



HM Government

# **COVID-19 RESPONSE: LIVING WITH COVID-19**

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# 1. INTRODUCTION

1. The Government's aim throughout the COVID-19 pandemic has been to protect the lives and livelihoods of citizens across the United Kingdom (UK). This document sets out how the Government has and will continue to protect and support citizens by: enabling society and the economy to open up more quickly than many comparable countries; using vaccines; and supporting the National Health Service (NHS) and social care sector. It also sets out how England will move into a new phase of managing COVID-19. The Devolved Administrations will each set out how they will manage this transition in Scotland, Wales and Northern Ireland.
2. The global pandemic is not yet over and the Government's Scientific Advisory Group for Emergencies (SAGE) is clear there is considerable uncertainty about the path that the pandemic will now take in the UK.<sup>1</sup> This document therefore also sets out how the Government will ensure resilience, maintaining contingency capabilities to deal with a range of possible scenarios.

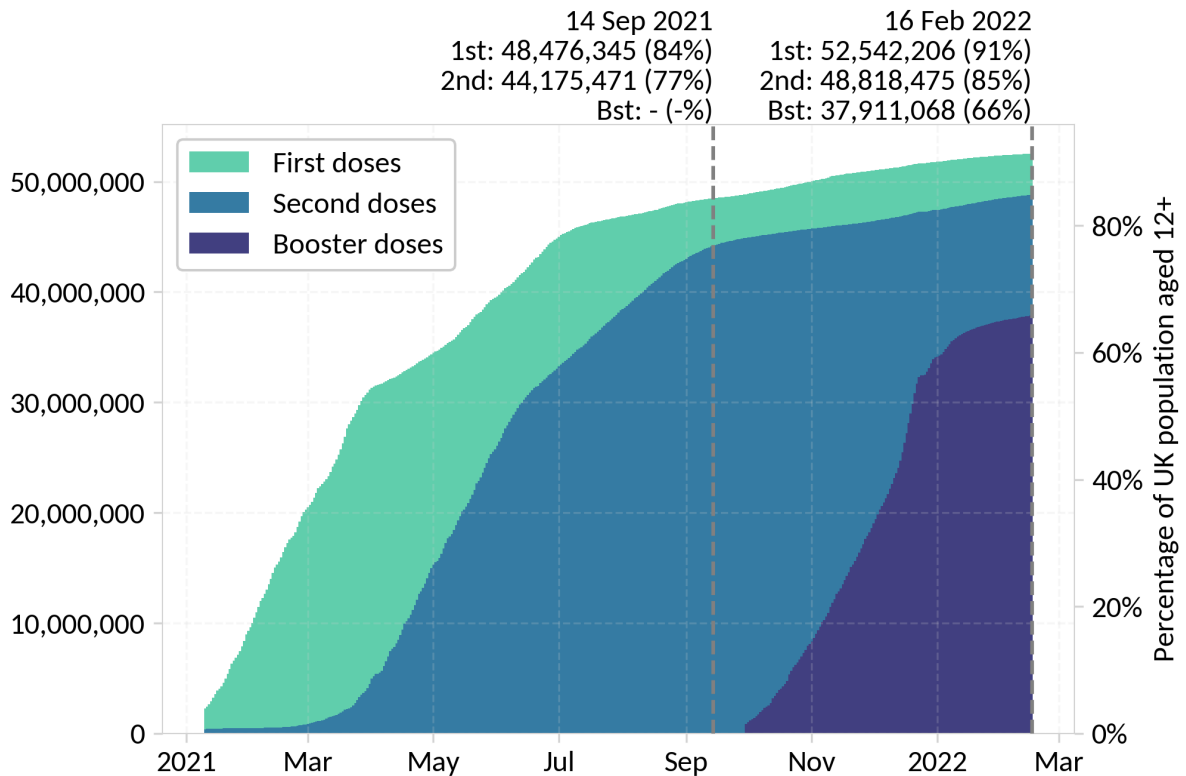
## COVID-19 response: Roadmap to the present day

3. Vaccines have enabled the gradual and safe removal of restrictions on everyday life over the past year, and will remain at the heart of the Government's approach to living with the virus in the future. The Government and the NHS, with the help of volunteers, has delivered one of the largest vaccination programmes in history.

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<sup>1</sup> SAGE 105, [SAGE meeting on COVID-19](#), 10 February 2022.



