in February 2022,[22] will help improve the quality and experience of care for individual patients, service users and carers, as well as outcomes for local populations.

Building on the Health and Care Act 2022, the white paper sets out to bring NHS and local government closer together to join up health and social care services through the design of a shared outcomes framework, with a single accountable person who will be responsible for the delivery of these shared outcomes including shared health and care plans for people locally.

It also sets out the actions the government will take, working with key partners, to make progress across the key enablers of integration including workforce, data and technology, financial pooling and alignment, oversight and leadership to make integrated health and social care a reality for everyone across England.

24. We endorse the Health and Social Care Committee's call for additional resources to be directed to social care. That Committee has made the case for an increase of £7 billion a year by 2023/4. We note that despite the government's recent announcement the level of new investment in social care from 2023/24 remains unclear.

The government notes the Committees' endorsement of its approach.

The government has announced a range of funding for social care over the next three years, both to address core pressures facing the sector, and to kickstart a programme of reform. The new funding announced for the Spending Review (SR) period (financial years 2022 to 2023 to 2024 to 2025) will reform the social care charging system, enable local authorities to move towards paying providers a fair rate of care, and make improvements to the adult social care system.

On 7 September 2021, the government announced significant investment in health and social care of around £13 billion per year on average across the UK as part of the 'Build Back Better' plan, funded by a new Health and Social Care Levy from April 2022.

This included a commitment to invest £5.4 billion over three years in adult social care reform, starting in 2022 to 2023. Over £3.6 billion will be available to reform the social care charging system, including £1.4 billion to enable all local authorities to move towards paying providers a fair rate for care. More than £1.7 billion will be made available to improve the adult social care system in England.

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[22] **Health and social care integration: joining up care for people, places and populations** – GOV.UK *(https://www.gov.uk/government/publications/health-and-social-care-integration-joining-up-care-for-people-places-and-populations)*

The adult social care white paper, 'People at the Heart of Care', published on 1 December 2021,[23] sets out more detail and describes the government's priorities for investment with initial funding commitments. The white paper states that beyond the next three years, an increasing share of funding raised by the levy will be spent on social care in England.

The Local Government Finance Settlement for 2022 to 2023 makes available an additional £3.7 billion to councils. This will ensure councils across the country have the resources they need to deliver key services and respond effectively to the core pressures facing the adult social care sector, which include rising demographic and unit cost pressures.

As part of this settlement, local authorities can make use of over £1 billion of additional resource specifically for social care in 2022 to 2023. This includes the increase in Social Care Grant and the improved Better Care Fund, a 1% adult social care precept and deferred flexibilities from last year's settlement.

For many councils, the provision of social care for adults and children are key priorities and the largest areas of spending. Councils are not expected to rely solely on this earmarked funding to meet the inflationary and demographic pressures facing these services; they also have access to funding from unringfenced grants, including the 2022 to 2023 Services Grant, and from Council Tax.

[23] **People at the Heart of Care: adult social care reform white paper** – GOV.UK *(https://www.gov.uk/government/publications/people-at-the-heart-of-care-adult-social-care-reform-white-paper)*

25. The government should review the provision of infection prevention and control measures, including infection prevention and control nurses, to social care and ensure that social care providers, particularly care homes, are able to conduct regular pandemic preparedness drills. The government must ensure that care homes have isolation facilities and social care providers are able to provide safe visiting for family and friends of care home residents.

The government partially accepts this recommendation.

IPC is a core part of delivering adult social care. Guidance has been updated throughout the pandemic to reflect the importance of IPC, and DHSC published updated IPC guidance on 31 March 2022[24] to set out the next phase of the response in adult social care. The updated 'Every Action Counts'[25] toolkit was published in March 2021, which provides a suite of resources for care homes and visitors to support the delivery of infection prevention and control. A wide range of training on IPC is available to the sector.

On 11 November 2021, DHSC launched the IPC Champions Network for Adult Social Care, led by the Chief Nurse for Adult Social Care. To accompany this launch, DHSC created a Good Practice Guide detailing examples of IPC measures and best practice across various care settings.

The government undertakes exercises regularly, both at a national and local level, as they are an essential part of assessing both its pandemic preparedness and its planning for a wide range of scenarios. The lessons learned from exercises and incidents are integrated into the government's preparedness plans. For example, 2016's Exercise Cygnus was a Tier 1 national exercise that considered the implications of responding to an influenza pandemic, the highest-rated risk on the NRR. The lessons learned from Exercise Cygnus informed a workplan that was taken forward across government by the Pandemic Flu Readiness Board. Specific guidance for local resilience forums on preparations for a pandemic is published online.[26] While there is no expectation that individual care homes will need to conduct regular pandemic preparedness drills, local authorities will need to satisfy themselves and work with local providers to ensure they are appropriately undertaking contingency and business continuity planning.

