



BMA Covid Review 4

The public health response by
UK governments to COVID-19

Executive Summary

How effectively did the UK governments manage their public health responses to the COVID-19 pandemic? This question has been at the forefront of the debate surrounding the virus and its impact across the country, with many now interrogating the decisions taken by the governments of the United Kingdom, Northern Ireland, Scotland, and Wales.

To help answer this question, in late 2021, the BMA conducted a call for evidence survey to set out the experience of the medical profession during the pandemic and to learn lessons for future pandemics. We found that widespread underfunding, coupled with poor decisions by governments, hindered the public health response, with the exception of the vaccination programme:

- Public health systems across the UK entered the pandemic without the resources, workforce, capacity, structures, or voice they needed to shape and influence governmental responses to COVID-19.
- The UK was slow to react to the emergence of COVID-19 globally, failing to respond to the increasingly clear threat posed by the virus in China and then Italy.
- Public health measures and interventions, such as the wearing of face coverings, were introduced too late and then removed too early to properly contain the spread of the virus, as well as often being inconsistently applied across the UK.
- Governments neglected to adopt precautionary principles in their planning, with a focus on relaxing restrictions hindering preparations for further spikes in cases, waves, or variants.
- National public health messaging and government communications were often incoherent and inconsistent, particularly in England. This undermined public understanding and confidence.
- Vaccination programmes across the UK have been remarkable successes and are a testament to the NHS staff that have delivered them. Yet, it must be remembered that vaccination does not prevent the continued spread of COVID-19 and cannot and should not be seen as having ended the pandemic.
- Dismantling of COVID-19 infrastructure across the UK – including the scaling back of public health services and testing capacity – is premature and jeopardises the response to any resurgence of the virus or, critically, preparedness for any future pandemic.

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Foreword



The COVID-19 pandemic plunged every area of society into crisis, forcing us all to take unprecedented steps to protect one another. The commitment of the public at large to rise to this challenge was remarkable and it is incredibly difficult to find fault in their response to the pandemic. Yet the same cannot universally be said of the four UK governments and their responses to the virus, which, despite patches of undeniably successful policymaking, are too often pockmarked with bouts of indecisiveness and inconsistency.

As evidence emerged from China and then Italy, it was increasingly clear that the virus posed an enormous risk, and that decisive action was needed. However, it took weeks upon weeks of deliberation before meaningful steps were taken and, in the end, a lockdown introduced.

A core characteristic of this period of inaction was a sense within governments that the UK public would be unwilling to tolerate restrictions on their lives for long, if at all. The speed with which this misconception was subsequently disproved not only lays bare critical deficiencies in the judgement of some of those governments – notably the UK Government, but also throws into sharp relief the dangerous absence of public health expertise at the highest levels of their pandemic planning.

This failure to place public health specialists at the heart of the UK-wide and nation-specific responses to COVID-19 has never truly been resolved and, ultimately, is the consequence of the way in which pre-pandemic public health services were structured and underfunded across the UK. Nowhere is this more apparent than in England, where the destabilising and damaging shockwaves of the 2012 Health and Social Care Act continue to reverberate throughout public health services, leaving them with neither the voice nor the resources they needed to sufficiently influence and shape government policies.

Likewise, the inability of the UK Government to properly grasp the public's willingness to act in the early stages of the pandemic was compounded by frequent missteps in communicating public health messages, new guidance, or rule changes to them. While aspects of the public communications campaign surrounding COVID-19 were clearly successful – I am certain that 'Stay home, protect the NHS, save lives' will remain seared into many of our minds for years to come – often they fell flat or, worse, sowed confusion and doubt.

This is not to say that the four UK governments failed in every aspect of the COVID-19 response. There have been clear and profound successes over the now more than two-year long battle with the virus. Most obviously, this includes the development and implementation of mass COVID-19 vaccination programmes, delivered by the NHS, which have, alongside other measures, helped limit its severity.

All of these issues – the pace of decision-making, the evidence and assumptions that informed policy development, the role of public health specialists, and the quality of public messaging – are essential to any review of government-led responses to COVID-19 and should be the key criteria upon which their efficacy is judged.

It is with these criteria in mind that this report assesses the public health measures introduced by the governments of the UK, Northern Ireland, Scotland, and Wales. It raises profound questions about the quality of those responses which must be put to each of the four governments in all independent inquiries into the COVID-19 response.

A handwritten signature in black ink, appearing to read 'Phil Banfield', with a long horizontal flourish extending to the right.

Phil Banfield, BMA council chair

Acknowledgments

We would like to thank everybody who responded to our survey detailing their experiences of the pandemic. The BMA understands the immense sacrifice that continues to be made by medical professionals. If you do not see any of the text from your response included in our reports, please do know that every response was read and used to inform our conclusions. We are very grateful indeed.

Our fourth COVID review report is the work of Tom Bramwell, Nathan Trotter, Isabelle McLaren, Claire Chivers, Margot Kuylén, Duncan Bland, Emily Wester, Sarah Arnold, Suzanne Wood, Rob Kidney, Lena Levy, Alex Gay, and the BMA Wales, Scotland, and Northern Ireland teams. Contributions have come from BMA elected members and chief officers. The team of people in our Communications and Policy Directorate and staff across the BMA have made publication and promotion possible, including our strategic communications, media, public affairs and content and audience teams.

The BMA's COVID-19 review and research included in this report

Throughout the pandemic, the BMA has been critical of many elements of the four UK governments' decisions and handling of the pandemic response for patients, the population's health, and healthcare workers. The handling of the pandemic was [described by a cross-party select committee](#) last October as 'one of the most important public health failures the United Kingdom has ever experienced', reflecting on inadequate supplies and procurement of PPE; a test and trace system that failed to deliver; and delays in implementing public infection control measures to prevent the virus spreading.

It is important to learn lessons from the pandemic response so that action can be taken in the immediate future – as the UK's health services grapple with several pressures because of the pandemic and the biggest backlog of care in their history – and to be best prepared for future pandemics and avoid repeating past mistakes.

During November and December 2021, the BMA contacted its members and other key stakeholders, including Royal Colleges and leading think tanks, to understand the impact of the UK and devolved governments' handling of the COVID-19 crisis. We wanted to hear how it affected the lives of doctors, the health service, patient care, and the public's health. Our survey was largely qualitative, providing us with the voices of frontline doctors that we quote verbatim in this report, while we also include quantitative data from other research conducted by the BMA during the pandemic, including COVID tracker surveys and viewpoint surveys (more information about these resources can be found in Appendix A). Overall, we want to help inform a robust review into the handling of the pandemic, ahead of the statutory inquiries starting in 2022.

We are publishing five reports, each focusing on a particular aspect of the pandemic response.

- Protection of the medical profession from COVID-19
- The impact of the pandemic on the medical profession
- Delivery of healthcare during the pandemic
- Effectiveness of the public health response by UK governments to COVID-19
- The impact of the pandemic on population health and inequalities

Introduction

The emergence of the global COVID-19 pandemic was formally confirmed on 30 January 2020, with the WHO (World Health Organization) [declaring the disease a public health emergency of international concern](#).¹

Tragically, since the day of the WHO's announcement, there have been over [6 million confirmed deaths from COVID-19 worldwide](#),² which likely only represents a fraction of the true mortality burden of the pandemic.³ In the UK, as of July 2020, [over 200,000 people](#) have now lost their lives as a direct result of the disease.⁴ This a grim reminder of the continued threat of the virus and, [as the BMA is calling for](#), the need to reintroduce mask wearing in health and care settings to protect patients and staff.⁵

The scale of this loss of life keenly illustrates that COVID-19 represents arguably the greatest public health crisis in living memory. It has provided a monumental challenge to governments and public health agencies, forcing many to take unprecedented steps to protect the populations they serve.

This report examines the approaches and key decisions taken by UK governments and the public health measures they introduced in response to the pandemic. In so doing, the report will assess whether the choices governments made were timely, appropriate, and proportionate to deal with the threat and impact of COVID-19. This includes exploring the evidence base used to inform some critical decisions, who was involved in decision-making, how the political and public health impacts of key interventions were balanced, and the level of risk or risk aversion in decision-making processes. It also considers the effectiveness and credibility of public health communications and policy implementation.

The report addresses each wave of the pandemic in turn, examining the critical decisions made in response to the pandemic in a broadly chronological order. These decisions are assessed in the context in which they were made and based on the evidence available at that time, including recognition of the uncertainty facing decision-makers at the outset of the pandemic.

In so doing, it sets out a range of recommendations for UK governments and a series of questions we believe the official inquiries into the pandemic must include.

In this report, these waves are defined as:

- Wave one (February 2020 – September 2020)
- Wave two (September 2020 – April 2021)
- Wave three (May 2021 – December 2021)
- Wave four (December 2021 – Present).⁶

Importantly, this report is not a systemic study of the evidence base surrounding the potential efficacy of NPIs (non-pharmaceutical interventions) – such as lockdowns, social distancing, mask-wearing, and increased ventilation – albeit evidence that supports and supported the introduction of interventions does play a role.

Likewise, while comparisons are made where appropriate, this is not a comparative analysis of national or international responses to COVID-19. Appropriate and meaningful international comparisons of responses to the pandemic are extremely difficult to produce, not least due to the drastic differences in demography, geography, and connectivity seen across many nations.

To this point, we also note that the UK, Northern Irish, Scottish, and Welsh governments took broadly similar approaches to many of their pandemic policies, particularly in the first wave, with differences typically being in timing, tone, and detail rather than of fundamental principle.⁷ However, some more pronounced differences began to emerge as the pandemic progressed.

Pandemic preparedness and public health systems

In considering the efficacy of the public health response to COVID-19, it is essential to first look at the state of the UK's public health systems at the onset of the pandemic. This includes the critical issues of public health funding, structures, workforce, and pandemic preparedness.

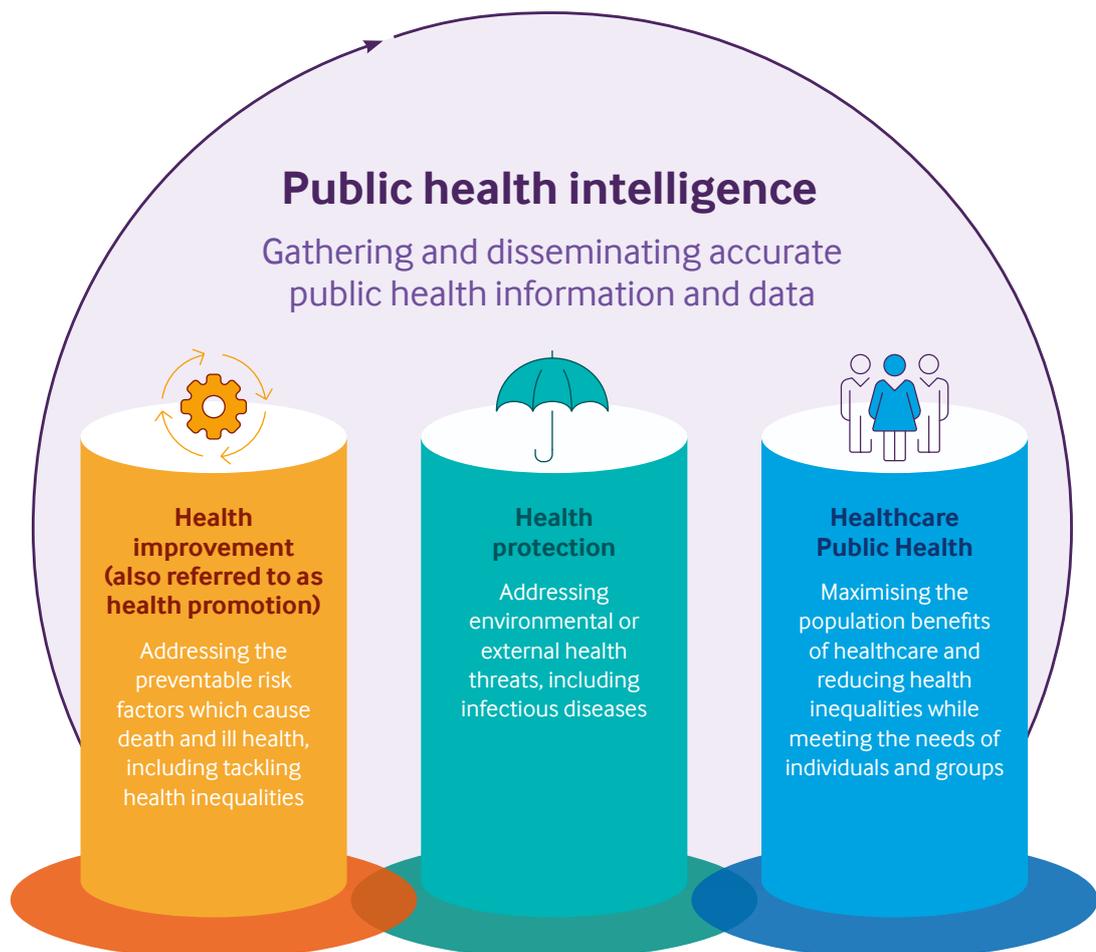
The health of the public itself was also an important factor in the impact of COVID-19 and the efficacy of the response to it and is examined in detail in the fifth report in this series, on the impact of the pandemic on population health.

The pre-pandemic structure of public health services across the UK meant that many were not best placed to address a pandemic

Many of the UK's public health structures have undergone major reform in recent years, and concerns were raised throughout the pandemic that these were not in an adequately prepared state to address a crisis like COVID-19.

To better understand these structures, Figure 1 outlines the key pillars of public health practice and Figure 2 provides a brief overview of how the responsibility for public health is structured within each nation.

Figure 1: Pillars of public health practice



Structure of public health responsibility

Respondents to our call for evidence survey pointed to the structure and organisation of public health services in their countries (see Figure 2) as having limited their capacity to effectively respond to COVID-19.

'Pre-existing structure [of public health was] ill prepared to deal with demands.'
(Consultant, Northern Ireland)

Figure 2: Overview of public health responsibility within each nation

Country	Date	Organisation		Public health responsibility
England	2003–2013	Health Protection Agency	Initially a special health authority within the NHS and then a non-departmental public body	Health protection
	April 2013–October 2021	Public Health England	An executive agency within the Department for Health and Social Care	Health improvement and health protection
		Local authorities	A department within each local authority	Health improvement and provision of public health services
	Since October 2021	UK Health Security Agency	An executive agency within the Department for Health and Social Care	Health protection
		Office for Health Improvement and Disparities	An office within the Department for Health and Social Care	Health improvement
		Local authorities	A department within each local authority	Provision of public health services
Northern Ireland	Since April 2009	Public Health Agency	An executive agency of the Department for Health	Health improvement and health protection
Scotland	November 2004–April 2020	Health Protection Scotland	An agency of the Scottish Executive	Strengthening and coordinating health protection in Scotland
	Since April 2020	Public Health Scotland	A special health board within the NHS	Health improvement and health protection
Wales	Since October 2009	Public Health Wales	A trust within the NHS	Health improvement and health protection

This sentiment was particularly prominent in England, where respondents stressed the impact of the changes brought in by the Health and Social Care Act 2012 which distributed responsibility for public health away from the NHS. They felt this caused lasting disruption to relationships between public health and the NHS at all levels, and meant that local public health services were hindered by cuts in local authority spending settlements in the years preceding the pandemic, both of which were also identified in an [analysis by the Kings Fund](#).⁸

'Public health has been starved of funding, made to compete with local authority budget.'

(GP locum, England)

Respondents also described what they saw as the negative impact of the Health and Social Care Act 2012 separating health protection from health improvement work in England. Some felt the change could have resulted in public health specialists in local authorities being less confident in their response to the health protection emergency presented by COVID-19, compared to when these responsibilities had not been separated.

'The separation of public health into Local Authorities and PHE meant that many public health consultants and teams in Local Authorities became deskilled in health protection work. This put a huge burden on the whole workforce, with Health Protection consultants having to manage the majority of the response, and provide detailed guidance and support to LA [local authority] colleagues, who felt unconfident and unprepared for dealing with infectious disease outbreaks.'

(Consultant, England)

'The response in England showed that the effects of the Lansley reforms of 2013 still lingered on. Relationships between various parts of the system especially in health protection was broken and information flow was therefore impeded. In addition colleagues in England seemed much more fearful of freely sharing information which was frustrating. Re-establishing those networks and restoring the culture of frank and open conversations should be a priority.'

(Public health consultant, Scotland)

Within England, some public health doctors in our call for evidence said a disconnect between PHE (Public Health England) and local directors of public health presented a significant barrier to effective health protection, in part because there might neither be the capacity locally to implement plans nor the knowledge and expertise centrally to advise on what is necessary for a local population.

'It exposed a great weakness in the system, [the] LA is responsible for its local population, the PHE delivers the health protection, however, it may or may not be able to do as good a job as is necessary and not all DPH [directors of public health] can in the middle of a pandemic demand better or more or anything different, they are just beholden to the PHE.'

(Public health consultant, England)

Relatedly, the high-profile approach to announcing changes in guidance to the public via the media at the same time they were being communicated within the public health community increased the challenge of interpreting and disseminating information and forming effective, trusting relationships.

'Central guidance was often not written and provided until long after changes in guidance were announced, leaving regional PHE teams with nothing to share with LA teams and destroying local relationships.'

(Public health consultant, England)

In contrast to England, public health responsibilities in Scotland and Wales sit within the NHS, while in Northern Ireland the Public Health Agency sits alongside HSCNI (Health and Social Care Northern Ireland) as an agency of the Department of Health.

While BMA members in Scotland have reported serious concerns with the resourcing of public health, they have also pointed to the retention of this direct link to the NHS as having a clear positive impact on the COVID-19 response, namely its coordination across health and public health services.

'Public health being rooted in [the] NHS has been helpful, and a strong territorial board response....'

(Public health consultant, Scotland)

'Funding for public health remained ring-fenced in Boards rather than in local authorities as in other UK countries. I feel this left them better able to respond to the pandemic.'