**Figure 1: Vaccines: UK Cumulative vaccinations<sup>2</sup>**

Since 14 September 2021, 46,619,933 vaccine doses have been administered

4. The speed of the vaccine rollout put the UK in a strong position. The UK was the first country in the world to authorise and deploy the Pfizer and Oxford / AstraZeneca COVID-19 vaccines.<sup>3</sup> The UK was the first major European economy and first G20 member to vaccinate 50% of its population with at least one dose,<sup>4</sup> and to provide boosters to 50% of the population.<sup>5</sup> Moreover, on JCVI advice, the UK prioritised those at highest risk from COVID-19 for vaccination early in the roll-out. Although other countries now exceed the UK's proportion of the total population vaccinated, the speed and highly targeted nature of the vaccination programme had a direct impact on the Government's ability to open up the economy and ease social restrictions sooner than other comparator countries, without placing the NHS under unsustainable pressure.
5. As a result of the vaccine rollout, the Government was able to ease restrictions in England through the first half of 2021 - following the plan set out in the Roadmap in the Government's 'COVID-19 Response: Spring 2021' publication.<sup>6</sup> The nationwide

<sup>2</sup> UKHSA, [Vaccination in the UK](#), 18 February 2022.

<sup>3</sup> DHSC, [UK COVID-19 vaccines delivery plan](#), 11 January 2021.

<sup>4</sup> Our World in Data, [Share of people who received at least one dose of COVID-19 vaccine](#), 16 February 2022.

<sup>5</sup> Our World in Data, [COVID-19 vaccine boosters administered per 100 people](#), 16 February 2022.

<sup>6</sup> Cabinet Office, [COVID-19 Response - Spring 2021 \(Roadmap\)](#), 22 February 2021.

lockdown introduced in January 2021 was lifted in four steps, with decisions to progress based on data not dates. Each step was taken at least five weeks apart, allowing time to assess the impact of the previous step against four key tests before taking the next step.

6. On 19 July 2021, the Government removed most restrictions in England at step 4 of the Roadmap and, in doing so, opened up earlier than many other comparable countries. The Government made a deliberate choice to do so at this point as it coincided with the end of the school term and meant that restrictions were removed over the summer period when more activities take place outdoors and there is less pressure on the NHS.
7. In September 2021 the Government published its 'COVID-19 Response: Autumn and Winter Plan', setting out a comprehensive plan for managing the virus over the colder months.<sup>7</sup> Plan A for England relied on booster vaccinations, testing and isolation, guidance on safer behaviours and measures at the border. The publication also outlined a Plan B which could be deployed later in the winter if the situation deteriorated. The measures in Plan B – mandatory face coverings, working from home guidance and COVID-19 certification – were designed to reduce transmission while minimising economic and social impacts.
8. From September to November 2021, the Government:
  - a. Extended the vaccine programme to children aged between 12 and 15 and started the booster campaign for those 50 and over and in high risk groups;
  - b. Maintained a lower level of restrictions than most European comparator countries; and
  - c. Managed relatively high levels of Delta infections without placing the NHS at risk of unsustainable pressures.
9. On 24 November, scientists in South Africa reported a new variant with troubling yet uncertain characteristics to the World Health Organization (WHO). This was subsequently named the Omicron variant.<sup>8</sup> The UK was one of the first countries to respond, initially through travel restrictions, then through accelerating and extending the COVID-19 vaccine booster campaign. The Government was in a position to implement Plan B measures in England at short notice as a result of the plans developed for managing the virus over the autumn and winter period.
10. Although the Omicron variant drove prevalence of the virus to an unprecedented high, adherence to Plan B, wider behaviour change and large-scale testing appeared to slow the growth sufficiently to buy time for the extended booster

<sup>7</sup> Cabinet Office, [COVID-19 Response: Autumn and Winter Plan](#), 14 September 2021.

<sup>8</sup> WHO, [Classification of Omicron \(B.1.1.529\): SARS-CoV-2 Variant of Concern](#), 26 November 2021.

campaign. This trend was improved by high and sustained vaccine-induced protection in the population against severe disease, and a decrease in severity found in the Omicron variant, which meant that hospitalisation rates remained lower than in previous waves. In particular, the proportion of patients being admitted to intensive care and requiring mechanical ventilation remained lower, with rates declining even when prevalence had increased.<sup>9</sup> This was in part also due to better clinical understanding of the disease.