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[24] **Infection prevention and control: resource for adult social care** – GOV.UK *(https://www.gov.uk/government/publications/infection-prevention-and-control-in-adult-social-care-settings/infection-prevention-and-control-resource-for-adult-social-care)*

[25] **Every Action Counts Toolkit** – CARE *(https://www.skillsforcare.org.uk/resources/documents/Developing-your-workforce/Care-topics/Infection-prevention-and-control/Every-Action-Counts/Every-Action-Counts-Toolkit.pdf)*

[26] **National Resilience Standards for Local Resilience Forums** – GOV.UK *(https://www.gov.uk/government/publications/national-resilience-standards-for-local-resilience-forums-lrfs)*

DHSC provides guidance on isolation in care homes, however this does not explicitly mean care homes must have dedicated isolation facilities, as this may not always be practical given the variation in layout and facilities within these settings.

Designated settings were set up to ensure that, during the peak of the pandemic, no COVID-positive patient would be discharged into a care home; rather they would go to a designated setting that would provide appropriate care throughout their period of isolation before they could be safely transferred to a care home. Designated settings played an important role during the second wave of the pandemic in helping to prevent the incursion of COVID-19 infection into care homes. Over the summer of 2021, DHSC conducted a review of designated settings policy with key stakeholders, including the Care Quality Commission (CQC), the Local Government Association, sector representative organisations, and individual providers, as part of its preparations for winter. Their feedback informed the policy direction for designated settings, ensuring that the scheme met local needs.

Funding for designated settings and the Designated Settings Indemnity Support Scheme was in place until 31 March 2022. Updated IPC guidance now outlines that care homes can admit residents discharged from hospital who have tested positive for COVID-19, if the home is satisfied that they can care for them safely. The guidance also outlines that those who have tested positive should be isolated from other residents and, where possible, have separate staff dedicated to their care.

DHSC's visiting guidance (incorporated into the IPC guidance published on 31 March 2022) also provides detail on how providers can enable safe visiting, including: lateral flow testing visitors carrying out personal care (up to twice weekly); twice weekly lateral flow testing of care staff; guidance on appropriate use of PPE, and guidance on IPC measures such as hand hygiene, ventilation, and distancing from other residents. The guidance makes it clear that visiting is crucial to residents' wellbeing and mental and physical health, and that visiting should be supported in all circumstances.

Clinical advice is regularly reviewed, and guidance updated to reflect the latest advice. As care recipients in adult social care remain at greater risk of hospitalisation and death from COVID-19 relative to the general population, and as the transmission risk remains high in vulnerable settings due to the close-contact care individuals receive, some protections remain in place for those in adult social care settings. The government has carefully reviewed measures in adult social care settings where staff care for the most vulnerable in society in the context of the 'Living with COVID-19' approach. The updated position was set out in guidance published on 31 March 2022 and updated on 3 May 2022. The government will continue to keep guidance under review to ensure it is proportionate to the threat to care home residents from COVID-19, based on the latest scientific advice.

At risk communities

26. The government should ensure its 'levelling up' agenda includes specific policies to reduce health inequalities, with a particular focus on ensuring that certain groups, including people from Black, Asian and minority ethnic backgrounds, do not continue to face unequal health outcomes.

The government accepts this recommendation.

The government is looking holistically at how recovery for ethnic minority groups and underlying disparities can be tackled in the longer term through the Levelling Up agenda and the newly formed Office for Health Improvement and Disparities (OHID).

Launched on 1 October 2021, OHID is systematically tackling the top preventable risk factors such as smoking and obesity, improving the public's health and narrowing health disparities. The Office is working with other government departments, local government and the NHS and with industry to drive change on the drivers and determinants of ill health and health disparities. Alongside the launch of OHID, the government has launched the Health Promotion Taskforce to drive cross-government action on the causes of ill health, in recognition of the fact the drivers of ill health are broad and complex, requiring concerted action beyond the health system.

Wide-ranging interventions have been implemented to minimise the unequal impacts of COVID-19 on disadvantaged groups including ethnic minorities. These have been summarised in the Minister for Equalities' quarterly reports to the Prime Minister, and the final report was published in December 2021 which made a series of recommendations for the government and which the Prime Minister accepted in full.[27]

In the short-term, and in close partnership with local authorities who know their communities best, the government has:

- Provided COVID-19 related guidance to improve health outcomes for at-risk groups, translated government messaging into a range of languages and accessible formats, and worked with 43 ethnic minority TV channels and stakeholders to share vital information.

- Invested in research to improve understanding of the unequal health impacts of COVID-19 across society.