(Consultant, Scotland)

In addition to the core location of public health responsibility, public health services in England were also affected by PHE being disbanded during the pandemic. Although this is an example of change being enacted swiftly when there is a political will to act, the timing was inappropriate and caused disruption and uncertainty for the organisation's staff, who were forced to spend time and resources arranging a restructure – rather than on COVID-19.

'Reorganising PHE mid-pandemic was really bad. It generated uncertainty at a key time and kept people occupied dealing with the reorganisation rather than managing the pandemic'

(Public health consultant, England)

It is also possible that this very public reorganisation of PHE may have had an impact on the public and healthcare staff's trust in the public health system and in the pandemic response measures more widely.

'I think that dismantling PHE during the pandemic...sent a worrying message to healthcare staff that the government didn't know what they were doing.'

(Junior doctor, England)

A new public health agency also came into effect during the pandemic in Scotland, with Public Health Scotland taking on its official duties from April 2020 following reforms and legislative changes in the country. Public Health Scotland took on immediate responsibility for various aspects of the country's COVID-19 response.

Furthermore, having different structures for public health in each of the devolved nations presented challenges for the pandemic response, such as data access across the multiple public health systems.⁹ Within England, the division of public health responsibilities across multiple organisations impacted the clarity and dissemination of advice and information. This was identified by respondents to our call for evidence as a weakness which impacted critical health protection functions, reducing the agility of the response to the spread of infection, particularly in the initial phases of the pandemic.

'LAs [local authorities] routinely had access to no, or very little data [sic], often well after the fact, such that they felt unable to truly understand the impact that COVID was having on their populations. This was not remedied until well over a year after the initial declaration of the pandemic.'

(Public health consultant, England)

'Data from different sources i.e., Hospital, CCG, vaccination centres were all on different dashboards and difficult to make connections or sense.'
(Public health consultant, England)

'Access to data affected the immediate response.'
(Public health consultant, England)

Independence and autonomy of public health specialists

While not a completely separate entity to the UK Government, Public Health England, and now UKHSA (UK Health Security Agency) – the body created in 2021 to provide UK-wide public health protection and infectious disease capability – are executive agencies meaning they have operational autonomy and powers to give independent advice. However, testimony from our members found that some felt unable to give robust advice or, such as when scrutinising guidance, constructively challenge during the pandemic.

'Reduced professional independence of public health professionals (through being placed within local and central government structures in 2013) to speak out and advise (and have that advice taken by politicians), [was one of] the biggest impactor on England's inability to respond effectively to the pandemic.'
(Public health consultant, England)

Others thought their experience and expertise were overlooked and they were discouraged from exercising their judgement, for the sake of consistent messaging.

'I was not able to make decisions based on my decades of experience of working in health protection and managing outbreaks. I was expected to follow narrow guidance, even for matters where there was limited consensus. Any deviation was deemed unacceptable.'
(Public health consultant, England)

This was regarded by some as contrary to both their professional autonomy and the scientific process, which requires careful observation and rigorous scepticism.

'Professional autonomy was sacrificed for a coordinated approach where critical appraisal and opposition were absent. Parroting information handed down regardless of scientific rigour does not allow for professional autonomy or robust advice.'
(Public health registrar, Northern Ireland)

Some respondents commented that the relatively centralised policy-making process, including on vital health protection, often left them unable to interpret or explain what this meant to others, thereby impeding communication on public health measures within teams.

'There was lack of transparency in terms of how health protection policy was being developed. There was lack of communication to public health teams about why decisions were being made centrally on a range of interventions and so we did not have the insights needed to apply professional judgement to different situations.'
(Public health consultant, England)

Involvement of public health specialists in governments' decision making

Respondents to our call for evidence also questioned the extent to which public health specialists were involved in the national-level decisions made by the UK and devolved governments. Many felt that the UK Government, in particular, chose to not seek, or ignore the expertise of those working in public health.

'Public health has tried its hardest but the Government cherry picks what it wants to do.'

(Consultant, England)

A prime example of this is the continued absence of a strong public health presence on SAGE (Scientific Advisory Group for Emergencies), the body providing scientific advice to the UK Government in emergencies.



Recommendations

- Each UK government should review its public health structures to ensure they enable the best possible development, distribution, and implementation of independent expert public health advice which is fully considered and given appropriate weight in government decision making – particularly at times of national crisis.



Questions for the inquiries to answer

- How, if at all, could local public health expertise (e.g. in health promotion or protection) have been used more effectively in the response to COVID-19?
- What was the role of public health structures in the response to COVID-19 and how effective were these structures?
- How independently were public health experts able to operate and to what extent was public health expertise considered in governments' decision-making at a national and local level?

Long-term underfunding of public health services across much of the UK hindered the immediate response to the pandemic

The period of public austerity implemented by successive UK governments for much of the decade preceding the pandemic saw a decline in the funding available to many public health bodies across the UK, leaving them less able to respond effectively to any public health crisis, let alone a pandemic.

This is reflected strongly in the responses to the BMA's call for evidence survey, with many respondents citing long-term underfunding and austerity as factors that they felt negatively affected the overall public health response to the pandemic.¹⁰

'The running down of public health funding progressively over last decade left the public health service understaffed and under-resourced and this inevitably reduced their ability to manage the pandemic.'

(SAS doctor, England)

'Public health has been scandalously under-resourced and I believe this has had a major negative impact on the UK-wide response to the pandemic, but especially in England.'

(Salaried GP, Wales)

In Northern Ireland, the Public Health Agency saw its budget (inclusive of funding distributed to trusts) decrease by approximately 2% in real-terms from 2016/17 to 2018/19.¹¹ Meanwhile, in England, PHE saw a real-terms budget cut (inclusive of funding distributed to local authorities) of 5% during the same period.¹² Data for PHE allows analysis up to 2019/20 and shows a real-terms budget decrease of 12% between 2016/17 and 2019/20.¹³

Changes to the public health structures in Scotland mean that it is difficult to accurately assess its long-term funding settlement, though BMA members have been clear that Scotland's public health services were underfunded and overstretched at the outset of the pandemic.¹⁴

In contrast, public health spending did increase in Wales in real terms in the years leading up to the pandemic.¹⁵

The nature of devolution and funding arrangements between the UK and devolved nations also frequently requires major financial decisions to be made by the UK Government, limiting the scope and pace of some decision-making by the governments of Northern Ireland, Scotland, and Wales. A primary example is the funding of the COVID-19 furlough scheme which could only be instituted by the UK Government and when in place, then allowed the devolved nations governments to implement further public health measures.¹⁶

'[Scotland] did not have sufficient capacity to set up its own expert advisory groups or manage a pandemic.'
(Consultant, Scotland)



Recommendations

- All UK governments should adequately fund public health services wherever they are located and ensure they are rapidly supported with additional resources to expand their functions when necessary.



Questions for the inquiries to answer

- What was the impact of long-term public health funding on both pandemic preparedness and the initial public health response to the onset of COVID-19?
What impact did austerity have on the efficacy of the response?

Shortages of public health staff have limited the availability of public health expertise, at a national and local level

The widespread deterioration of public health funding has occurred in concert with an equally concerning decline in the size and voice of the public health workforce. This meant that at a critical juncture like the COVID-19 pandemic, a dearth of public health staff has sometimes limited the crucial public health expertise needed to guide local and national responses.

'...it is not unfilled posts, it's that the posts are not there in the first place.'
(Public health registrar, England)

It can be challenging to build a full picture of the public health workforce; public health encompasses many different roles, including those with medical and non-medical training, and staff are often dispersed across multiple different organisations. However, the FPH (UK Faculty of Public Health) has recently published figures on the current number of public health specialists in each of the UK nations.¹⁷ They recommend having 30 FTE (full-time equivalent) public health specialists per million people in the population. As Figure 3 indicates, current numbers fall short of this target across all four nations.

Figure 3: The number of public health specialists compared to the recommended target

	England	Scotland	Wales	Northern Ireland
Current number of FTE public health specialists	1,064 (2021) ¹⁸	125 (2021) ¹⁹	79 (2021) ²⁰	29 (2021) ²¹
Latest population estimates	56.5 million (2021) ²²	5.5 million (2020) ²³	3.1 million (2021) ²⁴	1.9 million (2021) ²⁵
Target based on FPH's recommendation of 30 FTE per million people	1,695	165	93	57
Shortfall	631	40	14	28
Percentage increase needed to meet recommended target	59.3%	32.0%	17.7%	96.6%

In addition, a recent survey of local authorities in England and Wales found that they are 'finding it increasingly challenging to recruit and retain staff',²⁶ with over half saying their public health services were disrupted as a result.²⁷ In response, the LGA (Local Government Association) and the ADPH (Association of Directors of Public Health) have called on the Government to support councils' efforts to retain and recruit public health officials.²⁸ These staff shortages were also noted by many respondents in our call for evidence:

'Public health [services] were so lacking in staff that there was a lack of preparation, and a lack of response. This is entirely the fault of running down the service to nearly nothing.'

(Salaried GP, England)

'Public Health Services appear to be running on very reduced staffing levels and have been for several years.'

(GP contractor/principal, Scotland)

Overall, these shortfalls in the public health workforce very likely contributed to the limited public health capacity noted by some at the outset of the pandemic.

'At the beginning it was incredibly hard to get through to anyone in public health for advice. Now we don't even try. Very little contact with anyone from PH [public health] in my job.'

(GP contractor/principal, Scotland)

Respondents to our call for evidence explained that, where reorganisation of staffing took place during the acute phase of COVID, public health specialists were frequently redeployed, with resulting backfill colleagues also working intensely and at risk of being stretched beyond their competencies.

'Critical functions were protected where these were category 1 response functions under the Civil Contingencies Act. This was usually achieved by consultants who were in post both being redeployed to support the COVID response and manage critical functions with the support of more junior staff and as a result working far beyond their routine commitments.'

(Public health consultant, England)

Although the experience of public health doctors during the pandemic describes a speciality overstretched and under strain, in 2021, there were on average eight applicants for every available NHS training place in the UK. This meant the number of places – and thus public health specialists – could easily be expanded.²⁹

This lack of staff and adequate funding had a significant impact on public health structures across the UK, including on local health protection teams. This was, again, a particular issue in England where health protection work – including communicable disease control, environmental hazards to health and health emergency planning – is handled by local health protection teams. Pre-pandemic, these teams were a provider function of PHE and, in January and February 2020, contributed to understanding COVID-19 and supporting emerging case definitions known as FF100s – which assess the nature of a new illness in its first 100 days. Despite their importance, BMA members reported that these teams were rapidly overwhelmed and, in early March, were unable to sufficiently shift their work from understanding COVID-19 to containing it due to a substantial shortfall in capacity.



Recommendations

- The four UK governments should all urgently increase the numbers of public health staff at local and national level and increase the number of public health training places provided.



Questions for the inquiries to answer

- How could the public health workforce have been adequately staffed entering the pandemic? What impact could this have had on the governments' public health response?
- In the event of a future pandemic, how will UK governments ensure that the necessary number of public health experts are available and that their expertise is heard by decision-makers?

The UK's pandemic preparedness was too limited and failed to incorporate the findings of major exercises

The [first report in this series](#) addressed in more detail the issue of the UK's pandemic preparedness and the pre-COVID planning and exercises that shaped it. However, as those plans informed the initial response to the pandemic, they are important to consider briefly here, too.

The UK's pandemic preparation was focused entirely on an influenza-style pandemic, with preparations made to address a situation where [a flu-like virus was already widespread and incurring serious mortality](#).³⁰ As set out above, this report does not seek to apply hindsight to decisions made in their own particular context, however, it must still be noted that this approach arguably hampered the UK's initial response to COVID-19.

In the initial stages of the pandemic, the response across the UK was centred around increasing capacity within health and care systems to treat the illness. This was in contrast with countries that had experience of dealing with SARS (severe acute respiratory syndrome) or MERS (Middle East respiratory syndrome), where contact tracing, isolation and stockpiling of equipment and consumables were given high priority, [as in South Korea](#).³¹

There were several exercises – both UK-wide and in the devolved nations – that did look at planning for MERS which, despite being a different disease to COVID-19, is a coronavirus and shares some characteristics. [Exercise Alice](#), for example, made several informed recommendations that would have been relevant to the handling of the eventual COVID-19 pandemic, but these do not appear to have been acted on.³²

It is impossible to exactly predict the pathology of the virus that causes the next pandemic – but wider pandemic planning, at any time, must account for a variety of threats.



Questions for the inquiries to answer

- Why did the UK's pandemic preparation focus entirely on an influenza-style pandemic? What impact did this approach have on the UK's initial response to COVID-19?
- Why were recommendations from pre-pandemic planning exercises (particularly the exercises that focused on MERS) not acted on and included in eventual COVID-19 plans?

Wave one: February 2020 – September 2020

Key public health measures during wave one		
JANUARY 2020		
31 Jan	First confirmed case of COVID-19 in the UK ³³	UK-wide
FEBRUARY 2020		
2 Feb	Launch of first COVID-19 public information campaign ³⁴	UK-wide
7 Feb	14-day self-isolation encouraged for symptomatic travellers from a broader range of countries beyond China ³⁵	UK-wide
10 Feb	COVID-19 testing expands from one laboratory to 12 ³⁶	UK-wide
MARCH 2020		
12 March	Contact tracing abandoned in all UK nations as the UK moves from the 'contain' phase to the 'delay' phase of the pandemic ³⁷	UK-wide
	Those with symptoms advised to isolate for seven days ³⁸	UK-wide
16 March	Self-isolation for those with symptoms extended from 7 to 14 days. Advice to avoid non-essential contact and travel, work from home where possible and to avoid hospitality and social venues. Mass events discouraged. ³⁹	UK-wide
	UK Government begins daily press briefings ⁴⁰	UK-wide
17 March	UK public advised to avoid all non-essential overseas travel ⁴¹	UK-wide
	Scottish Government begins daily press briefings ⁴²	Scotland
20 March	The UK public are advised to stay at home ⁴³	UK-wide
	Schools close except for the children of key workers ⁴⁴	UK-wide
22 March–7 April	Shielding introduced for those deemed to be clinically extremely vulnerable ⁴⁵	UK-wide
23 March	UK-wide lockdown begins, requiring people to stay at home except for very limited purposes, closing certain businesses and venues and stopping gatherings of more than two people in public. ⁴⁶ Public messaging slogan is 'Stay at home'.	UK-wide
APRIL 2020		
23–30 April	Symptomatic testing expanded to all essential workers ⁴⁷	UK-wide

MAY 2020		
11 May	Lockdown measures ease in England. ⁴⁸ Those who cannot work from home now encouraged to go to work, limits are removed on the frequency of outdoor exercise, and travel is allowed within England. Public messaging slogan changes to ' <i>Stay alert. Control the virus. Save lives</i> '.	England
	Scotland removes limits on the frequency of outdoor exercise	Scotland
14 May	Population-wide contact tracing begins in Northern Ireland ⁴⁹	Northern Ireland
18 May	Symptomatic testing expanded to everyone in the UK ⁵⁰	UK-wide
19 May	Lockdown measures ease in Northern Ireland. Outdoor mixing allowed for six people from different households ⁵¹	Northern Ireland
28 May	Lockdown measures ease in Scotland. ⁵² Outdoor mixing allowed for two households, but advice remains to stay local.	Scotland
	Population-wide contact tracing begins in England and Scotland. ⁵³	England and Scotland
JUNE 2020		
1 June	Lockdown measures ease in Wales. ⁵⁴ Outdoor mixing allowed for two households. Public advised not to travel more than five miles from home. Public messaging changes to ' <i>Stay local</i> '.	Wales
	Population-wide contact tracing begins in Wales ⁵⁵	Wales
	Further easing of measures in England. ⁵⁶ Outdoor mixing allowed for up to six people. Schools reopen for some age groups.	England
8 June	Anyone entering the UK now required to isolate for 14 days ⁵⁷	UK-wide
	Further easing of measures in Northern Ireland. Some shops selling non-essential goods allowed to reopen.	Northern Ireland
9 June	Face coverings recommended, but not mandatory, in Wales ⁵⁸	Wales
15 June	In England, shops selling non-essential goods are allowed to reopen and face coverings start to become mandatory in some settings (public transport) ⁵⁹	England
22 June	Further easing of measures in Wales ⁶⁰ including the reopening of non-essential businesses. Public still advised to stay local.	Wales
	Face coverings start to become mandatory in some settings in Scotland (public transport) ⁶¹	Scotland
23 June	UK Government stops daily press briefings	UK-wide
	Northern Ireland is first UK nation to allow people to meet indoors (groups of up to six people) ⁶²	Northern Ireland

29 June	Schools in Wales begin to reopen ⁶³	Wales
	Shops selling non-essential goods reopen in Scotland ⁶⁴	Scotland
30 June	UK's first full local lockdown is announced (Leicestershire) ⁶⁵	UK-wide
JULY 2020		
3 July	Limited reopening of indoor hospitality in Northern Ireland ⁶⁶	Northern Ireland
4 July	Several countries now exempt from the advice to avoid non-essential international travel from the UK ⁶⁷	UK-wide
	In England, two households are allowed to meet inside, most businesses allowed to reopen	England
6 July	Wales lifts 'stay local' rule, allowing travel into Wales ⁶⁸	Wales
10 July	Travel corridor exemptions come into effect in England ⁶⁹ and Wales (travellers from some countries no longer need to isolate) ⁷⁰	England and Wales
	Face coverings start to become mandatory in some settings in Northern Ireland (public transport) ⁷¹	Northern Ireland
13 July	Outdoor hospitality reopens in Wales ⁷²	Wales
26 July	First country (Spain) re-added back into the category of needing to isolate upon entering the UK ⁷³	UK-wide
27 July	Face coverings start to become mandatory in some settings in Wales (public transport) ⁷⁴	Wales
30 July	Self-isolation extended from seven to 10 days UK-wide for those with symptoms or a positive COVID-19 test ⁷⁵	UK-wide
	Northern Ireland launches UK's first contact tracing app	Northern Ireland
AUGUST 2020		
3 August	Indoor hospitality reopens in Wales ⁷⁶	Wales
11 August	Schools in Scotland reopen for all pupils ⁷⁷	Scotland
17–20 August	Northern Ireland reopens schools for some pupils. ⁷⁸ Other restrictions tighten including reductions in the numbers of people who can mix indoors and outdoors. ⁷⁹ Government press briefings resume. ⁸⁰	Northern Ireland
18 August	Wales issues a Coronavirus Control Plan for Autumn and Winter 2020 ⁸¹	Wales
22 August	Four-household 'bubbles' allowed in Wales for indoor mixing ⁸²	Wales

The first confirmed case of COVID-19 in the UK was announced on 31 January 2020, when two Chinese nationals in York tested positive for the disease, marking the beginning of the first wave of a pandemic which would lead to unprecedented public health interventions.