11. During this period, the public continued to show willingness to get vaccinated and boosted, to test and self-isolate if they had symptoms or tested positive, and to follow behaviours and actions that limit methods of transmission.
12. The people of the UK also owe much to the NHS and its brilliant staff - as well as to providers and staff in adult social care - who throughout the pandemic have drawn deeply on their professionalism, skills and training to do their very best for patients and care recipients. This includes hugely ramping up the booster campaign last winter in response to the Omicron variant. This response played a key role in avoiding the kind of stringent restrictions seen in other countries this winter. Against this backdrop, the Government reverted to Plan A on 27 January, maintaining England as one of the most open countries in Europe.

## COVID-19: Future outlook

13. There are a range of possible futures for the course of the pandemic. SAGE has recently considered four scenarios describing plausible outcomes, though these are not predictions.<sup>10</sup> All scenarios assume that a more stable position will eventually be reached over several years. In the 'reasonable best case' there may be a comparatively small resurgence in infections during autumn/winter 2022-23, and in the 'reasonable worst case' a very large wave of infections with increased levels of severe disease. The 'optimistic central' and 'pessimistic central' scenarios are considered the most likely.
14. The emergence of new variants will be a significant factor in determining the future path of the virus. New variants of COVID-19 will continue to emerge.<sup>11</sup> This could include variants that render vaccines less effective, are resistant to antivirals, or cause more severe disease.<sup>12</sup> The pathway to greater stability will also be affected by the use of vaccination and available treatments.
15. The term 'endemic' is sometimes used to denote when a more steady or more predictable state has been reached but it does not mean that a virus will necessarily

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<sup>9</sup> NHSE, [Weekly Admissions and Beds 10 February 2022](#).

<sup>10</sup> Academics supporting SAGE, [Viral Evolution Scenarios](#), 10 February 2022.

<sup>11</sup> SAGE, [Minutes from One-hundred-and-fifth SAGE meeting on COVID-19](#), 10 February 2022.

<sup>12</sup> NERVTAG, [Long term evolution of SARS-CoV-2](#), 26 July 2021.

circulate at low levels or that outbreaks cannot or will not occur. Given the uncertainty, the Government will need to continue to monitor how COVID-19 is behaving and be ready to respond to resurgences and new variants.

16. Once COVID-19 becomes endemic it should be possible to respond to the virus in a similar way to other existing respiratory illnesses, through sustainable public health measures. The transition to an endemic state will be highly dynamic and affected by the international situation. It will occur at different times globally due to differences in the spread of the disease and access to vaccines.
17. The Government expects that the population's defences against new variants will continue to strengthen as immunity increases through advances in vaccine technology and repeated exposure to the virus. As with other human coronaviruses, children will very likely be exposed to COVID-19 during their childhood and future generations are likely to become progressively more protected by the combination of vaccination and infection.
18. Studying other infectious diseases can offer insights into the future of COVID-19, though comparisons are imperfect. While a different disease to COVID-19, the most common comparison is to influenza. Both viruses can result in severe illness and complications and are thought to spread in similar ways. The virus that causes COVID-19 is far more contagious and can cause more serious illness, even in otherwise healthy people. Influenza is managed through ongoing surveillance, annual vaccination and annual public messaging, including campaigns to increase vaccine uptake and the 'Catch it, Bin it, Kill it' campaign to reduce transmission from coughs and sneezes. Influenza still produces regular winter epidemics, causing pressure on the NHS every winter. The interaction of future COVID-19 waves with other respiratory infections, like influenza, will be important to monitor. Co- or sequential circulation could lead to an increased or longer period of pressure on healthcare services.
19. Over time, though hard to predict, it is likely that COVID-19 will become a predominantly winter seasonal illness with some years seeing larger levels of infection than others. This may take several years to occur and waves of infection may occur during winter or at other times in the year.

## COVID-19: Future response

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

21. To meet this objective, the Government will structure its ongoing response around four principles:
  - a. **Living with COVID-19:** removing domestic restrictions while encouraging safer behaviours through public health advice, in common with longstanding ways of managing most other respiratory illnesses;
  - b. **Protecting people most vulnerable to COVID-19:** vaccination guided by Joint Committee on Vaccination and Immunisation (JCVI) advice, and deploying targeted testing;
  - c. **Maintaining resilience:** ongoing surveillance, contingency planning and the ability to reintroduce key capabilities such as mass vaccination and testing in an emergency; and
  - d. **Securing innovations and opportunities** from the COVID-19 response, including investment in life sciences.
  