[27] **Final report on progress to address COVID-19 health inequalities** – GOV.UK *(https://www.gov.uk/government/publications/final-report-on-progress-to-address-covid-19-health-inequalities/final-report-on-progress-to-address-covid-19-health-inequalities)*

- Ensured that self-isolation support remains in place for those in occupations where they are financially unable to self-isolate.

- Developed targeted measures to encourage ethnic minority uptake of both testing and vaccination through culturally sensitive campaigns to address misinformation and disseminate information. In addition, local authorities could flex delivery models to respond to differing local circumstances. For example:

    - The Community Champions scheme, which has supported grassroots action, using trusted local voices to deliver public health messaging and encourage vaccine uptake. The Community Vaccine Champions scheme was launched in December 2021 with a further £22.5 million of funding.[28]

    - The targeted community testing programme, which backs local authorities to reach and support disproportionately impacted and underserved groups by delivering hyper-local, targeted asymptomatic testing using innovative and agile approaches that reach into the heart of communities.

Since the beginning of the pandemic, the NHS has also accelerated its preventative health programmes which proactively engage those at greatest risk of poorer health outcomes to address health inequalities including better targeting of long-term conditions and prevention programmes such as obesity reduction, tackling smoking and diabetes.

The government is determined to tackle healthcare inequality and improve access to health services. Improving public health and wellbeing is a critical part of levelling up, which will improve public health services by enhancing prevention services and reversing health inequalities. The 'Levelling Up the United Kingdom' white paper contains further details of how this will be achieved.

In March 2022, the government's response to the report by the Commission on Race and Ethnic Disparities[29] 'Inclusive Britain'[30] set out a ground-breaking action plan to

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[28] **£22.5m of funding announced in new community push to get nation boosted now** – GOV.UK *(https://www.gov.uk/government/news/225m-of-funding-announced-in-new-community-push-to-get-nation-boosted-now)*

[29] **Report of the Commission on Race and Ethnic Disparities** – GOV.UK *(https://www.gov.uk/government/publications/the-report-of-the-commission-on-race-and-ethnic-disparities)*

[30] **Inclusive Britain: government response to the Commission on Race and Ethnic Disparities** – GOV.UK *(https://www.gov.uk/government/publications/inclusive-britain-action-plan-government-response-to-the-commission-on-race-and-ethnic-disparities)*

tackle negative disparities, promote unity and build a fairer Britain for all. Among the 74 actions in the plan are a number of measures to tackle health disparities.

27. **It is essential that in any future crisis, NHS staff from Black, Asian and minority ethnic backgrounds are included in emergency planning and decision-making structures. NHS England should accelerate efforts to ensure that NHS leadership in every trust, foundation trust and Clinical Commissioning Group is representative of the overall Black, Asian and ethnic minority workforce.**

28. **Leadership in NHS England and Improvement should also increase their engagement with Black, Asian and minority ethnic worker organisations and trade unions to ensure that Black, Asian and minority ethnic members of staff feel valued by the organisation, are involved in decision-making processes and feel able to speak up when they are not being protected.**

The government accepts these recommendations.

The proportion of staff in senior leadership roles in the NHS in England who are from an ethnic minority background has accelerated due to targeted action on recruitment and retention of staff from ethnic minority backgrounds, standing currently at 9.2%, (against a September 2021 target of 8%). NHS England is also developing ambitious targets for representation of women and disabled staff in senior leadership roles as part of the review of Long Term Plan commitments.

NHS England is committed to further ensuring that the NHS is representative of the communities it serves. It is delivering work in several areas to make sure that leadership structures are more diverse and representative. To support these efforts, NHS England is working on the following:

- Focusing nationally on six high-impact actions to promote inclusive recruitment and promotion practices to advance ethnic minority representation at every level in Trusts and Integrated Care Systems (ICSs). In addition, for 2022 to 2023 there is a programme of work being developed to focus on other touchpoints within the recruitment pathway, including exploring how technology and innovation will help reduce recruitment turnaround time.

- The NHS England national Equality and Inclusion team has been closely involved in the ICS Chair and Chief Executive Officer, and Integrated Care Board (ICB) recruitment to ensure that ICS leadership is diverse, inclusive

and representative of the population it serves as well as its workforce and has been supporting ICBs with their recruitment process.

- The national Equality and Inclusion Team, in collaboration with a range of external and internal stakeholders, is developing the first workforce equality, diversity and inclusion (EDI) strategy for the NHS expected in 2022 to 2023. The objective of the strategy will provide clear actions for systems and employers to improve equality across all protected characteristics and staff groups in the NHS, including a focus on intersectionality. This will ally to the provision of organisational level equality and inclusion data so that organisations can both see where their local challenges lie as well as have a resource to develop a bespoke action plan.