This section outlines the key public health decisions made by governments during this tumultuous period and assesses why they were made and what could have been done differently.

COVID-19 emerged worldwide at the start of 2020, but the UK was slow to act

Uncertainty typified the very early stages of the pandemic at the start of 2020 when the UK – like much of the world – remained understandably unsure of exactly what risk COVID-19 posed. Indeed, at this time, China was the only country experiencing a significant outbreak of the disease.

However, even at this stage, the fact that the UK Government considered COVID-19 an emergency level threat was clear from the meetings of SAGE, which, during this initial phase, was the central body within the UK Government assessing the risk of and response to COVID-19. SAGE is an advisory group made up of senior government and university-based experts from the sciences and other disciplines across the four UK nations and is responsible for providing coordinated scientific advice to support UK cross-government decisions. SAGE has been supported throughout the pandemic by NERVTAG (New and Emerging Respiratory Virus Threats Advisory Group), which provides advice to the UK Government on the threat posed by respiratory viruses. Notably, SAGE lacked – and still lacks – sufficient specialist public health expertise, undermining the breadth and depth of its advice to government.

Minutes of SAGE meetings from January 2020 reflect both the uncertainty and the troubling nature of the situation at that point. It is noted, for example, that SAGE was unsure about the origin of the disease, the dynamics of transmission of COVID-19, and when people were at their most infectious. It is clear, though, that [SAGE quickly understood the gravity of the situation in China](#), where it acknowledged that the virus had a high reproduction rate and a doubling time of around four to five days.⁸³

There are substantial differences between the UK and China, such as their relative population sizes and population density, which means that information applicable to one does not necessarily translate directly to the other. Despite this, SAGE was clearly aware of and concerned by, the fraught situation in China at an early stage.

Moving into February 2020, the scientific community was slowly building evidence on the nature of COVID-19, though pivotal questions remained unanswered. There were, however, now the first mentions of the kinds of measures that would become commonplace around the world. Interventions like encouraging social distancing, mask-wearing, and isolation are all cited in the SAGE notes from this month. Their efficacy at responding to COVID-19 was at this point difficult to measure. However, throughout February and into March, assessments began of the kinds of measures which would subsequently go on to form the basis of the UK's policy responses.

Contact tracing was also ongoing in all UK nations at this early stage, with testing of all suspected COVID-19 cases followed by efforts to locate and advise anyone who may have been in close contact with those testing positive. Run by local and national public health services, these services were attempting to proactively limit the presence and initial spread of COVID-19 in the UK. This initial contact tracing was, however, abandoned in all UK nations on 12 March 2020, ostensibly in response to the UK Government moving from the 'contain' to the 'delay' stage of the pandemic. It later emerged that this decision was at least partly due to a lack of capacity.⁸⁴

Most notably, February saw the pandemic accelerate drastically in Europe while COVID-19 was seeded across the continent, with sustained community transmission in Italy in particular. Yet the sharply growing presence of COVID-19 in Europe did not trigger the sort

of response we might have expected from the UK's leadership. While it was fair to broadly conclude that the data coming out of China were worrying but uncertain, the sustained community spread of COVID-19 in Italy still did not become the trigger point in the UK for action in the way it did for so many other western European nations.

'Did they not see what was happening in China, Hong Kong, Singapore, Italy etc. It was like they thought it would not come here.'

(Consultant, Scotland)

One illustration of the sharp contrast between this inaction and the steps being taken elsewhere was the failure to cancel major sporting events in England despite the onset of the pandemic. In mid-March, just days before the UK Government's announcement of national restrictions, tens of thousands of people attended Cheltenham Festival (10–13 March) and a Champions League football match between Liverpool FC and Atletico Madrid (11 March), events which have since been identified by some as having [caused increased suffering and even deaths](#).⁸⁵ Notably, on 19 February 2020, another Champions League football match – this time between Atalanta B.C. and Valencia in Bergamo, Italy – was seen as the catalyst for the initial spread of COVID-19 in the area and was [later labelled 'Game Zero' in local media](#).⁸⁶ Despite coming several weeks before the match in Liverpool, this event did not prompt any action by the UK or sporting authorities. In contrast to the UK, Italy [suspended all sporting events nationally on 9 March 2020](#), with those in the areas heavily impacted by COVID-19 having been cancelled as early as February.⁸⁷

It was difficult to see a clear policy approach from the UK Government that February. The action it did take was limited and focused on attempting to prepare the NHS to handle the significant increase of cases that might occur in the UK. As the BMA has set out in the third report in this series, this preparation was not successful.



Questions for the inquiries to answer

- How and to what extent did the UK Government assess the situation in China in early 2020 as a potential threat to the UK? To what extent did the UK Government apply precautionary principles as a result of this assessment? Why did it not respond sooner to the concerns raised by SAGE?
- Why did the UK Government choose not to act when the situation in Italy reached the stage of suspending large-scale events?

The UK slowly began to take limited action from March 2020

In March 2020, the UK Government published its [Coronavirus action plan](#), which set out what it had done so far and its intended plans for dealing with COVID-19.⁸⁸ This was a long and procedural document discussing the mechanisms of governments and contingency plans. It contained brief mentions of population-wide distancing strategies – such as reducing large gatherings and introducing larger-scale home working – but did not state when they would be implemented. Instead, the plan concluded only that any such decisions would have to be balanced against ensuring the country continued to run smoothly – a question of priorities that would be debated repeatedly over the pandemic. It was 23 March – 20 days after the publication of the plan – before the UK Government decided to implement these elements of its strategy.

This is even more surprising given that community testing and population-level contact tracing were abandoned in all UK nations on 12 March 2020, 11 days earlier. SAGE had previously been advised by scientific modellers, including those from PHE, that without additional resources contact tracing could not be scaled up to sufficiently meet the upcoming demand.⁸⁹ They also advised that, even with additional resources, transmission would reach a rate at which contact tracing would no longer be effective and would then need to be abandoned.⁹⁰ As such, in mid-March, the UK Government decided to halt resources for community testing and contact tracing and instead focus on making tests available for hospital patients and healthcare staff.⁹¹

It has been reported that this [lethargy in response was by design](#).⁹² It is unclear exactly why the UK Government delayed implementing measures it had previously discussed when the situation now appeared to be quickly getting out of control.

It has been suggested that the UK Government was pursuing a herd immunity strategy initially. This is arguably a simplification; herd immunity is a scientific concept that explains a level of population-wide immunity that controls the spread of a pathogen, it is not a public health strategy. Nevertheless, there was seemingly a degree of fatalism within the UK Government regarding the number of people who would inevitably be exposed to COVID-19 and an underlying assumption that NPIs were merely delaying cases, rather than preventing them altogether. Similarly, there was a strong sense that the UK Government had taken its stance on delaying population-wide distancing based on a [disputed interpretation of the concept of 'behavioural fatigue'](#), which it seemingly felt would limit the amount of time the public would tolerate restrictions like distancing.⁹³

This period also saw the introduction of daily television broadcasts from the UK and Scottish Governments, which was soon followed by the launch of regular television broadcasts in Wales and Northern Ireland as the first wave progressed. These televised briefings provided detailed information to the public and ensured a degree of clarity around the spread of COVID-19. However, as the fifth report in this series highlights, more could have been done to ensure these briefings were inclusive. Respondents to our call for evidence have indicated that these press conferences were often where frontline staff first heard about changes to rules and guidance, suggesting more could have been done to give frontline staff advance notice of key changes and the scientific rationale for making them.

'I work in a Health Board Public Health Department. The first we knew about changes was usually when we saw it on the news and someone walked round the office to tell everyone about a policy change. Often the change was announced and the details did not follow for days, leaving us to try to work out what was meant in a press conference and to then apply it to queries, hoping that we had understood it.'

(Consultant, Scotland)



Questions for the inquiries to answer

- What information did PHE use to inform its advice that scaling up capacity for testing was not possible? Was this advice from PHE challenged sufficiently when this course of action would go on to be implemented merely weeks later?
- The decision to shift capacity away from contact tracing took place on 12 March 2020, why did it take 11 days for the UK Government to introduce population-wide distancing measures when there was already acknowledgement that community transmission of COVID-19 was such that attempting to test and contact trace would overwhelm the system?
- What role did behavioural science play in the UK Government's decision not to quickly impose a package of NPIs against COVID-19? Was this driven by an incorrect assumption that adherence would quickly wane?

A nationwide lockdown was finally introduced on 23 March 2020

By mid-to-late March the prevalence of COVID-19 accelerated rapidly across the UK, though with significant regional variations. In Wales, for example, the variation in prevalence between different parts of the country was reflected in the more gradual and locally determined introduction of restrictions, before the nationwide restrictions being introduced as part of the UK-wide lockdown on 23 March. Similarly in England, the prevalence was initially highest in London – by 15 March 2020, London had a rate per 100,000 people that was over double that of all other regions in the country.⁹⁴

From 16 March 2020, the UK Government began to encourage the public to change their behaviour, although this was left up to personal choice but people aged 70 or above were advised to take particular care. Advice included avoiding non-essential contact, working from home where possible and not going to hospitality or social venues. Mass events were also discouraged (although still permitted) by withdrawing the support of emergency services.

However, it was not until seven days later, on 23 March, that a UK-wide lockdown was implemented, a policy that SAGE had been discussing for some time by this stage.⁹⁵ By this date, there were already 4,873 people across the UK in hospital with COVID-19.⁹⁶ [Modelling from Imperial College London](#), predicting that the NHS would be overwhelmed if nothing was done, appeared to be a significant catalyst for the UK Government to introduce more comprehensive interventions and to do so more quickly.⁹⁷

The UK-wide lockdown involved closing non-essential businesses and venues, prohibiting gatherings of more than two people in public, and requiring people to stay at home except for very limited purposes. People were only permitted to leave their homes to shop for necessities, for one form of exercise per day, for medical or care needs, and for travelling to and from work where this was necessary and could not be done from home. Face-to-face teaching in schools and universities also stopped, with the exception of vulnerable children and those of critical workers.

This delay in implementing restrictions is a defining characteristic of the UK Government's response to the first wave of the COVID-19 pandemic. Many respondents to our call for evidence felt strongly that non-pharmaceutical interventions were not implemented soon enough.

'Too little too late. These measures work but they seemed always to be deployed only when it was absolutely obvious that something had to be done. They would have been so much more effective – so much less disruption and harm would have been caused – if they had been deployed earlier and followed more assiduously.'
(Consultant, England)

Funding arrangements between the UK Government and devolved nations often limited the capacity of the leaders of Northern Ireland, Scotland, and Wales to take decisive action. While legally able to implement major public interventions independently, throughout the pandemic the devolved nations governments were often awaiting a UK Government policy decision and a subsequent release of funds before they could act. As the Institute for Government has identified, the UK Government's approach of only releasing additional funds to the devolved nations when it increases spending in England has been a source of frustration for their governments, who feel that this policy has made it harder for them to plan and implement their own responses to the pandemic.⁹⁸

Despite previous fears over the public acceptance of restrictions, once introduced the vast majority of people were happy to take these steps to protect one another. There were, however, notable, and high-profile incidents whereby key decision-makers, from governments, advisory bodies, and elsewhere, failed to meet the expectations of the public or of the lockdown. A number of long drives to visit dramatic scenery, loved ones, or second homes were followed by contrite apologies or languid press conferences. Exactly how these instances impacted nationwide adherence and confidence in restrictions is unclear, but questions remain as to their long-term impact on public perceptions of COVID-19 restrictions and trust in those in responsible roles during the pandemic. Indeed, the deputy first minister of Northern Ireland acknowledged that her own breaking of lockdown restrictions during the first wave undermined the public health message.⁹⁹ Public trust has not been helped by recent revelations of lockdown parties in Number 10 and could be a serious risk for adherence to similar restrictions when another pandemic arrives on the UK's shores.

These concerns were also reflected in our call for evidence, as many felt that government leaders had set a poor example, especially in central government.

'[Government] advisors breaking lockdown, that was really crushing to our patients and led immediately to lots of lockdown breaking. And now with parties reported last Christmas season in downing street...I can predict our patients will again throw caution to the wind. The UK [Government] is not great at setting a good example!'

(GP locum, Northern Ireland)

'Late implementation, mixed messages and high-profile cases of famous individuals flaunting these [measures] had led to poor compliance and limited effectiveness.'

(Junior doctor, England)



Questions for the inquiries to answer

- Why was decisive action on NPIs not taken earlier in 2020?
- Why did the UK Government spend the seven days from 16–23 March 2020 advising voluntary behaviour changes rather than introducing lockdown?
- What was the impact of high-profile failures to adhere to lockdown rules on public support and adherence, and on trust in COVID-19 interventions? What is the potential impact of this on public behaviour in future pandemics?

Wider restrictions followed the introduction and extension of the first national lockdown – including mask wearing

Despite the eventual implementation of lockdown, COVID-19 cases and hospitalisations continued to rise because of the extent of transmission before its introduction.

We now know that lockdowns were not without consequential harms and knock-on effects on people's mental health and children's socialisation and education, which have been increasingly documented and are addressed in the fifth report in this series, on the impact of the pandemic on population health. However, lockdowns were the only tool available at this point to sufficiently limit COVID-19 transmission, cases, hospitalisations, and deaths, and to prevent the UK's health services – which had entered the pandemic understaffed and underfunded – from becoming overwhelmed. They were therefore a significant but necessary measure to prevent the UK's health and care systems from being overwhelmed.

At this stage, the issue of mask-wearing and face coverings emerged. While masks were recommended for health and social care settings, they were not initially recommended for use by the general public. This recommendation appeared to stem from fears related to inadequate supplies of PPE; as detailed in our first report, health and social care settings experienced widespread shortages of PPE during the first wave. It was also likely influenced by the difficulty of collecting and appraising evidence of effectiveness during a pandemic. For example, due to a lack of direct comparability between prior evidence and the context of a global pandemic, variations in the type of face covering studied and the tendency for studies to be observational, rather than clinical.

Population-wide studies now suggest that face masks do have a notable effect in reducing transmission.¹⁰⁰ While face masks were eventually required in public forums in the UK – such as supermarkets, restaurants, and performance venues – no specification was ever set for the quality or composition of masks, with homemade coverings being the norm for many. This was in contrast to other countries, including Austria, where FFP2 masks were required in shops, museums and on public transport from January 2021.¹⁰¹

In early April 2020, organisations [like the ECDC \(European Centre for Disease Control\)](#) and the CDC (Center for Disease Control and Prevention) began to reconsider their positions and recommend face masks.¹⁰² This change in approach was based on a better understanding of the mechanics of transmission and the adoption of a precautionary approach to COVID-19. However, it took until June 2020 for England and Scotland, followed by Northern Ireland and Wales in July 2020, to begin to mandate mask-wearing by members of the public in any setting at all. All four nations took an approach of requiring masks to be worn on public transport first, before later requiring them in other settings such as the retail sector. In Wales, mask-wearing was recommended from 9 June 2020 but not mandated in any setting until seven weeks later (27 July), at which point they were required on public transport. Noticeably, it was not until mid-September 2020 that Wales required face masks to be worn in settings such as shops, this came two months after the same measure had been introduced in Scotland on 10 July and then, two weeks later, in England on 24 July.

The BMA lobbied for face masks to be introduced far earlier and was [critical of the delay in introducing mandated mask wearing across the UK](#) and particularly in England – with BMA members arguing that the [UK Government should have followed the example of the Scottish Government](#) more rapidly in relation to mandatory mask-wearing in shops. Moreover, consistency and ease of understanding are both important aspects of public health messaging and, given the frequency of changes to mask wearing requirements, were sadly lacking in this context.



Questions for the inquiries to answer

- Why was the decision to require mask-wearing in public taken as late as it was?
- What role did shortages of PPE play, caused by a lack of adequate stockpiling and maintaining of national stockpiles?