22. Vaccines underpin all of these principles and form the basis of the Government's strategy for living with COVID-19. Effective vaccines have allowed the economy and society to reopen and the country's ability to live with the virus in the future will continue to depend on deeper and broader population immunity conferred by vaccines and infections. In line with this:
  - a. The Government will continue to be guided by JCVI advice on deploying vaccinations. This includes the recent decision to offer vaccination to all 5-11 year olds later in the spring. Subject to JCVI advice, further vaccinations (boosters) may be recommended for people who are most vulnerable to COVID-19 this autumn and, ahead of that, a spring booster for groups JCVI consider to be at particularly high risk.
  - b. To enable any further vaccination programme, if necessary, the Government has procured enough doses of vaccine to anticipate a wide range of possible JCVI recommendations. The UK's procurement approach will continue to consider a range of long term contingency plans to ensure adequate protection is always available for those who need it and to respond quickly in an emergency.
  - c. The Government has secured contracts with vaccine manufacturers that secure UK access to the most up-to-date vaccines - including protection against emerging variants. The UK remains an attractive destination for life sciences investment, and the Government is committed to supporting UK resilience for future pandemics, by considering how to support research, development and manufacturing capability.

- d. The Government will help build global resilience to COVID-19 by meeting its commitment to donate 100 million vaccine doses by June 2022 and by continuing to support the ACT Accelerator. The Government is also working domestically and with the G7, G20, and international partners to reduce the impact of future pandemics through the 100 Days Mission.<sup>13</sup>
23. Work is underway across the health and care system to consider how vaccines will be procured, prioritised and deployed in the future. The Government's aim is to capture the best learning from the pandemic response.

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<sup>13</sup> Cabinet Office, [100 Days Mission](#), 12 June 2021.

## 2. COVID-19: DATA AND IMPACTS

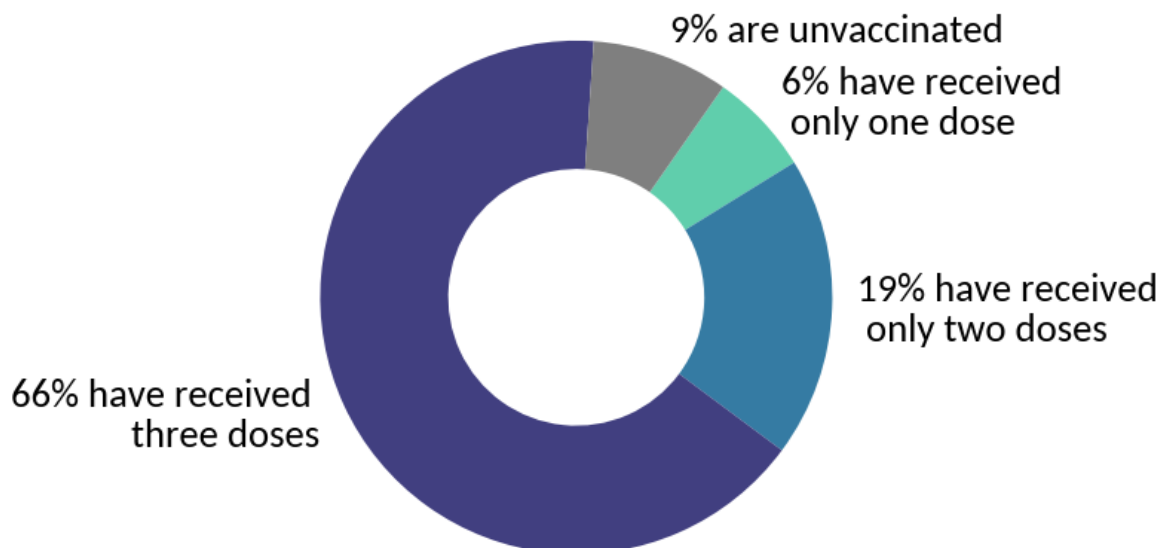
### Vaccination, infection and hospitalisation rates

24. Booster doses of a COVID-19 vaccine provide good protection against severe disease and hospitalisation for the Omicron variant. Following two doses of the Pfizer or AstraZeneca vaccines, a Pfizer booster initially gives around 90% protection against hospitalisation, though this effect wanes over time.<sup>14</sup> Similarly, a Moderna booster gives 90 to 95% protection against hospitalisation up to 9 weeks after vaccination.<sup>15</sup>