- Providing each Trust and system with bespoke organisational level workforce race equality standard (WRES) data reports to identify opportunities for improvement in workforce equity and equality at a Trust and ICS level. This approach is linked to engagement with systems and regions to ensure that these opportunities are realised and that information on 'what works' is shared widely. Similar reports are expected to be developed for WRES in the next annual reporting cycle.

Ensuring that ethnic minority members of staff feel valued in the workplace, both in terms of decision-making and freedom to speak up, is integral to the NHS People Promise. The ambition is that NHS staff will not just have a voice, but an active stake in the way their work and organisation is run. Examples of ongoing work to achieve this include:

- Following the 2020 People Plan, which identified the importance of additional support for ethnic minority colleagues to speak up, a series of WRES training programmes specifically for Freedom to Speak Up Guardians, is being rolled out this year. To further support members of staff from ethnic minority backgrounds of staff, a specific inclusive and EDI-focused Health and Wellbeing offer is being developed, in addition to the aspects of the current offer specifically tailored for staff from people from ethnic minority backgrounds. NHS England also has in train a range of work at a national level that looks to support colleagues from ethnic minority backgrounds to speak up, and improve speaking up overall.

- NHS England continues to invest in developing and growing its ethnic minority staff networks. In 2021 to 2022, NHS England reached out to systems and Trusts to gain a baseline assessment of staff network maturity within their organisation, and are currently developing a Staff Network Maturity Framework to provide systems with an insight into actions that they can take to improve and embed effective and empowered staff networks.

NHS England is also working on introducing a Staff Network Chair development programme, drawing on positive practice, to ensure that staff networks continue developing consistently and providing an equitable experience for staff from ethnic minority backgrounds. It is also working with Trust and ICS leaders on how they can formalise staff networks as part of local decision-making processes. Work is in train with organisations like the Seacole Group and the Disabled NHS Directors Network in order to identify and develop talent to improve board representation of under-represented groups.

29. It is unacceptable that staff from Black, Asian and minority ethnic communities did not have equal levels of access to appropriate and useable personal protective equipment as their white colleagues during the pandemic. The government must learn from the initial shortage of appropriate PPE for these staff and set out a strategy to secure a supply

The government accepts the recommendation to set out a strategy to secure a supply of appropriate PPE that works for all staff in the NHS and care sectors. These findings are in line with Recommendation 5 in the Public Accounts Committee report 'COVID-19: Government procurement and supply of personal protective equipment',[31] which has been implemented.

The government expects that PPE should be distributed fairly to all health and care workers. The global pandemic created significant logistical challenges. Despite these challenges, as of 31 March 2022 19.8 billion items had been delivered to help protect frontline workers. The government acknowledges that in the early stages of the pandemic there were points where stock in certain areas was extremely low but as the National Audit Office's report, 'The Supply of PPE during the COVID-19 Pandemic'[32] recognised, "all of the NHS providers they spoke to were always able to get what they needed in time."

While the government does not accept that staff from ethnic minority backgrounds had unequal access to the correct PPE, it acknowledges that some ethnic minority staff may have had difficulty with the fit of some items of PPE. The following steps have been taken to identify and respond to the diverse needs of the health and social care workforce in the supply and distribution of appropriate PPE:

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[31] **COVID-19: Government procurement and supply of personal protective equipment** – www.parliament.uk *(https://publications.parliament.uk/pa/cm5801/cmselect/cmpubacc/928/92802.htm)*

[32] **The supply of personal protective equipment (PPE) during the COVID-19 pandemic** – NAO *(https://www.nao.org.uk/report/supplying-the-nhs-and-adult-social-care-sector-with-personal-protective-equipment-ppe/)*

- Customer engagement panels have been established through which staff groups with protected characteristics, including those from different ethnic backgrounds, are engaged in discussions on their experiences of using PPE. Several issues raised have now been addressed, and their experiences are already being incorporated into future PPE provision.

- One issue raised centred on staff from different ethnic backgrounds reporting difficulties with FFP3 masks fitting correctly. Having an appropriately fitting mask is essential for effective protection. A further eight types of mask are available, and over 16 different models are supplied, providing a portfolio of different shapes and sizes of mask to cater to a diverse range of users of PPE.

- Alongside supply of FFP3 masks, NHS Trusts and staff are supported with fit testing. Since November 2020, over 220 fit testers have been recruited and trained to Health and Safety Executive standards. Over 100,000 tests have been completed so far with a current pass rate of over 80% on the range of masks currently available. Data indicates that there is now a good fit-test performance achieved across protected characteristics, including ethnicity. Positive feedback has been received from NHS Trusts and staff about the effectiveness of this support.