Easing of restrictions began in May 2020, but failure to prepare for a looming second wave was a defining feature of summer 2020

The easing of COVID-19 restrictions began in May 2020

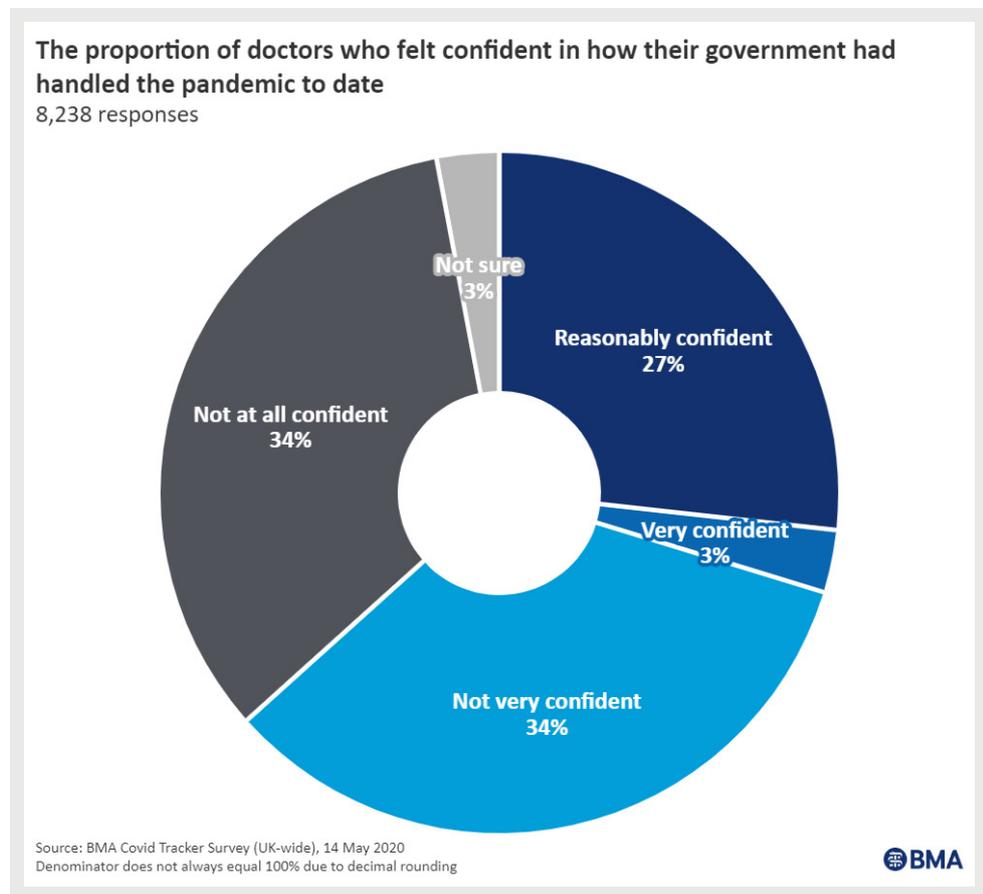
COVID-19 cases and hospitalisations reached their first peak in mid-April 2020; on 12 April, 20 days after the UK-wide lockdown was implemented, there were over 21,000 people across the UK in hospital with COVID-19.¹⁰³ COVID-19 deaths similarly reached their first peak in mid-April, with 8 April marking the highest number of daily deaths recorded during the first wave (1,077 deaths across the UK), 16 days after the lockdown began.¹⁰⁴ Cases fell rapidly throughout May 2020 and, as a result, decision-makers began to consider easing the restrictions introduced in March 2020.

Throughout May and early June, restrictions in all four nations of the UK began to ease. Although this process saw some differences emerge between the policies of the UK and devolved governments, particularly around the timing of certain restrictions being lifted, the responses were broadly similar. Changes during this period typically included removing limits on the frequency of outdoor exercise, permitting social contact outdoors with a limited number of other households and the limited reopening of schools. These early changes were followed by a further easing of restrictions across the UK's nations as June 2020 progressed, including the reopening of non-essential shops and other businesses. Northern Ireland was the first UK nation to permit indoor social contact, with groups of six people permitted to meet indoors from 23 June 2020.

These policy changes came at a time when many doctors across the UK were losing confidence in their respective government's handling of the pandemic. At this point, many had been working in unsafe environments and harrowing conditions for several months, faced a rising backlog of non-COVID care and saw governments planning to relax public health restrictions without any apparent evidence for the measures being proposed or a sustainable longer-term plan for how to manage the pandemic and its

impact on stretched health and public health services longer-term. In our UK-wide COVID tracker survey in May 2020,¹⁰⁵ 68% of doctors said they did not feel confident in how their government had handled the pandemic so far.

Figure 4: Doctors' confidence, as of May 2020, in how their government had handled the pandemic to date



This lack of confidence was highest among doctors working in England (70%), and lowest among those working in Scotland (47%). In July 2020, [the BMA called for improvements to systems of testing and contact tracing, as well as greater clarity in public health messaging](#), to manage a second spike in infections.

From June to September 2020, the UK experienced some of its lowest rates of COVID-19 hospitalisation across the whole pandemic. With this perceived decline in risk, public and political opinion arguably began to side-line COVID-19, possibly due to fatigue and the move into summer. This period also saw the advent of new policies targeted specifically at promoting economic growth, with the UK Government's EOHO (Eat Out to Help Out) scheme serving as a particularly prominent example and one which encouraged a degree of social mixing for the apparent benefit of the hospitality sector and the wider economy. This is one of the clearest examples of the balance between public health and the economy shifting, given the overriding prioritisation by the UK Government of the economic benefits of the scheme over any health risks it may have posed. It is likely this policy had a health cost however, as it has been [estimated EOHO may have seeded between 8 and 17% of new infections](#) at the end of the summer and into early autumn.¹⁰⁶

'Summer 2020 provided a window to get on top of prevention, tracing etc. and to maintain control. Instead, we had 'eat out to help out'. A huge wasted opportunity.'

(Medical academic consultant, England)

At this time, public messaging regarding working from home became noticeably [mixed and confusing](#).¹⁰⁷ It was a measure adopted with relative ease across many sectors of the economy, helping to control the spread of coronavirus. However, by the end of the summer, there was encouragement from within parts of the UK Government for workers to return to the office, despite uncertainty about the readiness of workplaces to accept employees safely and from some people to work as they did previously, with psychological safety also a major concern.

This approach seemed not to be a result of carefully reconciled cross-Government policy-making on longer-term measures necessary to control coronavirus during a continuing pandemic, but a short-term response to concerns over city centre economies and rapid liberalisation of working practices, when it was already probable that infections would soon rise again in early autumn.

This reflected a broader shift in focus on the part of the UK Government, with increasing emphasis on the need to both increase economic activity and relax limits on mixing. Hinging on a misconception that limiting the spread of COVID-19 was – and is – incompatible with a strong economy, this position came to dominate much of the UK Government’s perspective during the pandemic. However, it remains the BMA’s view that protecting public health and limiting the spread of illness, including COVID-19, is pivotal to a strong economy.

As the BMA argued at the time, any revision to the restrictions should have been evidence-based; well-timed to avoid significant worsening in the rate of COVID-19 transmission; communicated clearly; and protected the NHS, key workers, and vulnerable populations. We stressed that this could only be delivered once there was sufficient capacity to test, track, isolate, support and follow up suspected and confirmed cases of infection, in every area of the UK. In our view, this was not achieved by the time COVID-19 restrictions were pared down.

Governments failed to sufficiently prepare for a looming second wave of COVID-19

The dominant political narrative at this point was not caution or preparation for any future wave of COVID-19, but rather a focus on ending restrictions as widely and as quickly as possible.

Despite the optimism of some during the summer of 2020, the [BMA joined other organisations in calling on the UK governments to prepare for a second wave](#) and was increasingly cognisant of the risk a further wave of COVID-19 presented.¹⁰⁸ This included an explicit call for a rapid, forward-looking, and cross-party review focused on evaluating national preparedness in the lead up to winter.

Some preparations for a second wave did take place, though these steps came as part of a notable shift away from a nation-wide approach in favour of more localised interventions. As detailed below, this included the eventual introduction of local lockdowns, as seen in Northern Ireland, Wales, and England, with localised lockdowns put in place in certain areas of each country from summer 2020 onwards.

Critically, though, the [UK Government did not use the time it had in this period to build a functional test and trace system](#) that would be better able to handle an increase in cases.¹⁰⁹ Likewise, BMA members in Scotland have reported that the test and trace system developed there was also insufficient, if less expensive than its English counterpart.



Recommendations

- The UK Government must assess the impact the Eat out to Help Out scheme had on both the economy and on the transmission of COVID-19 to guide similar decisions and debates in any future pandemic.



Questions for the inquiries to answer

- Why did UK governments not take more cautious approaches during the summer of 2020 in preparation for a second wave?
- How did each UK government make decisions during this intra-wave period, and how effectively did they use this time to prepare for a second wave of COVID-19?

Testing and contact tracing was inadequate

Systems for testing and contact tracing are key tools for managing transmission, and the summer of 2020 was a pivotal point for these systems to keep transmission rates as low as possible and ensure the UK was adequately prepared for the inevitable second wave. However, the poor performance of these systems meant the UK entered the second wave inadequately prepared.

Insufficient testing capacity led to delays

To minimise transmission, testing must be readily available to those who need it and tests processed promptly. In the UK, the first tests available were PCR (polymerase chain reaction) tests, which needed to be sent to a laboratory for analysis. In all four nations, eligibility for a test was first made available to a small cohort (those with a medical need and some critical workers), before gradually being expanded to a wider group over time.¹¹⁰ By the end of August 2020, everyone in the UK with symptoms was eligible for a test.

However, test eligibility is not the same as test availability. In England, there was a critical failure to ensure sufficient laboratory capacity to meet the demand for testing, which became a significant issue in September 2020, with the public left unable to arrange tests or being offered appointments 100 miles away from their homes.¹¹¹

This shortfall in testing capacity has been partly ascribed – including by the BMA – [to the failure to utilise the 44 pre-existing NHS laboratories and an overreliance on both the private sector and the seven Lighthouse Laboratories](#) created by the UK Government to provide additional capacity.¹¹²

‘National testing services failed initially due to new infrastructure which took tests out of existing, capable labs.’

(Consultant, England)

‘In our hospital we had the expertise to analyse PCR (we were doing rapid flu testing prior to the pandemic) but all COVID samples had to be sent to London and took several days to process in the first wave. Testing has improved hugely in the last 12 months but there was an unnecessary delay in allowing local labs to test.’

(Consultant, England)

The expense and effort of using these alternative laboratories, which operate independently of public health and NHS infrastructures and use different software and systems, was seemingly unnecessary and created unhelpful fragmentation.

COVID tests in Scotland, Wales and Northern Ireland were processed by a combination of Lighthouse Laboratories, NHS-run laboratories and, in some cases, private laboratories. In Wales, for example, 50% of the COVID tests conducted between April and September 2020 were processed by Lighthouse Laboratories.¹¹³ This use of UK-wide infrastructure meant that Lighthouse Laboratory delays impacted testing capacity in all four UK nations. As a result, from September 2020 Wales chose to shift capacity towards laboratories run by Public Health Wales instead.¹¹⁴

Contact tracing restarted but the outsourced model in England was a critical and costly failure

By design, contact tracing systems were intended to inform all those who had been in contact with someone who has tested positive for COVID-19 that they now needed to self-isolate for a defined period – at least 10 days at this point – to minimise the spread of the contagion.

Contact tracing restarted in all four UK nations during May and June 2020, after previously being halted on 12 March 2020. As seen in Figure 5, approaches to the delivery of these systems varied across the UK.

Figure 5: Overview of contact tracing systems in each of the UK nations

England	<ul style="list-style-type: none"> – <i>NHS Test and Trace</i> contact tracing programme run by a combination of NHS staff and private companies. Piloted from 5 May 2020, followed by widespread rollout from 27 May 2020. – <i>NHS Test and Trace</i> app (England and Wales) launched on 24 September 2020.
Wales	<ul style="list-style-type: none"> – <i>Test, Trace and Protect</i> contact tracing programme run in partnership by Public Health Wales, local authorities, and health boards. Widespread rollout from 1 June 2020. – <i>NHS Test & Trace</i> app (England and Wales) launched on 24 September 2020.
Northern Ireland	<ul style="list-style-type: none"> – <i>Test, Trace and Protect</i> contact tracing programme run by the Public Health Agency. Piloted from 27 April 2020, followed by widespread rollout from 14 May 2020. – <i>StopCOVID NI</i> app launched on 30 July 2020.
Scotland	<ul style="list-style-type: none"> – <i>NHS Test and Protect</i> contact tracing programme run by NHS Scotland. Piloted from 18 May 2020, followed by widespread rollout from 28 May 2020. – <i>Protect Scotland</i> app launched on 10 September 2020.

NHS Test and Trace in England has been widely regarded as a critical and costly failure. The £37bn programme took over PHE's initial role in national contact tracing as well as a wider responsibility for mass testing. In order to facilitate this, a major recruitment programme was launched [to recruit 15,000 call handlers and 3,000 qualified public health and clinical professionals](#), though [approximately 21,000 contact tracing staff](#) were eventually employed, a large number via Serco.¹¹⁵

This outsourcing to external organisations had implications for the contact tracing success rate, with reports of inexperienced and inadequately trained staff.¹¹⁶ Testimony from BMA members suggests that some outsourced staff may also have been using ineffective contact tracing techniques, for example phoning each member of a household individually, which teams with more experience in contact tracing may have avoided. Furthermore, contact tracing requires the ability to share data easily and effectively across public health systems, which is always challenging but was arguably complicated further by the need to share data across public and private sectors in England.¹¹⁷

Despite its cost and the size of its staff, analysis conducted by the Health Foundation in September 2020 found that in [its first two months England's *NHS Test and Trace* was unable to reach a large number of COVID-19 cases and their contacts](#),¹¹⁸ consequently, as many as 20% of cases passed to the programme were uncontactable and [only 60% of the non-complex cases contacted by call handlers were reached](#) and subsequently advised to isolate.¹¹⁹

'Test and trace has been an ineffective financial disaster. If public health was resourced properly they could have managed it better.'
(Consultant, England)

'It was shocking to see how much better our local DPH [Director of Public Health] did at contact tracing with limited resources and a handful of retired clinicians than the ridiculously expensive Serco setup. I really wish they had had all that resource that was so wantonly wasted, imagine what they could have done!'

(GP locum, England)

'Public health has been under-resourced, which had a significant impact on the contact tracing. If Public health had been adequately resourced and allowed to organise track and trace, the infection rate could have been better controlled.'

(Salaried GP, England)

Many have pointed to publicly-run models as being both more effective in limiting transmission and significantly cheaper to run, although direct comparisons are difficult to make.¹²⁰ Responses to the BMA's call from evidence suggests that the approach taken in Wales (see Figure 5) had the added benefit of giving local authority staff with an understanding of their community the responsibility to make calls to contacts, potentially ensuring greater public trust in the system and enhancing the quality of the data collected. In Wales, each of the 22 local authorities across the country managed their own track and trace operations.

Indeed, there have been repeated calls, both at this time and since, for England's contact tracing systems to be run at a local authority level. This is something that NHS Test and Trace did eventually start to do; local authority public health teams began to be given responsibility for some contact tracing from August 2020, with indications that these teams had higher success rates.¹²¹ However, this shift towards local authority involvement was slow and by October 2020, only one-third of England's local authorities had local contact tracing systems in place.¹²²

In Wales, once local authorities restarted day-to-day work as lockdowns lifted, staff who had been responsible for the test and trace systems began to return to their regular roles. This forced the Welsh Government to oversee the training of additional staff to replace them and manage the service.

Alongside these factors, wider policy decisions also impacted the success of the test and trace systems, particularly regarding public participation and adherence. As has been widely noted, many people were reluctant to test, self-isolate, or use the test and trace app due to concerns about the impact of isolation on their livelihoods. A clear link has been drawn from this to the fact that [the UK offers the lowest sick pay in the entire OECD and that the payments available to support those isolating at this stage of the pandemic were insufficient](#) and with only a third of applicants being successful, extremely difficult to access.¹²³ This likely contributed to the NAO's (National Audit Office) estimates that suggested that anywhere [between just 10% and 59% of the population were in fact fully adhering to self-isolation rules](#).¹²⁴ Respondents to our call for evidence raised concerns about self-isolation payments being inadequate.

'Economic support measures have been inadequate. I have had numerous patients who refused to countenance a diagnosis of Covid for economic reasons and therefore refused to be tested.'

(Salaried GP, England)

The Scottish national test and trace system – Test and Protect – while not suffering from the exact challenges experienced by its English counterpart, also faced significant operational problems as pointed out in our call for evidence survey.

'Scottish test and protect services [were] too fragmented between a national system and Health Board systems. Too many different databases.'

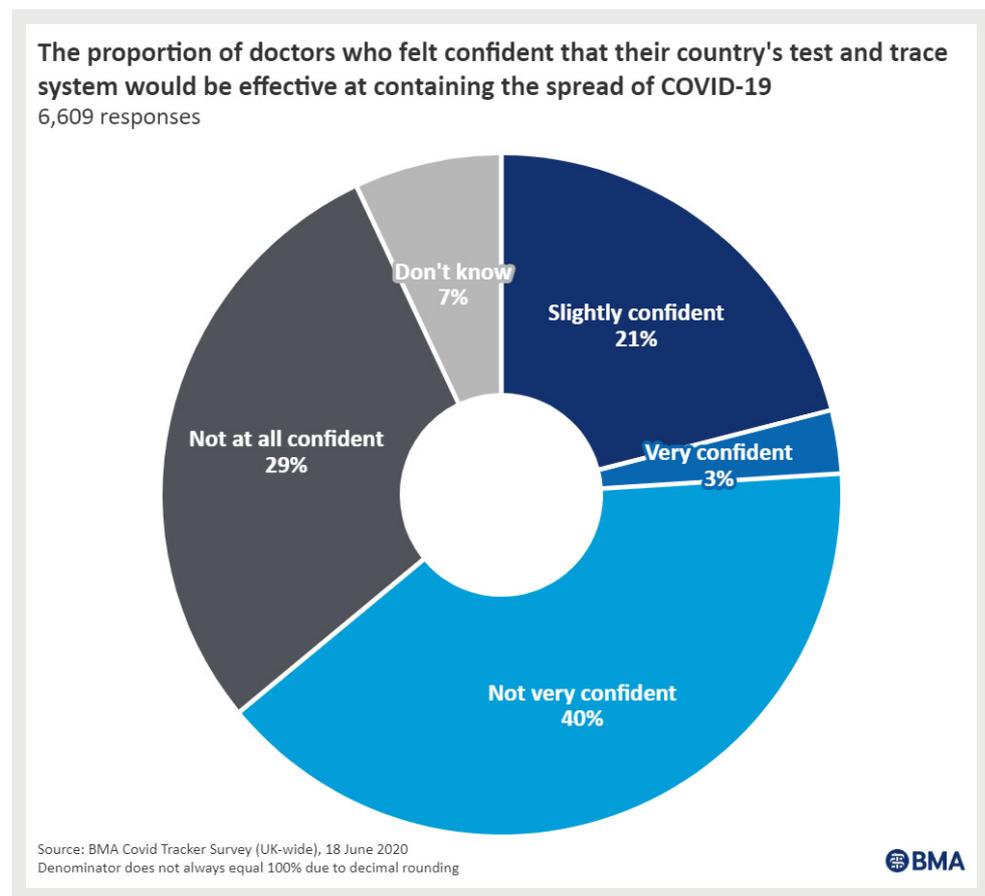
(Retired doctor, Scotland)

'Completely over-run when had more cases in terms of contact tracing. Test and Protect has been unpoliced and results so slow from lighthouse labs that proper infection control non-existent.'