#### *Vaccine uptake*

25. In England, over 65% of all those aged 12 and over have received a booster, increasing to 66% across the UK.<sup>16</sup> <sup>17</sup> Vaccination rates are even higher among those most vulnerable to COVID-19 - who were prioritised for vaccination - and in England, over 93% of those aged 70 and over have received a booster.<sup>18</sup>

**Figure 2: UK population COVID-19 vaccine coverage, by dose, of those aged 12 and over as of 16 February 2022<sup>19</sup>**



<sup>14</sup> The UK does not currently administer the single shot Janssen vaccine.

<sup>15</sup> UKHSA, [COVID-19 vaccine surveillance report](#), 3 February 2022.

<sup>16</sup> UKHSA, [Vaccination in the UK](#), 17 February 2022.

<sup>17</sup> UKHSA, [Vaccination in England](#), 17 February 2022.

<sup>18</sup> NHSE, [COVID-19 Vaccinations](#), 17 February 2022.

<sup>19</sup> UKHSA, [Vaccination in the UK](#), 18 February 2022.

26. Since the start of September 2021 over 1.5 million adults over the age of 18 in England have come forward for a first dose of COVID-19 vaccine, long after receiving an initial offer.<sup>20</sup> As a result, the percentage of the population aged over 18 in England who have received at least one dose has increased from 88 to 92%.<sup>21</sup> However, over 3.4 million people in England aged 18 and older remain unvaccinated.<sup>22</sup>
27. Whilst vaccine uptake has increased across many groups, it remains considerably lower amongst certain communities. The UK Health Security Agency (UKHSA) data show booster uptake was lowest amongst Black and Pakistani adults (below 35%).<sup>23</sup> Data also shows that adults living in the most deprived areas of England also had lower booster uptake (53%) than those living in the least deprived areas (84%).<sup>24</sup> Analysis also shows that disparities in vaccine uptake are also present in younger age groups: only 39% of 18 to 24 year olds in England have received a booster dose, much lower than for older age groups.<sup>25</sup>
28. The proportion of 12 to 15 year olds who have received at least one dose of vaccine is lowest in Gypsy/Roma, Traveller Irish, Black Caribbean and Black African groups (all below 30%), with a 63 percentage point difference between the most and least vaccinated ethnic groups.<sup>26</sup> There is also large variation in vaccine coverage by deprivation in 12 to 15 year olds. In the least deprived areas in England 70% of this age group have received at least one dose, compared to 36% in the most deprived.<sup>27</sup>
29. Overall, the accumulation of immunity, as well as the use of effective treatments, means the link between COVID-19 infections and progression to severe disease is substantially weaker than in earlier phases of the pandemic. Patients in hospital per 100 infections have remained low over the last six months, with less than 1 hospitalisation per 100 infections compared to above 4 per 100 infections during the Alpha variant peak.<sup>28</sup> <sup>29</sup> Lower hospitalisation is partly due to improved treatments but also in part attributable to the lowered virulence of the Omicron variant.

<sup>20</sup> NHSE, [COVID-19 weekly announced vaccinations](#), 17 February 2022.

<sup>21</sup> NHSE, [COVID-19 weekly announced vaccinations](#), 17 February 2022.

<sup>22</sup> NHSE, [COVID-19 weekly announced vaccinations](#), 17 February 2022.

<sup>23</sup> Booster uptake for: any black background; Black African; Pakistani; and Black Caribbean adults stands at around 30%, 34%, 34% and 34% respectively in the latest data (to 13 February 2022). UKHSA, [National flu and COVID-10 surveillance reports: 2021 to 2022 season](#), 17 February 2022.

<sup>24</sup> NHSE, Monthly [COVID-19 Vaccinations](#), 10 February 2022.

<sup>25</sup> NHSE, Weekly [COVID-19 Vaccinations](#), 17 February 2022.

<sup>26</sup> ONS, [Coronavirus \(COVID-19\) vaccination uptake in school pupils, England: up to 9 January 2022](#), 1 February 2022.