- In March 2021, a Cabinet Office COVID-19 Taskforce Field Team undertook engagement with health and social care workers, including those from different ethnic minority backgrounds, to better understand their experiences of PPE. The outcomes broadly confirmed that the actions already taken to address their PPE needs are the right ones in particular, on ensuring access to appropriate fitting PPE.

The government remains committed to learning the lessons from the pandemic, particularly in relation to the experience of health and care staff with different protected characteristics, and wants to continue to build an integrated and resilient PPE supply chain which is informed by the needs of frontline staff.

30. The NHS, local authorities and the government should ensure that health advice during the remainder of the pandemic and in any future emergencies should be available in a full range of languages, and that outreach programmes should reflect what is most effective in the cultural context of different communities.

The government accepts this recommendation.

UKHSA is committed to providing accessible health advice which recognises the different cultural contexts in different communities. During the pandemic the government has:

- Made the NHS COVID-19 App accessible to those with language and disability requirements.
- Provided accessible services to those without internet access via 119.
- Ensured those with visual or hearing impairments can access testing via the Be-My-Eyes app and British Sign Language (BSL) services through 119.
- Provided verbal translation services in more than 200 languages via 119.
- Translated guidance in a range of languages; for example, all COVID-19 vaccination programme guidance, including leaflets, posters, and social media assets, were made available in 27 languages.
- Ensured vaccine information is accessible, for example by providing versions in Braille, BSL, videos, and large print. Easy read resources are also available for individuals with low literacy or a learning disability.
- Provided online access to easy read PCR self-testing instructions in English and 12 other languages, including Welsh.
- Worked through local and trusted services and community leaders by training up 'Community Champions' to disseminate advice, counter misinformation and ensure testing sites are placed in communities at higher risk.
- Organised monthly webinars for community organisations as well as faith and voluntary sector leaders to share information and provide access to resources.

As the government plans for the future, it will ensure that lessons learned during the pandemic are built on to ensure that in any future emergency as many people as possible are reached.

31. In planning for future health emergencies, the Department of Health and Social Care and the NHS should consider the specific difficulties faced by people with learning disabilities and their families and recognise the barriers to understanding and communication which, if not overcome, can lead to avoidable deaths of vulnerable people.

The government accepts this recommendation and recognises the importance of considering the specific needs of people with a learning disability, autistic people, and their families in health emergencies.

Throughout the pandemic, a range of measures has been put in place to ensure people with a learning disability and autistic people are protected from the worst outcomes of COVID-19, including adding adults with Down's syndrome to the group considered to be clinically extremely vulnerable. Access to testing in care homes was increased, regular retesting launched in high-risk supported living settings, and new guidance published on regular testing for their home care (domiciliary care) staff. NHS England and NHS Improvement also introduced 'blended' annual health checks, enabling general practitioner (GP) and practice support to continue during the pandemic, with both virtual and face to face appointments (when safe to do so) for people with a learning disability.

The government recognises the importance of enabling effective communication with people with a learning disability and autistic people. It is vital that public information on COVID-19 is accessible to all, which is why the government is committed to improving key COVID-related communications in a way that is accessible and inclusive. Progress in this area means that important health communications, for example regarding COVID-19 symptoms, Stay Alert and NHS Test and Trace content, are available in alternative formats, including easy read, BSL and audio. The government has welcomed many partnerships, including with disability organisations, that have helped to disseminate critical messages and advice.

DHSC is working in partnership with the Cabinet Office Disability Unit who are considering cross-government guidance on producing alternative formats.

Throughout the pandemic, the NHS has given guidance and support to local systems about the importance of supporting good communication and reasonable adjustments to care. This includes specific guidance for frontline staff on effective support for people with a learning disability and autistic people; delivery of online Care (Education) and Treatment Reviews; reasonable adjustments in hospital visiting; and information and training resources for vaccinators about how to make reasonable adjustments (for example vaccinating the person and their carer at the same time).

A co-production group within NHS England has worked to develop easy read and accessible COVID-19 resources for people with a learning disability and autistic

people. This has included easy read vaccination invite letters; accessible information sheets; and guidance and films on the virus, the risks, advice to keep safe and the importance of getting a vaccination.

DHSC continues to engage with stakeholders to discuss issues for people with a learning disability and autistic people in relation to COVID-19.

The inappropriate use of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions in relation to some people with a learning disability has been consistently challenged by the government and the NHS including, in Autumn 2020, an expectation that GPs would review all the DNACPRs in place for their patients with a learning disability to ensure that they were appropriate.

Throughout the pandemic, letters have been issued to the system from Senior NHS England leaders on this issue highlighting the inappropriateness of blanket approaches to DNACPR. At the start of the pandemic, the National Medical Director and the Chief Nurse issued a letter[33] to the system reminding leaders of the importance of discussing patients' individual wishes particularly in regard to DNACPR.