(GP contractor/principal, Scotland)

Concerns about test and trace systems were also reflected in our UK-wide COVID tracker survey in June 2020,¹²⁵ which found that over two in three doctors (69%) did not feel confident that their country's test and trace system would be effective at containing the spread of COVID-19. Confidence was low amongst doctors in all four nations, although it was particularly low in England (72%).

Figure 6: Doctors' confidence in June 2020 that their country's test and trace system would be effective at containing the spread of COVID-19



Questions for the inquiries to answer

- Why did the UK Government choose to take this approach to testing and opt not to use existing public capacity? How much money was used on private sector services, what procurement process was followed, and how effective was that spending? Could better value for money and effectiveness have been achieved by using existing public sector laboratories?
- What was the structure, value for money, and performance of the various contact tracing systems deployed across the UK throughout the pandemic? What were the comparative merits and demerits of a localised, public health-led test and trace system in comparison to national, private, or publicly-led models? How could surge capacity have been best identified and retained for the duration of the pandemic?

Wave two: September 2020 – April 2021

Key public health measures during wave two		
SEPTEMBER 2020		
3 September	Self-isolation requirements for international arrivals begin to vary between the UK nations ¹²⁶	UK-wide
8–10 September	Local restrictions introduced in Wales and Northern Ireland for the first time ¹²⁷	Wales and Northern Ireland
10 September	Contact tracing app (<i>'Protect Scotland'</i>) launches in Scotland ¹²⁸	Scotland
14 September	Limits on group size for indoor and outdoor mixing in England and Scotland, ¹²⁹ and indoor mixing in Wales ¹³⁰	England, Scotland, and Wales
22 September	Measures tighten in Northern Ireland, with no indoor mixing permitted and limits on outdoor mixing ¹³¹	Northern Ireland
23 September	Measures tighten in Scotland, with bans on visits inside homes and a 10pm curfew for hospitality settings ¹³²	Scotland
24 September	UK-wide tightening of restrictions, including encouragement to work from home, a 10pm curfew (except in Northern Ireland) and table service for hospitality settings ¹³³	UK-wide
	Contact tracing app (<i>'NHS Covid-19'</i>) launches in England and Wales	England and Wales
28 September	Self-isolation required by law for those testing positive ¹³⁴	UK-wide
OCTOBER 2020		
9 October	Scotland introduces further restrictions on hospitality venues ¹³⁵	Scotland
14 October	Local restrictions introduced in England through a three-tier system categorising local areas as on either 'very high', 'high' or 'medium' alert, with corresponding levels of restrictions ¹³⁶	England
16 October	Wales restricts travel into Wales from the rest of the UK ¹³⁷	Wales
	Measures tighten in Northern Ireland with the closure of schools and hospitality ¹³⁸	Northern Ireland
23 October	National lockdown introduced in Wales ¹³⁹	Wales
NOVEMBER 2020		
2 November	Local restrictions introduced in Scotland through a five-level local framework ¹⁴⁰	Scotland
	Schools reopen in Northern Ireland ¹⁴¹ but tighter restrictions remain in place for other sectors	Northern Ireland

5 November	National lockdown introduced in England until 2 December 2020 ¹⁴²	England
9 November	National lockdown ends in Wales. ¹⁴³ New measures allow two households to form a bubble and businesses to reopen	Wales
	Availability of asymptomatic lateral flow testing in England begins to be expanded ¹⁴⁴	England
24 November	Announcement of a UK-wide easing of restrictions for five days over the Christmas period ¹⁴⁵	UK-wide
27 November	National lockdown introduced in Northern Ireland. Schools remain open ¹⁴⁶	Northern Ireland
DECEMBER 2020		
2 December	National lockdown ends in England and restrictions return to a three-tier regional system ¹⁴⁷	England
	First COVID-19 vaccine approved for use in the UK	UK-wide
4 December	Wales re-introduces restrictions on hospitality venues, ¹⁴⁸ and travel restrictions for entering Wales from the UK ¹⁴⁹	Wales
	Some senior executives arriving into the UK are exempted from full self-isolation in England ¹⁵⁰	England
8 December	First vaccines administered in the UK	UK-wide
10 & 11 December	Self-isolation reduced from 14 days to 10 days UK-wide	UK-wide
11 December	National lockdown ends in Northern Ireland including opening of non-essential shops ¹⁵¹	Northern Ireland
14 December	Some schools close in Wales ¹⁵²	Wales
15 December	International arrivals into the UK can pay for a COVID test in order to leave self-isolation after five days ¹⁵³	England
20 December	Three-tier regional system in England expanded to four tiers	England
	National lockdown introduced in Wales ¹⁵⁴	Wales
	UK Government announces that easing of restrictions over the Christmas period will now only apply to one day and will not include those living in a Tier 4 area ¹⁵⁵	UK-wide
25 December	Restrictions temporarily eased on Christmas Day for those living in Tiers 1–3 ¹⁵⁶	UK-wide

26 December	Three-tier regional system reintroduced in England	England
	National lockdown resumes in Wales and Northern Ireland ¹⁵⁷	Wales and Northern Ireland
	National restrictions tighten in Scotland, including bans on travel between Scotland and the rest of the UK	Scotland
JANUARY 2021		
4 January	All schools close in Wales except for children of key workers ¹⁵⁸	Wales
5 January	National lockdowns implemented in England and Scotland ¹⁵⁹	England and Scotland
10 January	Asymptomatic testing begins to be available to everyone in England ¹⁶⁰	England
12 January	Scotland introduces testing requirements for some international arrivals ¹⁶¹	Scotland
16 January	Scotland further tightens lockdown restrictions, including the closure of non-essential click and collect services and the restriction of alcohol consumption in public places ¹⁶²	Scotland
18 January	Wales introduces testing requirements for some international arrivals ¹⁶³	Wales
FEBRUARY 2021		
15 February	Mandatory hotel quarantine first introduced for travellers arriving from certain countries ¹⁶⁴	UK-wide
17 February	Expansion of testing in Scotland; now available to close contacts of positive cases ¹⁶⁵	Scotland
	Schools in Scotland and Wales reopen for some age groups ¹⁶⁶	Wales
MARCH 2021		
8 March	National lockdown ends in England. Step 1 on the roadmap for lifting restrictions begins; schools reopen and outdoors mixing allowed between two adults from two households ¹⁶⁷	England
	Schools in Northern Ireland begin to reopen for some pupils	Northern Ireland
10 March	Expansion of testing in Wales; now available to close contacts of positive cases ¹⁶⁸	Wales
12–13 March	National lockdowns end in Scotland and Wales, with limited outdoor mixing permitted ¹⁶⁹	Scotland and Wales
27–29 March	Further easing of restrictions in Wales and England; outdoor mixing of up to six people and no requirement to stay local ¹⁷⁰	Wales and England
APRIL 2021		

2 April	Further easing of restrictions in Scotland; 'stay at home' restrictions replaced with 'stay local', and some non-essential retail reopens ¹⁷¹	Scotland
12 April	Further easing of restrictions in England (step 2 on the roadmap for lifting restrictions). Outdoor hospitality, indoor leisure facilities and non-essential shops reopen ¹⁷²	England
	Further easing of restrictions in Wales; schools reopen for all pupils, non-essential shops reopen, and restrictions are lifted on domestic travel into and out of Wales ¹⁷³	Wales
	National lockdown ends in Northern Ireland; outdoor mixing permitted for 10 people and the 'stay at home' message is replaced by 'stay local' ¹⁷⁴	Northern Ireland
16 April	Scotland permits domestic travel within Scotland and outdoor mixing of up to six people from six households ¹⁷⁵	Scotland
16–26 April	Asymptomatic testing available to everyone in Wales ¹⁷⁶ and Scotland ¹⁷⁷	Wales and Scotland
30 April	Further easing of restrictions in Northern Ireland; outdoor hospitality and non-essential shops reopen	Northern Ireland

The second wave of COVID-19 began with a sustained rise in cases from September 2020 onwards, with a brief period between the first and second waves and before restrictions – largely localised at first – were reintroduced in earnest.

As [the BMA stated in our exiting the lockdown paper](#), the June 2020 end of the first lockdown was not accompanied by a coherent plan for keeping COVID-19 at bay in much of the UK. As a result, it was followed by rising infection rates, the imposition of local lockdowns, a subsequent tiered approach to restrictions intended to limit infection rates in defined localities, and, ultimately, a further UK-wide lockdown.¹⁷⁸

Local restrictions were meant to avoid another national lockdown, but their failure made one inevitable

The early period of the second wave saw increasingly localised approaches to minimise the spread of COVID-19. This included decisions to focus efforts and restrictions on areas where cases were rising fastest to avoid restricting economic and social activity in other parts of the country, rather than implementing national lockdowns to maintain a low case rate across the whole country.

This took various forms, at first with certain areas placed under specific restrictions and later with a system of tiers emerging in England – with every area of the country placed into first one of three and later one of four categories depending on their prevalence of COVID-19. A local area's tier would, for example, dictate where and with how many people a resident could socialise. Those living in tier one areas were able to mix with up to six people from different households inside or outside, whereas those in tier four could meet with one person and only do so outdoors.¹⁷⁹

In Wales, local restrictions were first announced in early September 2020, for the Caerphilly local authority area. This meant people could not leave the county boundary, meeting people indoors and extended households were banned, and anyone above the age of 11 had to wear face coverings in shops. Similar restrictions were implemented across most counties in Wales over the next months.

The rationale for imposing enhanced restrictions in localities (local lockdowns) was widely recognised, where greater disruption to the lives of a smaller population is balanced against the need to minimise economic and other harms across a wider region/country.

However, for locally enhanced restrictions to be successful in driving down infections, they must be accompanied by abundant testing, efficient contact tracing, and appropriate support for isolation. Though the desire to avoid nation or region-wide measures was understandable given the impacts of the first nationwide lockdowns, as we have already set out, the systems relied upon to provide local health surveillance were often not effective enough or too centralised.

As a result, serious questions remain over the efficacy and implementation of local lockdowns and restrictions, as evidenced by the eventual need for further national lockdowns throughout the UK. Indeed, of all the areas in England placed under localised lockdown, Leicester was the only one that [saw a sustained decrease in cases](#).¹⁸⁰

The efficacy and clarity of the tier systems deployed in England, Wales and Scotland were also questionable – Northern Ireland did not have the same tier system. The UK-wide analysis presented to SAGE in November 2020 suggests that local epidemics shrunk in some of the higher-tier areas, but the picture was mixed for areas placed under lower-tier restrictions.¹⁸¹ Decisions on how tiers were determined were often opaque and subject to rapid change. For example, it took less than three weeks from London being placed in tier two for it to then leapfrog into tier four. There is a need to balance political and societal needs, but from a public health perspective, this made little sense. As set out below, the UK Government did eventually, though only following the England-wide November circuit-breaker lockdown, attempt to address the poor communication of exactly why a region was placed into a specific tier. This included clarifying that metrics such as the number of overall cases and in those over 60 years of age; the percentage of tests returning positive in each area; the rate of rise or fall in cases; and the pressure on local NHS services were all considered.

Although these metrics were clear, the thresholds needed to be reached for a decision to be taken and the geography over which these metrics were taken was not. Parts of London, for example, had some of the highest rates of COVID-19 cases in the country but were placed in a lower tier based on their wider geography, integrated economy, and transportation.



Recommendations

- All UK governments should review their approach to – or policy on – localised restrictions in the event of a future pandemic, to ensure that, if used again, these processes are clear, inspire confidence, and are enforceable.



Questions for the inquiries to answer

- What was the effectiveness of local lockdowns on case rates and their wider implications on the wellbeing of the populations affected?

The standard of communication between national and local bodies risked undermining implementation and consistency of lockdown policies

The quality, coherence, and quantity of communications between national and local bodies presented a major challenge throughout the pandemic and particularly during the period of local lockdowns.

In response to the BMA's call for evidence, doctors pointed to a lack of communication between the centre and frontline services impacting their ability to support the public. Scottish doctors in particular reported problems with communication reaching those working on the frontlines, with many relying on the news rather than official channels.

Communication between local and central government was often a perennial issue, too. Within England, [Leicester City Council was unaware of which areas would be covered under the local lockdown restrictions until a day before they were implemented](#), and local public health teams struggled to access data they needed to effectively manage this localised approach.¹⁸²



Questions for the inquiries to answer

- How effective and consistent was communication and information sharing between national and local government, particularly around the implementation of local lockdowns?
- What was the standard of communication between NHS services and private healthcare providers, and between government policymakers and frontline public health staff?

Variable clarity and quality of public messaging risked limiting buy-in and understanding of local restrictions

Communication and clarity of public health messaging were a particular problem across the second wave.

This was arguably demonstrated by the UK Government's use of public COVID-19 slogans, which were not just changed repeatedly, but frequently lacked clarity in their instructions to the public.¹⁸³

The UK Government's initial slogan – 'stay home, protect the NHS, save lives' – sent an instructive message and left little doubt about what was expected of the public, or why. Yet, in May 2020, this was replaced with the opaque 'stay alert, control the virus, save lives' which left the public to determine what exactly they should stay alert to and how to control the virus. This was succeeded in September 2020 by 'hands, face, space', focusing on hand washing, face coverings, and social distancing, though hinging on public understanding of what exactly this entailed. Ultimately, and potentially reflecting the urgency of the situation and the original slogan's efficacy, 'stay home, protect the NHS, save lives' returned to use in January 2021. The frequency and nature of the changes risked undermining the understanding of core public health messaging and hindered the maintenance of a cohesive, consistent, and clear narrative around expectations for public behaviour.

Christmas 2020 presented a further example of confusing and opaque communication from the UK Government. On 2 December 2020, the second national lockdown ended in England, leaving some hope that social mixing would be possible during the coming festive period. This hope was affirmed by the prime minister on 15 December, with a public statement that rules would be relaxed over Christmas. This allowed the public to make plans, arrange travel, and commit to family celebrations. Yet, just four days later, the prime minister announced the introduction of a new fourth tier of restrictions which would come into effect on 21 December – instructing the public to 'stay at home' – across London and the Southeast. This meant that millions of people were now forced to reconsider plans, cancel travel, or make a rapid exit from tier four areas to spend Christmas with family and friends – likely contributing further to the spread of the virus across the country.

The resultant confusion and frustration risked undermining trust in public messaging and adherence to restrictions, casting doubt on the strategy being pursued by the UK Government. It has since emerged as part of the so-called 'Partygate' scandal that illicit social gatherings were being held in 10 Downing Street on 17 and 18 December, further compromising what trust remains in the UK Government's COVID-19 messaging. The COVID-19 pandemic is not yet over and case rates remain concerningly high, which only reinforces the impact and continued risk posed by this loss of trust – especially if further measures are necessary in the future to protect the public health from the virus.

In contrast, public communication across Northern Ireland, Scotland, and Wales was considered to be more effective and received stronger buy-in from their local populations.

'...as a citizen and resident in Wales, I – and all my neighbours and colleagues – have consistently felt that the firm and cautious control (and communication) by the Welsh Government has been safer than, and much preferable to, that of "London" – the Westminster UK/England government.'
(Salaried GP, Wales)

'I think measures in Scotland were more effective as consistent messages throughout helped clarify what was and was not allowed.'
(GP contractor/principal, Scotland)

However, the issue of UK Government messaging intermingling with, and potentially undermining, announcements from the Scottish, Northern Irish, and Welsh Governments has remained prominent throughout the pandemic. Likewise, the heavy UK-wide media coverage of the UK Government's decisions has sometimes meant that those policies have dominated public discourse, which has risked undermining nation-specific messaging. Consequently, the public in the devolved nations have at times interpreted England-specific policy as applying to their own nations, creating uncertainty.

'The four nations approach was understandable but led to lots of confusion about what was and wasn't "allowed".'
(Consultant, Scotland)

'Difficult having the different nations of the UK all adopting different public health measures and messaging – confusing and affects the public's compliance.'
(Consultant, Wales)

'Mixed messaging with different lockdowns and rules in UK have led to greater confusion and non-compliance as measures were relaxed.'
(GP contractor/principal, Scotland)



Questions for the inquiries to answer

- How effective were the UK Government's public communications, including its cultural competence, and what was the impact of these communications on local adherence to and understanding of restrictions? What impact did the timing of key announcements have? What was the impact on public trust and adherence to restrictions?
- How effectively did the UK governments communicate their different approaches to public health interventions and wider guidance? Did the use of the same platforms to disseminate advice from four different governments have a negative impact on adherence and understanding of key rules?

National lockdowns followed rising cases and the emergence of the Alpha variant

By October 2020, rising cases and the failure of local lockdowns to sufficiently contain the spread of COVID-19 meant that further action was needed across the UK. SAGE meeting notes detail the grave nature of the situation, highlighting that serious action was needed.

At this point, SAGE also noted the need for a 'circuit breaker' lockdown covering September and October to stall the increase in cases. Despite this, immediate action was not taken. Eventually Wales, in October, and England and Northern Ireland, in November, did implement time-limited circuit breaker national lockdowns. Scotland, though it did not deploy a circuit-breaker lockdown, already had comparatively stronger restrictions in place than the rest of the UK at this stage.