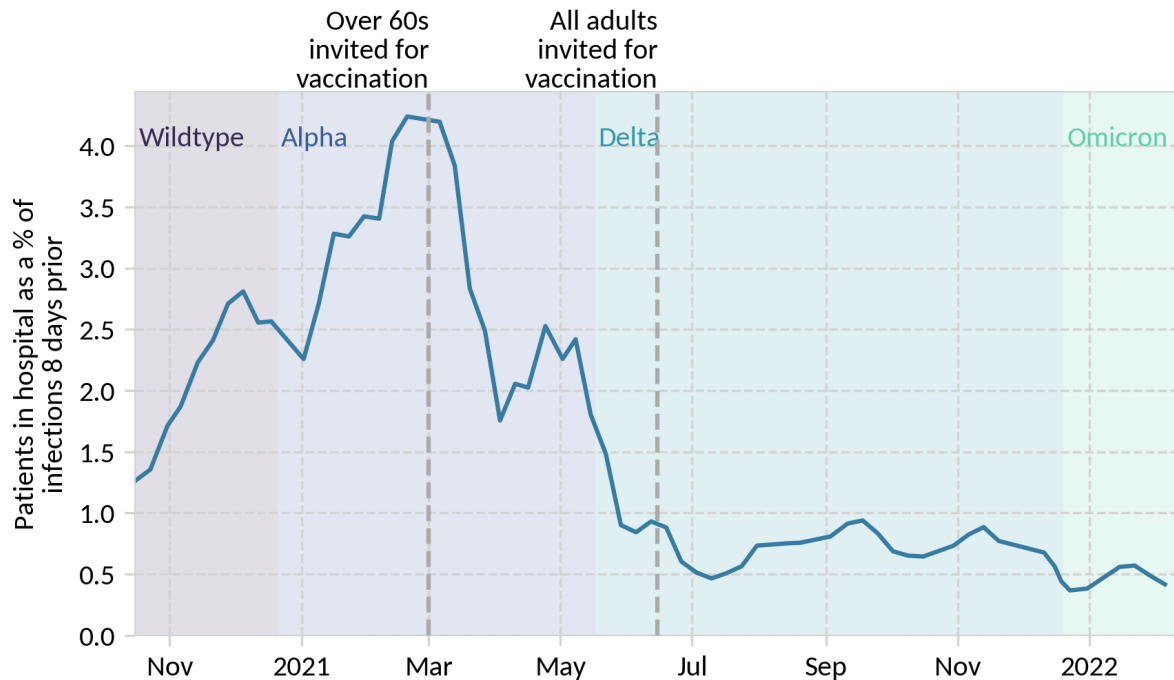
<sup>27</sup> ONS, [Coronavirus \(COVID-19\) vaccination uptake in school pupils, England: up to 9 January 2022](#), 1 February 2022.

<sup>28</sup> UKHSA, [Patients in hospital: Coronavirus \(COVID-19\) in the UK](#), 18 February 2022.

<sup>29</sup> ONS, [Coronavirus \(COVID-19\) latest insights: Infections](#), 18 February 2022.



**Figure 3: UK: Patients in hospital with COVID-19 per 100 infections using ONS COVID-19 Infection Survey estimates<sup>30 31</sup>**



*The ratio is lagged by 8 days (the difference in the peak infections to peak admissions), reflecting the estimated number of infections that occurred 8 days ago that went on to be admitted to hospital on a given date.*

## Reporting on COVID-19

30. As testing reduces and the Government's approach to managing COVID-19 further evolves, UKHSA will keep the content and frequency of reporting on COVID-19 under close review - including the Gov.uk Dashboard - to ensure that statistics are being produced with the appropriate level of quality and transparency, and remain useful and relevant as per the Code of Practice for Statistics.

## Impact of COVID-19 response to date on the economy and society

31. Since March 2020, to reduce transmission, protect the NHS from unsustainable pressure and to reduce mortality, the Government has had to introduce stringent measures by restricting social and economic activity.
32. The measures introduced were necessary because COVID-19 was a new disease to which the population had no immunity, and for which there was no readily

<sup>30</sup> ONS, [Coronavirus \(COVID-19\) latest insights: Infections](#), 18 February 2022.

<sup>31</sup> UKHSA, [Healthcare in the UK](#), 18 February 2022.

available treatment. However, the measures introduced had extraordinarily high social and economic costs with unprecedented impacts on individuals and families, public services and private businesses.

33. In particular, the health and education sectors have been significantly affected, as well as the provision of other public services such as the court system. The pandemic has also caused a period of unparalleled global economic uncertainty. Restrictions to control the virus - including social distancing, business closures and reduced international travel - on top of voluntary behaviour change, had significant economic costs, and disrupted the delivery of critical private and public sector services.