The government commissioned the Royal College of Physicians to develop, in conjunction with the Society of Acute Medicine, an acute care toolkit. This was published on 1 April 2022 with the aim of supporting clinical staff in acute care settings to engage with and treat people with a learning disability and autistic people, ensuring that their needs are met.[34]

32. The NHS should improve the data it holds on people with learning disabilities so that this group of patients can be more appropriately considered for vaccination.

The government accepts this recommendation.

The government agrees it is important to ensure there are accurate and comprehensive data on people with a learning disability to inform policy and support action such as vaccination.

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[33] **Maintaining standards and quality of care in pressurised circumstances: Letter from Professor Stephen Powis and Ruth May** – nhs.uk *(https://www.england.nhs.uk/coronavirus/publication/maintaining-standards-pressurised-circumstances/)*

[34] **Acute care toolkit 16: Acute medical care for people with a learning disability** – Royal College of Physicians *(https://www.rcp.ac.uk/projects/outputs/acute-care-toolkit-16-acute-medical-care-people-learning-disability)*

People with a learning disability can ask their GP to add them to their GP Learning Disability Register. NHS guidance for primary care supports the identification of people with a learning disability.[35] The guidance includes a list of clinical diagnoses that should automatically ensure a patient is included on the Learning Disability Register.

In addition, anyone providing unpaid care who is not already known to their local health and care services can ask their GP to record them as a carer on their GP record.

The 'Learning from lives and deaths – People with a learning disability and autistic people' (LeDeR) programme provides the largest body of evidence of deaths of people with a learning disability at an individual level anywhere in the world. The primary aim of the programme is to improve services for people with a learning disability and reduce the inequality in life expectancy between people with a learning disability, and those without.

The most recent annual LeDeR report identified that, for people aged 18-49, there was an increased likelihood of dying if they had not had an annual health check in the year prior to death. The NHS Long Term Plan set an ambition that by 2023 to 2024, at least 75% of people on a GP Learning Disability Register receive an annual health check. In 2020 to 2021, 71.3% of those eligible for an annual health check had received one.

Annual health checks are available to everyone on the Learning Disability Register aged 14 and over to maintain their health. This can identify undetected health conditions early and ensure the appropriateness of ongoing treatments. By identifying concerns early and ensuring that long term conditions are managed appropriately, it can help to reduce health inequalities and ensure that people with a learning disability receive the right care.

33. The NHS should ensure the guidance on DNACPR notices is clear and properly understood by healthcare professionals and individuals, especially in circumstances where a patient's carer or advocate may not be able to be present in hospital.

The government accepts this recommendation and recognises the importance of ensuring guidance on DNACPR decisions is clear and properly understood by all health and social care professionals as well as the patients involved.

The recommendation aligns well with the work already being carried out by the Ministerial Oversight Group on DNACPR decisions, which was established following

[35] **Improving identification of people with a learning disability guidance for general practice** – nhs.uk *(https://www.england.nhs.uk/publication/improving-identification-of-people-with-a-learning-disability-guidance-for-general-practice/)*

the CQC's report 'Protect, respect, connect – decisions about living and dying well during COVID-19'.[36] The government welcomed the recommendations of this report and the Ministerial Oversight Group.

DHSC will continue to work with partners to ensure system-wide guidance on DNACPR is clear and properly understood in all settings, particularly by those patients who may not have a carer or advocate present or need reasonable adjustments to remove communication barriers. This includes NHS England and NHS Improvement, HEE, NHSX, Skills for Care, the British Medical Association, the GMC and many other partners across health, social care, local government, voluntary and community services.

A key outcome of this partnership working are the Universal Principles for Advance Care Planning which were published in March 2022.[37] These principles will be adapted across health and care settings to consider different groups of people, ensuring every person understands and feels involved in their advance care plans. In addition, NHS England and NHS Improvement have published patient facing guidance on DNACPR on nhs.uk[38] setting out how DNACPR decisions should be made and how individuals or their families can get support if they have concerns about a DNACPR decision.

[36] **Protect, respect, connect – decisions about living and dying well during COVID-19** – CQC *(https://www.cqc.org.uk/publications/themed-work/protect-respect-connect-decisions-about-living-dying-well-during-covid-19)*
[37] **Universal Principles for Advance Care Planning (ACP)** – nhs.uk *(https://www.england.nhs.uk/publication/universal-principles-for-advance-care-planning/)*
[38] **Do not attempt cardiopulmonary resuscitation (DNACPR) decisions** – nhs.uk *(https://nhs.uk/conditions/do-not-attempt-cardiopulmonary-resuscitation-dnacpr-decisions/)*

Vaccines

34. It is essential that support for, and investment in, the UK science base is protected and enhanced. This should include delivering the government commitment from Budget 2020 and the 2021 R&D roadmap to invest £22 billion per year in R&D by 2024/25. Science has saved the world from the even greater catastrophe of COVID-19 without the defence of vaccines. The experience should alert us to the risk of unforeseen threats against which a world-class and experienced scientific capability is the best investment.