Once introduced, these circuit-breaker lockdowns had a pronounced effect on reducing cases and hospitalisations over the months they were in place. However, they came too late to reduce cases sufficiently and were lifted too early to prevent the new Alpha variant of COVID-19 from spreading rapidly.

The Alpha variant – first discovered in Kent – emerged in November 2020 when the circuit-breaker lockdowns were about to be lifted. It is more transmissible than the original Wuhan strain of COVID-19 and quickly established itself as the dominant strain in the UK with cases and hospitalisations rising quickly throughout December 2020.¹⁸⁴

These short-term circuit-breaker lockdowns all ended within a month, but it would be barely another month before further national lockdowns were imposed throughout the UK, between late December and early January 2021. There is, therefore, a strong argument that these temporary lockdowns ought to have been extended, given the severity of the impact COVID-19 had across the period between the circuit breaker and subsequent national lockdowns because of the emergence of the Alpha variant – with cases in late December reaching up to 83,088 per day, up from an average of 14,677 per day in late November 2020.¹⁸⁵

These new lockdowns also came with a renewed focus from the UK governments on suppressing COVID-19 not until it passed, but until vaccines – which were in the late stages of development by the winter of 2020 – were widely available. This focus on suppressing COVID-19 was something the BMA called for specifically in our November 2020 report [*Exiting the lockdown – a strategy for sustainably controlling the transmission of COVID-19 in England*](#).¹⁸⁶



Questions for the inquiries to answer

- Why did the UK, Northern Irish, and Welsh Governments, which had adopted circuit-breaker lockdowns, choose not to extend them, only to implement national lockdowns a month after they ended?

The delivery of a first COVID-19 vaccine signalled a new approach and a move away from lockdowns

December 2020 and January 2021 brought both grim and good news. The new year marked the start of the second UK-wide lockdown but, the rollout of the UK's vaccination campaign had also just begun.

The deployment of the [first effective COVID-19 vaccines](#) came in late 2020,¹⁸⁷ with the [first dose in the UK delivered on 8 December](#) to the then 90-year-old Margaret Keenan.¹⁸⁸ For many, this was the first sign of a potentially sustainable route out of the cycle of lockdowns, but the most recent round of UK-wide restrictions would still last for several more months.

Following the advice of the independent JCVI (Joint Committee on Vaccination and Immunisation), a list of nine priority groups who would receive the vaccine first was published. The rollout started with staff and older residents of adult care homes (priority group one), followed by those aged 80 and above and frontline health and social care workers (priority group two) – something the BMA had lobbied hard for. The rollout then moved down through age groups and risk categories.¹⁸⁹ **See figure 7 for a full list.**

Figure 7: JCVI priority groups

1	Residents in a care home for older adults and their paid carers
2	All those 80 years of age and over and frontline health and social care workers
3	All those 75 years of age and over
4	All those 70 years of age and over and clinically extremely vulnerable individuals (not including pregnant women and those under 16 years of age)
5	All those 65 years of age and over
6	All individuals aged 16 years to 64 years with underlying health conditions which put them at higher risk of serious disease and mortality, and unpaid carers
7	All those 60 years of age and over
8	All those 55 years of age and over
9	All those 50 years of age and over

All four nations took a mixed-delivery approach, using a large network of vaccination sites including hospital hubs, GP surgeries, pharmacies, and mass vaccination centres. The rollout was delivered by the NHS and spearheaded by general practice, with individuals working many additional hours to deliver the programme alongside a range of other demands.

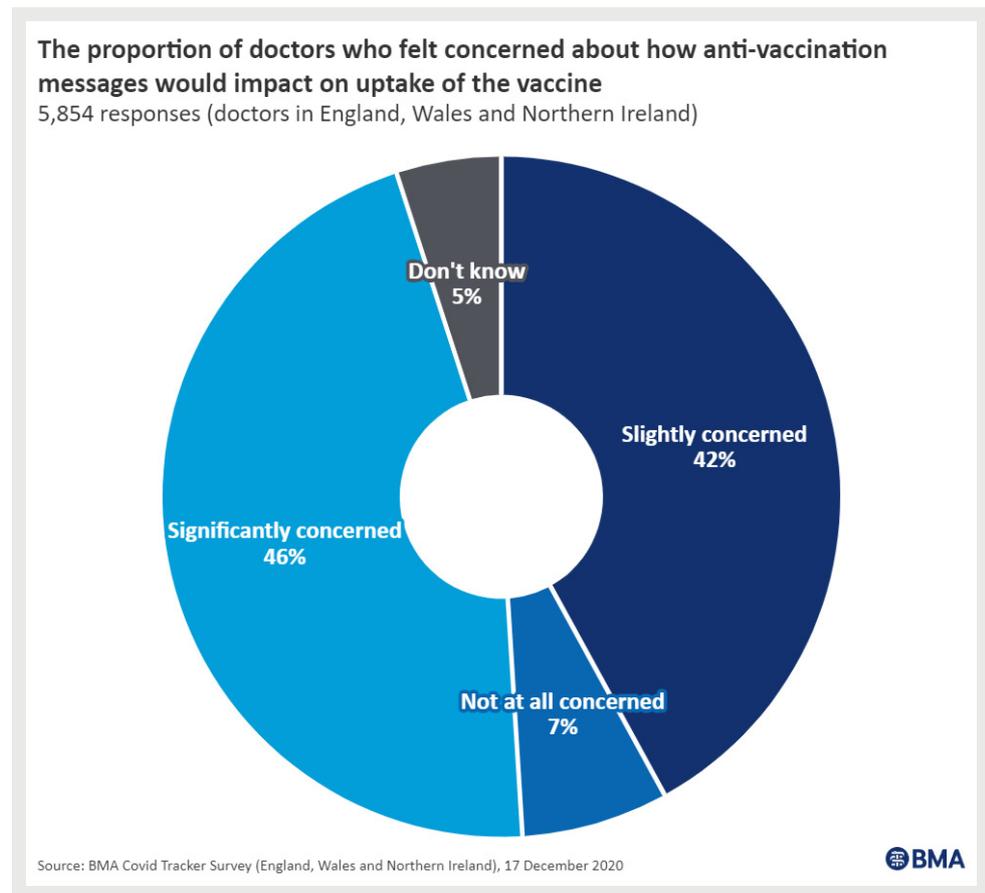
Widespread vaccination coverage provided a new and extremely effective intervention against COVID-19. It entirely changed the policy context of how COVID-19 could be approached. This saw the response to the pandemic shift gears, pulling away from limiting transmission and driving toward minimising the risk the disease poses to the public, including the most vulnerable. Consequently, the dominant political and policy mantra became a question of vaccinating as many people as possible before easing restrictions and following roadmaps out of lockdown.

However, vaccination was an effective but imperfect tool for preventing COVID-19 transmission. Cases of COVID-19 continued to rise and fall throughout the mass vaccination programme but as of writing this report, remain high. Vaccinations have been a hugely successful and pivotal part of the pandemic response, but while they are highly effective at protecting against severe disease, hospitalisation and long COVID, they do not prevent transmission of the virus. This was central to the cautious position maintained by the BMA during the vaccine rollout. The association continually called for the maintenance of restrictions as although the vaccine limited the worst impacts of the virus, it did not reduce or limit infections, nor prevent the emergence of new COVID-19 variants, such as Delta. Consequently, those more vulnerable to the virus – for example, those for whom vaccines were less effective – remained at significant risk.

Although the overall vaccination rollout was hugely successful, there was also variation and inequity in vaccine take up. Data from 2022 shows that the vaccine uptake tends to be higher in areas of greater affluence and gradually decreases with deprivation.¹⁹⁰ The fifth report in this series examines the impact of the pandemic on population health and will consider these inequalities in greater detail.

Alongside the vaccine rollout, there was also a small but significant level of anti-vaccination messaging.

Figure 8: Doctors' level of concern about the impact of anti-vaccination messaging on vaccination uptake



In our COVID tracker survey in December 2020, 88% of respondents said they were concerned about how anti-vaccination messages would impact on uptake of the vaccine. As such, the BMA [called on the UK Government to take more action to tackle misinformation online](#) and launched a [social media campaign to address vaccine hesitancy](#), particularly amongst ethnic minority groups. The need for governments to do more to combat this messaging was also raised by respondents in our call for evidence.

'[There is] the need for clear and consistent public messaging and for the involvement of community leaders in informing and supporting populations to come forward for vaccination.'

(Public health consultant, England)

'Communication is key, and as with so much else, the government's communication was woeful. Even now, the community are confused as to why the vaccine is not eradicating covid. End result being that people are not careful enough and we have ongoing problems in society and healthcare.'

(Junior doctor, Northern Ireland)

'I would have liked to see clearer public health messaging about the benefits of vaccination to try to counter the disinformation on social media (and stronger sanctions for those spreading disinformation).'

(Salaried GP, Wales)

Spring 2021 saw the end of wave two, with restrictions easing in all four nations between March and May 2021 and the rapid expansion of the vaccination programme. While specific measures varied between the UK's nations, this period was broadly characterised by the reopening of schools and the return of outdoor social mixing in limited numbers.

The second wave of the pandemic saw a number of major public health decisions taken by the UK's four governments. The NHS-led rollout of the vaccination programme was a vital success that saw the second wave end on a positive note and one which highlighted the immense role of the health service and frontline staff in fighting the pandemic.

However, this high note was dulled by the failings and missteps that typified the earlier months of wave two – not least the moves in and out of lockdowns, the patchwork of localised interventions, and the increasingly inconsistent national messaging around the virus. The UK Government in particular routinely failed to take the [precautionary approach](#) called for by the BMA and others throughout the second wave, which hindered attempts to limit the spread of COVID-19. This failure was compounded by poor public communication, inconsistent policies and restrictions, and a growing focus on the political and economic imperatives of 'reopening' society.

Wave three: May 2021 – December 2021

Key public health measures during wave three		
MAY 2021		
17 May	Aligned rules for international arrivals agreed by Wales, Scotland, and England ¹⁹¹	Wales, Scotland, and England
	Further easing of restrictions in England (step 3 on the roadmap for lifting restrictions) with outdoor mixing permitted for 30 people, indoor mixing permitted for six people and most indoor hospitality reopens ¹⁹²	England
	Indoor hospitality reopens in Wales with limits on group size ¹⁹³	Wales
	Further easing of restrictions in most areas of Scotland including increased numbers permitted to mix indoors ¹⁹⁴	Scotland
24 May	Easing of restrictions in Northern Ireland, including six people permitted to mix indoors and the reopening of indoor hospitality	Northern Ireland
JUNE 2021		
7 June	Further easing of restrictions in Wales; increased numbers permitted to mix indoors and outdoors, and larger organised outdoor events resume ¹⁹⁵	Wales
JULY 2021		
17 July	Further easing of restrictions in Wales including no limits on outdoor mixing and the reintroduction of larger indoor organised events ¹⁹⁶	Wales
19 July	Most legal restrictions lift in England (step 4 on the roadmap for lifting restrictions, dubbed 'Freedom Day'). Remaining venues reopen. ¹⁹⁷	England
	Further easing of restrictions in Scotland; increased numbers permitted to meet indoors and outdoors, physical distancing reduced, and larger events permitted ¹⁹⁸	Scotland
	Fully-vaccinated international arrivals from some countries no longer need to self-isolate	UK-wide
AUGUST 2021		
7 August	Self-isolation no longer required for fully-vaccinated close contacts of positive cases ¹⁹⁹	Wales
	Wales removes legal limits in indoor and outdoor mixing. Those with symptoms or who test positive still required to isolate, and face coverings still mandatory in some places. ²⁰⁰	Wales

9 August	Scotland removes legal limits on indoor and outdoor mixing and on physical distancing (with the exception of healthcare settings). Self-isolation no longer required for fully-vaccinated close contacts of positive cases. ²⁰¹	Scotland
16 August	Self-isolation no longer required for fully-vaccinated close contacts of positive cases in Northern Ireland and England	Northern Ireland and England
SEPTEMBER 2021		
2 September	Asymptomatic testing available to everyone in Northern Ireland ²⁰²	Northern Ireland
10 September	Further easing of restrictions in Northern Ireland, including increased numbers permitted to mix indoors	Northern Ireland
OCTOBER 2021		
1 October	Proof of full vaccination needed to enter nightclubs and larger events in Scotland ²⁰³	Scotland
4 October	Fully vaccinated travellers from most countries can use lateral flow tests instead of PCR tests	UK-wide
11 October	Proof of full vaccination or a negative test needed to enter nightclubs and larger events in Wales	Wales
29 October	Wales tightens self-isolation guidance for household members of somebody with symptoms or a positive test ²⁰⁴	Wales
31 October	Nightclubs reopen in Northern Ireland	Northern Ireland
NOVEMBER 2021		
15 November	Entry requirement of proof of full vaccination or a negative test extended to a wider range of settings in Wales ²⁰⁵	Wales
23 November	Working from home advised in Northern Ireland ²⁰⁶	Northern Ireland
26 November	Restrictions for some international arrivals begin to tighten in response to the Omicron variant	UK-wide
30 November	All international arrivals required to self-isolate until a negative test is received	UK-wide

The third wave of the pandemic, brought on by the spread of the Delta variant of COVID-19 in the UK, commenced in May 2021. Critically, however, it emerged when vaccination coverage across the UK was becoming widespread. Vaccination changed the context of the pandemic in the UK. It meant severe illness and death were largely preventable via means other than restrictions and that psychological safety within society could be gradually regained for many. But, even with the increased spread of vaccination, this period saw varying perceptions of risk and safety in different parts of society. For those who were categorised as CEV (clinically extremely vulnerable) – some of whom were not as effectively protected by vaccines as others – there remained a sense of, and a need for, continued caution. This issue is covered in detail by the fifth report in this series.

However, plotting a route out of the pandemic in the presence of a sustained threat from the Delta variant, which continued to spread despite widespread vaccination coverage, posed a range of complex new challenges for decision-makers.

One such challenge was the trade-off of longer-term impacts of the virus – namely long COVID – and the mental health impacts of lockdowns and restrictions on mixing and movement. This was a factor in the narrowing margins by which the relative costs of measures could be weighed against their benefits – whether increasing vaccine coverage negated the need for restrictions that limited the risk of transmission. However, profound questions remain regarding how all UK governments approached the pivotal issue of protecting those considered to be CEV against COVID-19 as they increasingly focused on removing restrictions. This was partly why the BMA continued to push for a cautious approach alongside the vaccine rollout, one which included measures to protect the most vulnerable and aimed to minimise the risk of long COVID becoming a major new driver of ill health.



Questions for the inquiries to answer

- How effectively did UK governments support people categorised as CEV as they shifted towards policies of relaxing restrictions that limited the spread of the virus?
- Were the clear public health advantages of lifting restrictions, particularly to the population’s mental health, appropriately balanced with serious concerns around the impact of this wave on healthcare services and workforce capacity?
- How effectively did governments and relevant health agencies respond to the emergence of long COVID, and how have they continued to both treat and support those suffering from it?

Despite mass vaccinations, COVID-19 cases and hospitalisations remained high moving into the third wave of the pandemic

COVID-19 remained prevalent in the UK at the outset of the third wave, with hospitalisations increasing to over 800 daily admissions from the middle of July 2021 and remaining between 800 and 1,200 daily admissions throughout the third wave. Also, unlike in previous waves, admissions into hospital for patients with COVID-19 were now significantly more likely to be primarily due to COVID-19 itself, rather than the virus being a contributing or purely incidental factor for admission.²⁰⁷

This is because the higher prevalence seen from June until December 2021 was also when Delta became the dominant variant of COVID-19 in the UK. The Delta variant is more transmissible than its predecessor, Alpha, and so quickly displaced it. Critically, Delta is also more virulent than Alpha, more effective at infecting people even if they are already vaccinated,²⁰⁸ and evidence suggests that it led to poorer outcomes for those infected with it.²⁰⁹



Questions for the inquiries to answer

- Following the classification of Delta as a ‘variant of concern’ in the UK in May 2021, to what extent was its profile (increased transmissibility and virulence) considered by decision-makers when planning the timeline for the easing of restrictions?

The prevalence of COVID-19 and the emergence of the Delta variant placed even greater pressure on the NHS and frontline health and care services

The rapid spread of the Delta variant put further pressure on already heavily strained health and public health services which were working at the limits of their capacity to address both the ongoing threat of COVID-19 and an increasingly large backlog of non-COVID care. This issue – and its impact on doctors and health and care staff – remains a major concern for the BMA as set out in our report [Rest, recover, restore: Getting UK health services back on track](#) and also the second report in this series, which looks at the impact of the pandemic on the medical profession. The third report in this series also examines the delivery of healthcare throughout the pandemic in greater detail.

The BMA, therefore, took the view that caution was critical, due to the continued threat of the virus and the lack of certainty around the capacity of vaccines alone to suppress the Delta variant. This included calls to limit the number of COVID-19 cases as comprehensively as possible before any easing of restrictions to protect vulnerable people and reduce the overall burden on the NHS. Neither the success of the vaccine rollout nor political rhetoric should cloud the fact that the Delta variant posed a very real threat to public health and NHS services when it first emerged. The new variant was a cause of enormous concern – as reflected in the BMA's position at that time, if not the UK Government's.

Critically, the BMA emphasised that not prioritising limiting the spread of COVID-19 in the community had costs. We argued strongly that this approach would be counterproductive to resuming non-COVID care across the NHS, given the associated impact on admissions, and within the constraints of an understaffed workforce. In the BMA's view, it was better for the public, healthcare staff and patients – many of whom had at this point been waiting for non-COVID care for prolonged periods – to be cautious than to run the risk of having to reimpose measures in the future. We were also concerned that the increasing rhetoric about reclaiming freedoms made healthcare staff's lives on the ground more difficult and misrepresented both the ongoing public health challenge posed by the pandemic and pressures on NHS services, as made clear in **Box 1**.