### Impacts on health, education and public services

During the pandemic, over 720,000 patients have been admitted to hospital with COVID-19,<sup>32</sup> and over 160,000 people have now died within 28 days of a positive test in the UK.<sup>33</sup> Caring for this number of patients has restricted the ability of the NHS to provide other types of care. As a result the NHS elective backlog has reached a record high and waiting times for ambulances and emergency care have substantially increased.

The provision of other public services has also been significantly affected. The court backlog increased substantially during the pandemic<sup>34</sup> and restricting face-to-face education has had significant adverse impacts on children and young people's learning, development and mental health. Pupils and students from disadvantaged backgrounds experienced greater losses in learning than their more affluent peers as a result of the pandemic.<sup>35</sup> There is clear evidence that time out of education can be detrimental to children and young people's future prospects and earning potential, with implications also for long-term productivity.

Mental health and well-being have also been negatively impacted. Self-reported measures of personal well-being dropped to record lows during the first and second waves, with some groups experiencing particularly poor or deteriorating mental health - including women, young people, disabled people, those in deprived neighbourhoods, certain ethnic minority groups and those who experienced local lockdowns.<sup>36</sup> There was a marked increase in the number of under 18s referred to specialist care for issues such as

<sup>32</sup> UKHSA, [Healthcare in the UK](#), 18 February 2022.

<sup>33</sup> UKHSA, [Deaths in the UK](#), 18 February 2022.

<sup>34</sup> There has been a 302% increase in the number of cases waiting over a year to be heard. MoJ and HMCTS, [Reducing the backlog in criminal courts](#), 22 October 2021.

<sup>35</sup> DfE, [Understanding progress in the 2020/21 academic year: Findings from the summer term and summary of all previous findings](#), October 2021.

<sup>36</sup> Office for Health Improvement and Disparities, [COVID-19: mental health and wellbeing surveillance report](#), 18 November 2021.

self-harm and eating disorders in 2021.<sup>37</sup> Reports of domestic abuse increased during lockdown periods.<sup>38</sup>

## Impacts on the economy

The pandemic and associated non-pharmaceutical interventions (NPIs) created significant economic disruption and drove the largest recession on record, with the UK economy contracting by 9.4% in 2020.<sup>39</sup>

As experience allowed for improved understanding of the impact of restrictions, businesses, consumers and the Government adapted. For example, the Government was able to deploy more targeted interventions. Compared to pre-pandemic levels (February 2020), output was 25% lower during the first lockdown (April 2020), and 7% lower in November 2020, coinciding with much of the second lockdown and 8% lower at the height of the third lockdown (January 2021).<sup>40</sup>

The Government took unprecedented steps to support the economy through the pandemic. The Government has provided around £400 billion of direct support for the economy through the pandemic to date.<sup>41</sup> This has helped to safeguard jobs and businesses in every region and nation of the UK, and underpinned the faster than expected economic bounce back that occurred when restrictions were lifted. The Coronavirus Job Retention Scheme succeeded in supporting 11.7 million jobs and 1.3 million employers across the UK and the Self-Employment Income Support Scheme supported nearly 3 million self-employed individuals.<sup>42</sup>

As restrictions were lifted in 2021, supported by the vaccine rollout, consumer activity increased, driving recovery across the economy. As uncertainty declined, business confidence and investment also began to recover. 2021 saw faster than anticipated growth, with the economy regaining its pre-pandemic size in November 2021.<sup>43</sup> The emergence of the Omicron variant, workforce absences from illness and isolation, and

<sup>37</sup> NHS Digital, [Mental Health Services Monthly Statistics, Provisional October, Provisional November 2021](#), 27 January 2022.

<sup>38</sup> Demand for the National Domestic Abuse Helpline increased by 22% in the year ending March 2021, compared to the previous year, with the average number of calls and contacts increasing most in the quarters coinciding with the first and third national lockdowns. ONS, [Domestic abuse in England and Wales overview](#), 24 November 2021.

<sup>39</sup> ONS, [GDP quarterly national accounts, UK: July to September 2021](#), 22 December 2021.

<sup>40</sup> ONS, [GDP monthly estimate, UK: December 2021](#), 11 February 2022.

<sup>41</sup> Hansard, [HC Deb. vol.705 col.1143](#), 16 December 2021.