The government partially accepts this recommendation.

The government is increasing investment in research and development (R&D) to record levels. At the Autumn Budget 2021, the Chancellor announced the fastest ever sustained uplift in R&D funding, increasing to £20 billion per annum by the end of the SR period. This settlement will make significant progress towards the government's ambition to increase R&D spending to £22 billion by 2026 to 2027 and help drive economy-wide R&D investment to 2.4% of gross domestic product (GDP) in 2027. This represents a significant uplift against one of the most challenging fiscal positions of the last century and provides certainty to R&D partners for the next three years. It will help the whole R&D sector plan ahead, which will be particularly welcome given recent fiscal challenges arising from COVID-19.

The R&D funding announced at this SR represents an increase of around a quarter in real terms: the largest ever over an SR period. The funding will enable the country's world-renowned research base to continue developing pioneering innovations, such as the Oxford/AstraZeneca vaccine, and support the UK to build back better from COVID-19. The UK's ambitious R&D investment plans, combined with its system of generous R&D tax reliefs, will also give businesses the confidence to invest following the pandemic. Private sector investment must be leveraged to reach economy wide R&D investment of 2.4% of GDP in 2027, and to accelerate innovation across UK science and research.

The COVID-19 pandemic has highlighted the importance of R&D investment, and the government is committed to learning from that experience. This multi-year settlement will enable the UK science base to better prepare against some of the world's most pressing threats, from cyber security to AMR. The government's support of the UK Innovation and Science Seed Fund, for example, has led to innovations in AMR diagnostic techniques, so patients are prescribed antibiotics when they genuinely need them. Although the UK is already a world-leader in the fight against global threats due to its excellent science and research community, the government is not complacent. This record increase of public R&D investment announced in the Autumn Budget 2021 demonstrates the government's commitment to protecting the UK's position.

35. **A strategic approach should be taken to manufacturing vaccines. The Life Sciences Industrial Strategy identified vaccine manufacturing as an area in which the UK could and should be stronger and set out deliberately to act on this by creating the Vaccine Manufacturing Innovation Centre. Looking forward and comparing future opportunities and threats against current capability and acting to resolve them is a responsible approach.**

The government accepts this recommendation.

Domestically, the government has invested over £395 million to secure and scale up the UK's manufacturing capabilities to ensure a robust response to the current pandemic as well as longer-term resilience. This has included investments such as manufacturing at risk at a rapid deployment facility established at Oxford Biomedica, securing finish capacity at Wockhardt, and supporting skills training through the Advanced Therapies Skills Training Network.

The government continues to explore further opportunities to strengthen UK resilience for the COVID-19 response and future health emergency events. Leveraging academic, clinical, and regulatory expertise to secure new inward investment into UK vaccine development, production capacity, key materials, and services will be a key part of the government's strategy going forwards.

36. **The Vaccine Taskforce model of forming flexible teams outside of the usual Whitehall administration, but working with it, and comprising people with outside expertise working within it, is a successful one. It should be considered for delivering other government priorities. However, it is concerning to hear that the Vaccine Taskforce model is being eroded by incorporation into "the normal entropy process of Whitehall", and this erosion should be arrested. The procurement model deployed by the Vaccine Taskforce of making decisions at risk, outside conventional procurement procedures, proved highly effective. Lessons from this success should be applied to other areas of government procurement.**

The government partially accepts this recommendation.

It should be noted that the Vaccine Taskforce (VTF) was formed firmly within the Whitehall administration, exemplifying a multidisciplinary approach that drew together staff from a variety of backgrounds including military secondees, external secondees with industry expertise, and independent contractors, to achieve its aims. The strong partnership between government, academia, clinical experts, and industry was central to the UK's success in working at speed to expedite and coordinate the efforts to research and procure successful COVID-19 vaccines.

By refining existing processes to ensure that Ministerial decision-making could be supported by good evidence in an agile way, as befitted the emergency that was faced, the VTF continues to deliver on the government priority of 'Fighting coronavirus: supporting business through the pandemic and recovery'.[39] Work is underway to ensure the lessons learned from the VTF's unique multidisciplinary and collaborative structure are captured and shared beyond the VTF. These lessons are valuable not only in helping ensure the government is better prepared for future health emergencies, but in exploring where else similar processes and learning might be of benefit.

37. The UK's regulatory system responded with rigour but flexibility. It could be that the approvals process and the conduct of clinical trials could have proceeded even more quickly, for example by making use of human challenge trials. This may not be appropriate in anything but the most exceptional circumstances—i.e. a deadly pandemic—but an assessment of this should be made now before such an occasion might arise.