Box 1: Political rhetoric about easing restrictions made infection prevention in healthcare settings more difficult

The political narrative prevalent across the UK governments of the primacy of easing restrictions as the pandemic progressed resulted in a decrease in the proportion of patients wearing face masks in healthcare settings. Poor communication from governments placed the onus on staff to request those entering healthcare settings wear masks. In September 2021, over a third (37%) of respondents to a BMA survey in England and Northern Ireland said they did not feel supported by their government to ask a patient or visitor to wear a face mask if they were not already doing so.²¹⁰ Similarly, one in five respondents across England, Wales and Northern Ireland reported hostility from patients or visitors when requesting they wear a face mask, with this figure increasing to almost one in three (30%) for doctors working in primary care.



Questions for the inquiries to answer

- How could the governments' public health messaging during the third wave have been improved to support healthcare workers to maintain infection prevention measures in healthcare settings?

The easing of restrictions became the dominant political narrative as 2021 progressed

As roadmaps and strategies out of the pandemic were developed across the UK governments, the relaxation and even removal of COVID-19 restrictions become more and more central to political messaging.

The [UK Government's roadmap out of lockdown](#) governed the COVID-19 strategy in England at this time, with similar approaches in place across Wales, Scotland, and Northern Ireland.²¹¹ All followed a broadly parallel pattern of easing restrictions from Spring to Autumn 2021, though as with previous waves, some measures continued in the devolved nations that had been relaxed in England – namely mask-wearing.

Among the devolved nations, the Welsh Government took the most conservative approach to ending lockdown. It was the last UK nation to announce its route out of lockdown, on 13 March 2021, and caveated that any phased relaxation of steps over the next review period would be subject to public health conditions continuing to be favourable, with no end point or 'freedom day' identified. This step-wise approach continued over April and May 2021.

Respondents to our call for evidence reported that, as at previous points in the pandemic, messaging in England also influenced those living in the devolved nations, particularly in Wales.

'It's difficult to negotiate the Wales v England divide. Staff and patients tend to watch the news etc which is mostly England centric, so we can find patients who are following English rules rather than Wales rules. This was particularly evident around 'freedom day.'

(Locally employed/trust grade doctor, Wales)

In England, the narrative around the easing of restrictions eventually centred on a so-called 'freedom day' – 19 July 2021.²¹² This would be the day on which restrictions would end in the country and became a clarion call for a UK Government seemingly determined to leave COVID-19 behind, despite the conspicuous continued presence of COVID-19 and its variants. In fact, in his speech on 19 July, the prime minister actively stated that the decision to relax restrictions came despite persistently high COVID-19 case rates.

Moreover, while 'freedom day' did not signify the literal or legal end of COVID-19 restrictions, it undeniably and probably deliberately evoked an end to the limitations the pandemic had placed on people's lives. Consequently, it sent the message that the threat of the virus had been contained via vaccination, something which public health advice actively disputed.

The same speech also outlined that, as of August 16, 2021, people with two vaccinations in England would no longer be legally required to self-isolate if identified as a close contact of a positive COVID-19 case but would instead be asked to take a PCR test. This decision was based on the perception that the 'wall of immunity' provided by vaccinations would be sufficient to protect the population. More deeply, though, it reflected a longstanding goal of outsourcing responsibility for limiting transmission of the virus to individuals and taking it out of the UK Government's hands.

In contrast to the UK Government, the BMA was – alongside other organisations across the UK – active in [calling for the precautionary retention of certain measures](#), with a focus on keeping relatively low-cost interventions (such as mask-wearing and meeting outdoors wherever possible) in place to minimise interruptions to people's lives and, as far as possible, limit the spread of COVID-19 to reduce their likelihood of developing long-COVID.²¹³

The lack of confidence doctors expressed in their respective government's handling of the pandemic at this stage is clear from a survey the BMA undertook in November 2021.²¹⁴ Only 25% of respondents to the survey across England, Wales and Northern Ireland reported feeling confident in the current approach to managing the spread of COVID-19 in their country.

It was understandable that a population that had accepted restrictions for over a year would welcome a return to greater normality, especially as vaccination was becoming increasingly widespread. However, by frequently framing the removal of some restrictions in the context of 'freedom', the UK Government risked unnecessarily politicising public health measures that had been central to controlling the spread of COVID-19 and protecting the most vulnerable. What was needed was a more balanced messaging around the easing of restrictions and actions that were advisable to be maintained even without legal requirements in place – for example, the use of face masks in public places – particularly as it was highly likely that a rise in cases later in 2021 would necessitate a return to certain measures to control the spread of COVID-19.



Questions for the inquiries to answer

- Given the high levels of cases and hospitalisations, was the rate at which restrictions were lifted during the third wave appropriate?
- To what extent was data on vaccination coverage balanced with other factors such as case rates, hospitalisation rates and the impact of long COVID when making decisions about the easing of restrictions?

Wave four: December 2021 – present

Key public health measures during wave four		
DECEMBER 2021		
6 December	Scotland permits proof of a negative test, instead of full vaccination, when entering certain venues ²¹⁵	Scotland
8 December	England launches Plan B, reintroducing some restrictions including mandatory face masks in most indoor settings, encouragement to work from home and proof of vaccination or negative test to enter nightclubs and larger events. Booster programme brought forward. ²¹⁶	England
13 December	Proof of full vaccination or a negative test needed to enter licensed premises and entertainment venues in Northern Ireland	Northern Ireland
17 December	Tightening of restrictions in Scotland, including restrictions on some indoor mixing and encouragement to work from home ²¹⁷	Scotland
	Northern Ireland requires close contacts to self-isolate even if fully vaccinated	Northern Ireland
22 December	Tightening of restrictions in Wales, including restrictions on some indoor mixing and a ban on large events ²¹⁸	Wales
22 December – 6 January	Self-isolation for those who test positive reduced from 10 days to seven days (if two consecutive negative lateral flow tests are taken 24 hours apart) ²¹⁹	UK-wide
27 December	Further tightening of restrictions in Scotland and Northern Ireland, including limits on large events and the closing of nightclubs ²²⁰	Scotland and Northern Ireland
JANUARY 2022		
17 January	Scotland eases restrictions for large outdoor events ²²¹	Scotland
17–28 January	Self-isolation for those who test positive reduced from seven days to five days (if two consecutive negative lateral flow tests are taken 24 hours apart) ²²²	England, Wales, and Northern Ireland
19 January	England no longer encourages working from home ²²³	England
21 January	Wales eases restrictions for all outdoor activities ²²⁴	Wales
24 January	Further easing of measures in Scotland, including nightclubs reopening and removing limits in indoor events ²²⁵	Scotland
25 January	Wales no longer advises only essential international travel ²²⁶	Wales
27 January	England eases restrictions (returning to Plan A) with face coverings no longer needed (except in health and care settings) and proof of vaccination or negative test no longer required ²²⁷	England
28 January	Wales eases restrictions for all indoor activities ²²⁸	Wales
31 January	Scotland eases working from home advice ²²⁹	Scotland

FEBRUARY 2022		
15 February	All restrictions are removed in Northern Ireland and replaced with guidelines ²³⁰	Northern Ireland
18 February	Proof of negative test or full vaccination no longer required to access any venues in Wales ²³¹	Wales
24 February	All restrictions are removed in England with the exception of face coverings in health and social care settings. Self-isolation no longer required for those testing positive and routine contact tracing ends ²³²	England
28 February	Proof of negative test or full vaccination no longer required to access any venues in Scotland ²³³	Scotland
MARCH 2022		
28 March	All restrictions are removed in Wales with the exception of face coverings in health and social care settings and COVID-19 specific risk assessments by employers ²³⁴	Wales
31 March	Free asymptomatic testing ends for the public in England and Wales. Free symptomatic testing remains available in Wales but ends in England ²³⁵	England and Wales
APRIL 2022		
18 April	All restrictions are removed in Wales with the exception of face coverings in health and social care settings ²³⁶	Wales
22 April	Free asymptomatic testing ends for the public in Northern Ireland. Free symptomatic testing remains available	Northern Ireland
30 April	Free asymptomatic and symptomatic testing ends for the public in Scotland ²³⁷	Scotland
May 2022		
1 May	All remaining restrictions are removed in Scotland ²³⁸	Scotland
27 May	Requirement to wear face coverings in health and care settings ends – ending all COVID-19 regulations in Wales ²³⁹	Wales

The fourth wave of the pandemic has, thus far, been defined by the emergence of another new and even more transmissible strain of COVID-19, Omicron – which has several sub-variants – and the continued easing of public health interventions and restrictions intended to suppress the spread of the disease.

Omicron spread rapidly and there were renewed concerns of an overwhelmed NHS

As with previous new variants, Omicron has a natural reproduction advantage over its predecessor Delta and quickly displaced it worldwide as the dominant variant of COVID-19 during December 2021. This happening in winter was an enormous concern, with widespread fear that it could cripple NHS services which were already creaking after nearly two years of the pandemic. Health services which were attempting to reduce huge backlogs of care were now also preparing for their usual seasonal spike in demand for non-COVID care.

From July until around December 2021, the UK had consistently recorded between 35,000 and 50,000 cases per day.²⁴⁰ This equated to a persistent level of hospitalisations from COVID-19 of around 800 a day on average over the summer months. This exacerbated the concerns surrounding the arrival of Omicron and its rapid spread as it appeared likely to compound existing pressures in an already stretched system. At this stage, exhausted staff were firefighting to look after both COVID and non-COVID patients, while also attempting to clear mounting waiting lists for elective care. At the time of writing, these remain immense across the UK and continue to grow month-on-month.²⁴¹

Consequently, the BMA urged caution in the initial phases of this wave due to its potential impact on the public, particularly as there were significant unknowns about Omicron's virulence and its ability to evade vaccine-induced immunity or immunity acquired from a previous infection. A major concern was also the impact on the health service, with staff absences rising rapidly in December. At this point, [the BMA warned that](#) based on our projections, there could be almost 50,000 doctors, nurses and other NHS staff in England off sick with COVID-19 by Christmas Day, if the Government failed to introduce any further measures to stop the spread of the virus.

The reintroduction of measures across the UK and vaccine boosters were timely and a necessary precaution to limit the threat of Omicron

In response to the rising threat of Omicron and wider pressures on their health and care systems, governments across the UK began to implement alternative approaches, including the reintroduction of some previously relaxed restrictions on social mixing. While there were similarities in these approaches, they inevitably varied across the UK, depending both on local decision-making and, importantly, what measures were still in place.

In England, from 8 December 2021, the UK Government implemented its so-called 'plan B' and included mandated mask-wearing in public places, reintroducing working from home guidance, the use of NHS COVID passes for indoor venues, and daily testing for close contacts. Northern Ireland reintroduced measures on 17 December, requiring close contacts of COVID-19 cases to self-isolate even if fully vaccinated. On the same day, the Scottish Government brought back limits on indoor mixing and encouraged the public to work from home. In Wales, mask mandates in public places remained in place, as did the guidance for people to work from home where possible, but the Welsh Government introduced a further tightening of restrictions on 22 December, including restrictions on some indoor mixing and a ban on large events.²⁴²

Although the BMA welcomed the introduction of these measures in December, the association had [called for action months prior](#). Ahead of winter, it was clear that the already high levels of COVID-19, combined with an again rapidly growing backlog of care and expected routine winter pressures would massively increase pressure on already overstretched health services. All four UK governments should have altered their strategies and reintroduced interventions sooner.

The BMA also [highlighted the importance](#) of expanding vaccination through a large-scale booster programme alongside 'plan B' style measures, as a combined effort to curtail Omicron. The booster programme included the introduction of a booster jab for everyone over the age of 18, three months after their last jab. This was a third vaccine dose for the majority of people, but a fourth dose for those who received three vaccine doses as part of their primary course of vaccination, such as those who were immunocompromised. The large-scale booster programme followed an already planned rollout of booster doses for those who were in the nine priority groups established by the JCVI for the original vaccination rollout. Given the added threat of Omicron, this was expanded and from 15 December 2021 an offer of a booster dose was made to all over 18s who had received the vaccine at least 3 months previously. The original aim of offering all eligible adults their vaccine booster by the end of January 2022 was brought forward to the end of December 2021 as cases continued to rise and the UK Government's promise of no lockdowns over Christmas looked less achievable.

Booster jabs significantly increase short-term resistance to COVID-19, provide an important defence against symptomatic disease, and strengthen the longevity of protection from hospitalisation. Doctors and the NHS accelerated delivery of booster doses over the winter period, with doses administered increasing from approximately 19m on 1 December to 34m by 1 January 2022 (England 12.7m, Scotland 1.2m, Wales 0.77m, Northern Ireland 0.4m). This NHS-led booster rollout was incredibly successful, but placed a significant strain on healthcare services, in particular on general practice – the third report in this series looks at this in greater detail.



Questions for the inquiries to answer

- Why were alternative approaches – including the reintroduction of previously withdrawn measures – not adopted before December 2021?

Omicron was eventually found to be less severe than prior variants, limiting its potential impact and allowing a new strategy

It has since been established that Omicron is less severe – although not mild as has been suggested in some commentary – than the Delta variant.²⁴³ Likewise, vaccines are significantly less effective at preventing symptomatic infection from Omicron compared to Delta, which itself had already managed to lead to infections among the vaccinated, but their ability to protect against severe disease and death remains robust.²⁴⁴

In practice, this has meant that while COVID-19 has remained prevalent, the acuity of its risk to individual health for the majority of the population has reduced. This has subsequently allowed governments across the UK to adopt strategies based on living with the virus, rather than containing or eliminating it. Likewise, the extent of vaccine coverage across the UK and the advent of new therapeutic treatments for COVID-19 provide further support – both practical and political – for this shift in approach.

In line with this change in the perceived threat of COVID-19, all four UK governments adopted individual strategies for living with the virus in the first half of 2022. Although the specific details of these plans varied – particularly in their timeframes for the removal of certain restrictions – they all followed the same core mantra of moving towards the goal of replacing legal restrictions with guidance. Similarly, all strategies placed an increasing emphasis on the role of vaccines and therapeutic treatments, over measures like face coverings and social distancing.

In Scotland, this took the form of an updated [Strategic Framework](#) for managing COVID-19 in February,²⁴⁵ followed by a [Test and Protect Transition Plan](#) in March.²⁴⁶ The Welsh Government outlined its strategy in March with [Together for a Safer Future](#),²⁴⁷ followed by [Test Trace Protect Transition](#) in June.²⁴⁸ In Northern Ireland, the [Test Trace and Protect Transition Plan](#) was published in March 2022, setting out a new approach to testing, contact tracing, and isolation.²⁴⁹ The UK Government's plan for England was established with the publication of its [Living with COVID strategy](#) in February 2022.²⁵⁰

The pace and commitment with which the UK Government in particular acted to remove legal restrictions and key public health measures in England – in stark contrast with the frequently sluggish speed at which it introduced them – often appeared to ignore the continued threat posed by COVID-19. When the living with COVID strategy was launched, cases and hospitalisations remained high but were declining. However, as cases began to rise sharply again in March, the UK Government made no attempt to pause or slow the pace of its timeline. For example, the decision to end all free asymptomatic testing for the public still going ahead on 31 March in England and Wales, followed by Scotland and Northern Ireland three weeks later.

While the focus of these strategies on vaccines and therapeutics is important, the removal of key public health measures, such as free testing, self-isolation support payments, and statutory sick pay provision in England created a two-tier system, where

only those who could afford it could protect themselves. Therefore, although advice and guidance for the public to continue to self-isolate and minimise contact were positive, the practical tools that allowed individuals to do so were often removed, putting the most vulnerable at further risk.

Additionally, since the publication of the various strategies for living with the virus across the UK, the public advice included in them has frequently failed to be widely disseminated and public health messaging has often been scaled back. A lack of clear guidance from governments following the end of measures such as free testing – which ended on 1 April in England and 28 April in Scotland – has left many worried and confused, especially those most vulnerable and at-risk from severe disease.²⁵¹

Additionally, gaps in vaccine coverage remain and, worryingly, are more prominent in those groups at greatest risk from COVID-19 as well as children, for whom vaccination is either not yet available or was only recently made available. For the UK to safely live with COVID-19, protection from it must be as universal and as equitable as possible for those groups for whom the use of the vaccine has been approved and recommended by the JCVI – something it is clearly not at this stage.

As the BMA continues to argue, the deployment of these strategies must be tempered with sustainable and longer-term means of living with COVID-19. This must include efforts to monitor, manage and minimise the risk the disease still presents, both as a driver of ill health in the population and as a new respiratory illness in circulation. It is thus noteworthy that neither the increasing prevalence of long COVID nor its impact on sufferers appear to have been factored into considerations about how the UK can live sustainably with the virus, or how groups most at risk, like the clinically vulnerable or unvaccinated, are being adequately protected.



Recommendations

- We call on all UK governments to focus resources on promoting the COVID-19 vaccine amongst at-risk and under-vaccinated groups.



Questions for the inquiries to answer

- To what extent was prevalence of long COVID, which is associated with poorer health outcomes and is a further demand upon NHS services, considered in decisions by UK governments to ease restrictions?
- How effectively did each UK government adjust its plans and timescales for the scaling-back of legal restrictions and measures in response to increasing case rates in early 2022?

All UK governments must ensure they learn the lessons of COVID-19 – but early signs are less than encouraging as pandemic infrastructure is dismantled

It is widely accepted that the UK must live with and adapt to COVID-19. However, acute concerns remain regarding how effectively the different national governments across the UK are ensuring it they will be better prepared for any future spikes in COVID-19 cases or the emergence of a new pandemic. With the UK currently experiencing a further wave of COVID-19, largely caused by the BA.4 and BA.5 sub-variants of Omicron in June and July 2022, accompanied by very little in the way of public health communication to the wider public, this remains an important question.