The government partially accepts this recommendation.

The government's priority will always be to ensure patients have access to safe and effective medicines and clinical trials, and to ensure continued development of the country's world-leading life sciences sector. The Medicines and Healthcare products Regulatory Agency (MHRA) is proud of its fast and effective response to Covid-19 in processing vaccines submitted to it for approval in the shortest possible timeframes, while maintaining the excellent standards of assuring quality, safety, and efficacy. The MHRA's regulatory excellence was proven on a global scale as it was among the first Western regulators to approve a vaccine.

To support planning and preparations for future pandemics, MHRA will work to maintain this world-leading status by assessing its own lessons learned and looking to implement every possible measure to optimise this process in the event of future pandemics. Currently, human challenge trials do form part of the regulatory system where the challenge is well understood and characterised (for example in developing influenza or RSV vaccines). However, in the context of a deadly pandemic such as COVID-19, there exists the challenge of dealing with a virus of which the characteristics are relatively unknown. Employing such a strategy in this instance entails significant risk, both scientifically and ethically. Considerable work on this would be required in order to quantify, assess, and mitigate these risks before incorporating human challenge trials formally into the regulatory strategy for pandemic response.

[39] **BEIS Outcome Delivery Plan: 2021 to 2022** – GOV.UK *(https://www.gov.uk/government/publications/department-for-business-energy-and-industrial-strategy-outcome-delivery-plan/beis-outcome-delivery-plan-2021-to-2022)*

This is a matter that will continue to be considered as the pandemic preparedness strategy is developed.

38. The use of the Armed Forces—as well as civilian volunteer groups—proved effective in advancing the vaccine roll-out quickly and reliably. Protocols should be established to allow the Armed Forces quickly and at scale to participate, and the NHS should consider ways in which it can be more accommodating of volunteer support in normal times building on the experience and enthusiasm demonstrated during the pandemic.

The government does not accept this recommendation because it considers that protocols currently in place are fit for purpose.

Throughout the COVID-19 pandemic, MoD has provided an unprecedented level of support to the national response, completing over 440 deployments in support of civil authorities. Armed Forces personnel have assisted with tasks as varied as logistics and planning for the vaccine roll-out; mass testing and vaccination; and frontline healthcare support. During late 2021, for instance, more than 1,100 servicemen and women were made available to assist with accelerating the roll-out of COVID-19 booster vaccinations across England, Scotland and Wales.

The use of Armed Forces personnel and capabilities to support domestic resilience tasks and responses to crises is governed by the MACA process, as outlined in 'Joint Doctrine Publication 02: Operations: The Defence Contribution to Resilience and Security'. Under the MACA process, civil authorities are able to make requests for support from the Armed Forces in certain contexts.[40] These requests must be approved by a Minister in the requesting department of state and by a Defence Minister.

During the pandemic, MoD deployed SLOs across government and into the NHS to facilitate the provision of military advice at an early stage and help assist in the development of requests. This built upon the existing network of regionally based full-time JRLOs who engage with civil authorities at the operational level and who can provide advice and track potential signals of demand ahead of time.

The COVID-19 vaccines programme has also invested significant effort in setting up contingent staffing solutions to support the ongoing delivery of the programme. Since December 2020, St John Ambulance volunteers have provided over 26,000 volunteer vaccinators volunteering over 800,000 volunteering hours to the vaccine deployment

[40] **UK Operations: the Defence Contribution to Resilience** – GOV.UK *(https://www.gov.uk/government/publications/operations-in-the-uk-a-joint-doctrine-publication)*

programme. The response to Recommendation 7 above sets out further detail on volunteers.

Working with the charity, NHS England has supported rapid mobilisation of volunteers when there has been a need to increase vaccination activity. They have provided assistance through their mobile treatment vehicles to support roving and pop-up delivery of vaccines and continue to do so.

The vaccine deployment programme has worked with NHS Professionals to develop a new contingency staffing solution similar to the quick reaction forces. Vaccine operational support teams (VOST) were designed to be a fully staffed vaccine team that could be deployed within a geography. Regions and systems have been given the tools to commission VOST teams and work in partnership with NHS Professionals to deploy them, and there are currently 12 VOST teams ready across the country. The programme has also initiated work to ensure the long-term sustainability of the workforce solutions.

St John Ambulance has also provided similar styles of assistance to the wider health and care system through provision of volunteers in intensive care units and additional capacity to ambulance services. The government will explore developing a range of frameworks that regions and systems can draw upon to call on additional volunteering assistance.

The government has recognised the importance of reviewing vaccination site coverage with dedicated mapping services and has evolved this capability by making use of mapping tools.

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