This absence of effective and proactive public messaging was also apparent when the UK's various strategies for living with the virus were published and, subsequently, throughout their implementation. For example, although the UK Government's living with COVID strategy contained and sits alongside useful public health advice, a glaring absence of public messaging to accompany and promote this advice meant the idea

of living with COVID-19 became synonymous with the removal of restrictions and the notional end to the threat of COVID-19, rather than a carefully managed policy. The publication of the strategy coincided with the last ever UK Government COVID-19 press conference, marking an end to one of the few prominent sources of public communication surrounding the virus. While this issue may have been particularly acute in England, the governments of Northern Ireland, Scotland, and Wales must also all learn from these mistakes and ensure an improved programme of public messaging in the event of any further pandemic.

The scaling back of COVID-19 surveillance announced in the UK Government's strategy, including the withdrawal of funding for the [REACT](#) and [Zoe](#) studies and the scaling back of the [ONS infection survey](#), is worrying and affects all UK nations.²⁵² The recent decision to reduce the frequency of data released on the UK Government's COVID-19 dashboard adds to this concern. Likewise, Northern Ireland no longer reports COVID-19 cases or deaths, and Scotland has scaled back its reporting. This reduces the UK's ability to monitor disease transmission and prevalence and threatens the country's ability to rapidly react to future variants of concern by dialling up public health measures as required. All four of the national strategies across the UK have an important focus on pharmaceutical interventions to control outbreaks through vaccinations and treatments for those at highest risk of severe disease. However, to be successful, these must exist alongside testing, adequate PPE, sufficient IPC guidance and situation-appropriate public health measures.

The dismantling of testing infrastructure and end to free testing also weakens the UK's ability to monitor and appropriately respond to levels of COVID-19 in the community. Consequently, this increases the risk of NHS services experiencing surges in demand during potential future rises in infections, where COVID-19 remains in general circulation. It also potentially leaves more vulnerable members of our society at continued risk of contracting the virus.

The decision to end testing of people discharged from hospitals to care homes in England is thus particularly worrying.²⁵³ This concern is only heightened by the fact that the decision to end this testing follows a ruling that the UK Government's policy of discharging patients to care homes without testing during the first wave of the pandemic was unlawful.²⁵⁴ This should give any government considerable pause when proposing the removal of protections for the most vulnerable members of our society.

The UK Government's living with COVID strategy also announced the scaling back of measures at the UK's borders. For example, the removal of the need to test on day eight following arrival for those who are not vaccinated and the withdrawal of hotel quarantine facilities. It is essential the UK is ready to rapidly dial up appropriate protective measures in response to future outbreaks. The strategy stated that the bar for implementation of such measures in the future is 'very high'. We would argue that decisions around measures for international travel should instead be appropriate to the severity of the threat.

The public health workforce and the availability of vaccines have been critical to the UK's various public health responses to COVID-19, as demonstrated by a recent spring booster campaign in 2022 for the over 75s and immunocompromised. Without them, as established throughout this report, the present situation would have been unachievable. The UK would, though, have been in a stronger position had its public health systems been adequately resourced and staffed before the pandemic.

It is notable, therefore, that in England, for example, the UKHSA is reportedly [seeking to cut as many as 800 members of staff](#) – up to 40% of its total workforce.²⁵⁵ This decision suggests, in the event of a further pandemic or revival of COVID-19, the UK Government would lack immediate access to many of the tools that have facilitated much of its response to the pandemic to date.

Perhaps the most critical lesson of the pandemic has been that timely and decisive action saves lives, while inaction puts them at risk. It is for that reason and in the spirit of precautionary principles that the [BMA has responded to worryingly high rates of COVID-19 cases](#) and, tragically, increases in deaths from the virus, by calling for the reintroduction of mask wearing for patients in health and care settings. Rapid action from all four UK governments is critical on this issue not only to protect patients and NHS staff, but to also show that they have learned the lessons of the pandemic.



Recommendations

- All UK governments should take steps to ensure that the staffing, tools, and facilities needed to address any future pandemic can be scaled up quickly if necessary.
- All governments must reintroduce or re-emphasise mask wearing for patients in health and care settings, to protect patients and NHS staff.



Questions for the inquiries to answer

- Has the failure to accompany the removal of COVID-19 protections with clear, consistent, and ongoing public health messaging hindered the ability of UK governments and the public to realistically adopt a sustainable strategy of living with the virus?
- How are the UK governments maintaining or disposing of their pandemic assets – in the form of workforce or facilities in particular? Does this risk undermining any future pandemic response?

Conclusion

Throughout the pandemic, the UK governments and leading decision-makers have faced far greater and more tragic challenges than anyone could have predicted on the eve of 2020.

During this time, these governments have put previously unthought-of policies into action to protect lives, revolutionised – if reluctantly, at times – the way countless people work and learn and instituted a remarkable vaccination programme that can now allow the UK to ‘live’ with COVID-19. Many of these policies were successful and illustrated how effective national action can be in facing down public health challenges.

Despite this, it is undeniable that mistakes and missteps were committed in the development and application of critical aspects of the public health responses to the pandemic. These errors have – over more than two years of COVID-19 in the UK – put lives, livelihoods, and the long-term health and wellbeing of the population at far greater risk than was ever necessary and consequently have compromised the effectiveness of the public health response at large.

In confronting the first wave of the pandemic, the UK’s leaders made the fateful decision to delay the implementation of a nationwide lockdown despite ample warning from the continent of what this might mean. An underlying – and incongruous – fatalism about the UK’s ability to test and trace the virus meant vital attempts to do so were heavily and unnecessarily delayed. And, underpinning both decisions, was an overreliance on, or misrepresentation of, questionable behavioural science to inform ultimately incorrect assumptions about what restrictions the people of England, Northern Ireland, Scotland, and Wales would be willing to endure, and for how long, to protect themselves and, above all else, each other.

The second wave was marked, though not universally, by increasingly checkerboard approaches to restrictions, flowing in part from a political reluctance to again deploy national interventions. This saw the introduction of convoluted tier systems, localised lockdowns, winter circuit-breaker lockdowns, and, finally, a delayed UK-wide lockdown in January 2021. This approach was compounded by frequent failures to communicate effectively with local government and the public, which, alongside the increasing sense of inequality imparted by localised restrictions and high-profile breaches of COVID-19 rules, contributed to a gradual erosion of the public buy-in and trust in the pandemic response that had been a hallmark of the first wave.

The emergence of the Alpha variant made a third national lockdown inevitable. Yet even then, political prevarication meant that this was only finally – and, in England especially, chaotically – imposed on the public at the start of 2021.

Arriving in earnest in May 2021, the third wave presented an enormous challenge, with the high prevalence of COVID-19 necessitating intervention, but public patience was understandably wearing thin after over a year of restrictions on their freedom. However, fundamental questions remain about how effectively governments and decision-makers met this challenge and balanced these two factors. In particular, all four governments across the UK must address the timing of the decision to relax lockdown measures in March 2021 and why this was not delayed until case rates had fallen further.

The ever-looming spectre of the backlog of care reinforces this, with frontline services expected to tackle the monumental challenge of handling the continued threat of COVID-19 as well as the ever-growing lists of treatment, diagnostics, and appointments delayed or cancelled throughout the pandemic, in addition to the ‘hidden’ backlog of unmet need generated over the last two years. It is important to ask whether the relaxation of restrictions during wave three helped or hindered these efforts. Equally, it is essential to also consider what impact the relaxation of measures had on the continued

spread of COVID-19 and overall population health – including the deterioration of health conditions due to reductions in health system capacity, and the number of people developing long COVID.

The fourth wave of the pandemic in the UK has and continues to be, defined by a strategy of living with COVID-19, supported by a rapid rollout of the booster programme at the end of 2021 and a spring booster campaign in 2022 for those at greatest risk from the virus. This living with COVID-19 strategy increasingly appears to be ignoring the virus' continued threat and the impact of long COVID on population health in particular.

The BMA is clear that while COVID-19 continues to place a significant burden on healthcare systems and the workforce, adequate protective measures must remain in place to protect the health of the UK. Where measures have been scaled back, all four UK governments must be prepared to rapidly dial up these protections as required in response to future threats. Interventions must carefully balance the importance of public freedom with the need to protect the public from further spikes of COVID-19, with an emphasis on safeguarding the most vulnerable in society. Long-term, sustainable solutions to living with COVID-19 are essential and must allow everyone, including people categorised as CEV, to make informed and managed choices about their exposure to the disease. Likewise, all four UK governments must provide their public health, health, and social care services with the resources necessary to address the health impacts of the pandemic and the new long-term driver of ill health it has created, long COVID. Moreover, long COVID must be managed as comprehensively and proactively as other public health problems.

The most pressing question now facing the UK governments and the coming inquiries into the COVID-19 pandemic is how the experiences of the last two years will influence and improve the response to future pandemics. As set out in this report, while there are undeniably remarkable feats of policy-making peppered throughout the various interventions enacted since March 2020, the pandemic response is as defined by its unforeseen or unforced errors as it is by its successes – this balance has to be righted when the UK faces its next public health crisis.

Recommendations for Governments and questions for the public inquiries to answer

Recommendations

- Each UK government should review its public health structures to ensure they enable the best possible development, distribution, and implementation of independent expert public health advice which is fully considered and given appropriate weight in government decision making – particularly at times of national crisis.
- All UK governments should adequately fund public health services wherever they are located and ensure they are rapidly supported with additional resources to expand their functions when necessary.
- The four UK governments should all urgently increase numbers of public health staff at local and national level and increase the number of public health training places provided.
- All UK governments should take steps to ensure that the staffing, tools, and facilities needed to address any future pandemic can be scaled up quickly if necessary.
- The UK Government must assess the impact the Eat Out to Help Out scheme had on both the economy and on the transmission of COVID-19 – as a means of guiding similar decisions and debates in any future pandemic.
- All UK governments should review their approach to – or policy on – localised restrictions in the event of a future pandemic, to ensure that, if used again, these processes are clear, inspire confidence, and are enforceable.
- We call on all UK governments to focus resources on promoting the COVID-19 vaccine amongst at-risk and under-vaccinated groups.
- All governments must reintroduce or re-emphasise mask wearing for patients in health and care settings, to protect patients and NHS staff.

Questions for the inquiries to answer

Pandemic preparedness and public health systems

- How, if at all, could local public health expertise (eg in health promotion or protection) have been used more effectively in the response to COVID-19?
- What was the role of public health structures in the response to COVID-19 and how effective were these structures?
- How independently were public health experts able to operate and to what extent was public health expertise considered in government decision-making at national and local level?
- What was the impact of long-term public health funding on both pandemic preparedness and the initial public health response to the onset of COVID-19? What impact did austerity have on the efficacy of the response?
- How could the public health workforce have been adequately staffed entering the pandemic? What impact could this have had on the governments' public health responses?
- In the event of a future pandemic, how will UK governments ensure the necessary number of public health experts are available and that their expertise is heard by decision-makers?
- Why did the UK's pandemic preparation focus entirely on an influenza-style pandemic? What impact did this approach have on the UK's initial response to COVID-19?
- Why were recommendations from pre-pandemic planning exercises (particularly the exercises that focused on MERS) not acted on and included in COVID-19 plans?

Wave one: February 2020 – September 2020

- How and to what extent did the UK Government assess the situation in China in early 2020 as a potential threat to the UK? To what extent did the UK Government apply precautionary principles as a result of this assessment? Why did it not respond sooner to the concerns raised by SAGE?

- Why did the UK Government choose not to act when the situation in Italy reached the stage of suspending large-scale events?
- What information did PHE use to inform their advice that scaling up capacity for testing was not possible? Was this advice from PHE challenged sufficiently when this course of action would go on to be implemented merely weeks later?
- Following the decision to shift capacity away from contact tracing on 12 March 2020, why did it take 11 days for the UK Government to introduce population-wide distancing measures when there was already acknowledgment that community transmission of COVID-19 was such that attempting to test and contact trace would overwhelm the system?
- What role did behavioural science play in the UK Government's decision not to quickly impose a package of NPIs against COVID-19? Was this driven by an incorrect assumption that adherence would quickly wane?
- Why was decisive action on non-pharmaceutical interventions not taken earlier in 2020?
- Why did the UK Government spend the seven days from 16–23 March 2020 advising voluntary behaviour to change rather than introducing lockdown?
- What was the impact of high-profile failures to adhere to lockdown rules on public support and adherence, and on trust in COVID-19 interventions? What is the potential impact of this on public behaviour in future pandemics?
- Why was the decision to require mask-wearing in public taken as late as it was? What role did the availability of PPE caused by a lack of adequate stockpiling and maintaining of national stockpiles play in this decision?
- Why did UK governments not take more cautious approaches during the summer of 2020 in preparation for a second wave?
- How did each UK government make decisions during this intra-wave period, and how effectively did they use this time to prepare for a second wave of COVID-19?
- Why did the UK Government choose to take this approach to testing and opt not to use existing, public capacity? How much money was used on private sector services, what procurement process was followed, and how effective was that spending? Could better value for money and effectiveness have been achieved by using existing public sector laboratories?
- What was the structure, value for money, and performance of the various contact tracing systems deployed across the UK throughout the pandemic? What were the comparative merits and demerits of a localised, public health-led test and trace system in comparison to national, private, or publicly-led models? How could surge capacity have been best identified and retained for the duration of the pandemic?

Wave two: September 2020 – April 2021

- What was the effectiveness of local lockdowns on case rates and their wider implications on the wellbeing of the populations affected?
- How effective and consistent was communication and information sharing between national and local government, particularly around the implementation of local lockdowns? What was the standard of communication between NHS services and private healthcare providers, and between government policy makers and frontline public health staff?
- How effective were the UK Government's public communications, including its cultural competence, and what was the impact of these communications on local adherence to and understanding of restrictions? What impact did the timing of key announcements have? What was the impact on public trust and adherence to restrictions?
- How effectively did the UK governments communicate their different approaches to public health interventions and wider guidance? Did the use of the same platforms to disseminate different governments' advice have a negative impact on adherence and understanding of key rules?
- Why did the UK, Northern Irish, and Welsh Governments, which had adopted circuit breaker lockdowns, choose not to extend them, only to implement national lockdowns a month after they ended?

Wave three: May 2021 – December 2021

- How effectively did UK governments support people categorised as CEV as they shifted towards policies of relaxing restrictions that limited the spread of the virus?
- Were the clear public health advantages of lifting restrictions, particularly to the population's mental health, appropriately balanced with serious concerns around the impact of this wave on healthcare services and workforce capacity?
- How effectively did governments and relevant health agencies respond to the emergence of long COVID, and how have they continued to both treat and support those suffering from it?
- Following the classification of Delta as a 'variant of concern' in the UK in May 2021, to what extent was its profile (increased transmissibility and virulence) considered by decision makers when planning the timeline for the easing of restrictions?
- How could the governments' public health messaging during the third wave have been improved to support healthcare workers to maintain infection prevention measures in healthcare settings?
- Given the high levels of cases and hospitalisations, was the rate at which restrictions were lifted during the third wave appropriate?
- To what extent was data on vaccination coverage balanced with other factors such as case and hospitalisations rates when making decisions about the easing of restrictions?

Wave four: December 2021 – present

- Why were alternative approaches – including the reintroduction of previously withdrawn measures – not adopted earlier than December 2021?
- To what extent was prevalence of long COVID, which is associated with poorer health outcomes and is a further demand upon NHS services, considered in decisions by UK governments to ease restrictions?
- What was the basis for the UK Government removing remaining legal restrictions in England AND key public health measures such as free testing and self-isolation support payments when the Omicron variant, with its high transmissibility, had yet to peak?
- Has the failure to accompany the removal of most COVID-19 protections with clear, consistent, and ongoing public health messaging, hindered the ability of UK governments and the public to realistically move to a sustainable strategy of "living with COVID"?
- How are the UK governments maintaining or disposing of their pandemic assets – in the form of workforce or facilities in particular? Does this risk undermining any future pandemic response?

Appendix A

Overview of BMA COVID research

Title	Date	Responses	Coverage
Covid Tracker survey 1	6 April 2020	1,924	UK wide
Covid Tracker survey 2	16 April 2020	6,126	UK wide
Covid Tracker survey 3	30 April 2020	16,343	UK wide
Covid Tracker survey 4	14 May 2020	10,328	UK wide
Covid Tracker survey 5	28 May 2020	8,455	UK wide
Covid Tracker survey 6	18 June 2020	7,497	UK wide
Covid Tracker survey 7	9 July 2020	5,905	England/Wales
Covid Tracker survey 8	13 August 2020	4,279	England/Wales
Covid Tracker survey 9	22 October 2020	7,820	England/Wales/Northern Ireland
Covid Tracker survey 10	17 December 2020	7,776	England/Wales/Northern Ireland
Covid Tracker survey 11	8 February 2021	8,153	UK wide
Covid Tracker survey 12	19 April 2021	5,521	UK wide
Viewpoint survey 1	8 July 2021	2,478	England/Wales/Northern Ireland
Viewpoint survey 2	2 September 2021	1,749	England/Wales/Northern Ireland
Viewpoint survey 3	26 November 2021	2,424	England/Wales/Northern Ireland
Viewpoint survey 4	4 February 2022	1,320	England/Wales/Northern Ireland
Viewpoint survey 5	8 April 2022	1,194	England/Wales/Northern Ireland
Call for evidence	17 December 2021	2,484	UK wide

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- 2 6,335,831 confirmed deaths worldwide as of 30 June 2022 – <https://ourworldindata.org/covid-deaths>
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- 11 BMA analysis of Northern Ireland Public Health Agency accounts for 2016/17 and 2018/19 in real-terms (inclusive of funding distributed to Trusts). Comparisons cannot be made with 2019/20 accounts due to difficulties in separating out COVID-19 funding.
- 12 BMA analysis of Public Health England accounts for 2016/17 and 2018/19 in real-terms (inclusive of funding distributed to Local Authorities).
- 13 BMA analysis of Public Health England accounts for 2016/17 and 2019/20 in real-terms (inclusive of funding distributed to Local Authorities), exclusive of funding received for COVID-19.
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