<sup>42</sup> HMRC, [Coronavirus Job Retention Scheme statistics](#), 16 December 2021.

HMRC, [Self-Employment Income Support Scheme statistics](#), 16 December 2021.

<sup>43</sup> ONS, [GDP monthly estimate, UK, December 2021](#), 11 February 2022.

Plan B measures in England impacted economic activity in recent months, with GDP falling 0.2% in December 2021.<sup>44</sup>

Workforce absences due to illness and self-isolation have weighed on economic growth in periods of particularly high prevalence during the Delta and Omicron waves. Workforce absences disproportionately impacted those less able to work from home, who were more likely to be young, on lower incomes, or from certain ethnic minority groups.<sup>45</sup> Changes to self-isolation policy helped to mitigate these impacts while accepting a higher risk of transmission.

Government action has supported a strong recovery in the labour market. The number of payrolled employees in January 2022 was 436,000 above February 2020 levels.<sup>46</sup> Vacancies remained at a record level in the 3 months to January 2022, standing at 1.3 million.<sup>47</sup>

Following the easing of restrictions in summer 2021, supply pressures due to COVID-19 have acted as a constraint on output in many countries including the UK. This has been a result of: restrictions on people's ability to work; factory closures globally; and elevated consumer demand for goods. While supply pressures remain acute, there are some initial signs of easing with shipping costs falling from October 2021. However, the possibility of further outbreaks internationally and different approaches to COVID-19 taken by different countries could present further risks to the UK economy.

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<sup>44</sup>ONS, [GDP monthly estimate, UK: December 2021](#), 11 February 2022.

<sup>45</sup>ONS, [Homeworking in the UK Labour Market: 2020](#), 17 May 2021.

<sup>46</sup>ONS, [Earnings and employment from Pay As You Earn Real Time Information, UK](#), 15 February 2022.

<sup>47</sup>ONS, [Vacancies and jobs in the UK](#), 15 February 2022.

### 3. LIVING WITH COVID-19

34. The past 2 years have seen many necessary restrictions imposed on everyday life to manage COVID-19, but these have come with a huge toll on wellbeing and economic output. Scientists (including virologists, epidemiologists, clinicians, and many others) and the Government now understand more about COVID-19, how it behaves and how it can be treated. As the virus continues to evolve, it will be important to continue to add to this understanding.
35. Living with and managing the virus will mean maintaining the population's wall of protection and communicating safer behaviours that the public can follow to manage risk. The Government will move away from deploying regulations and requirements in England and replace specific interventions for COVID-19 with public health measures and guidance.
36. The Government is able to take this step now because of the success of the vaccination programme, and the suite of pharmaceutical tools the NHS can deploy to treat people who are most vulnerable to COVID-19 and the most severely ill (see chapter 4). The Government can only take these steps because it will retain contingency capabilities and will respond as necessary to further resurgences or worse variants of the virus (see chapter 5).

#### Removing the last domestic restrictions

37. The Government will remove remaining domestic restrictions in England, subject to appropriate parliamentary scrutiny.
38. **From 24 February**, the Government will:
  - a. **Remove the legal requirement to self-isolate following a positive test.** Adults and children who test positive will continue to be advised to stay at home and avoid contact with other people. After 5 days, they may choose to take a Lateral Flow Device (LFD) followed by another the next day - if both are negative, and they do not have a temperature, they can safely return to their normal routine. Those who test positive should avoid contact with anyone in an at risk group, including if they live in the same household. There will be specific guidance for staff in particularly vulnerable services, such as adult social care, healthcare, and prisons and places of detention.
  - b. **No longer ask fully vaccinated close contacts and those under the age of 18 to test daily for 7 days, and remove the legal requirement for close contacts who are not fully vaccinated to self-isolate.** Guidance will

set out the precautions that those who live in the same household as someone who has COVID-19, or who have stayed overnight in the same household, are advised to take to reduce risk to other people. Other contacts of people with COVID-19 will be advised to take extra care in following general guidance for the public on safer behaviours.

- c. **End self-isolation support payments and national funding for practical support. The medicine delivery service will no longer be available.** People who were instructed to self-isolate before this date will still be able to claim support payments within the next 42 days.
  - d. **Revoke The Health Protection (Coronavirus, Restrictions) (England) (No. 3) Regulations.** Local authorities will continue to manage local outbreaks of COVID-19 in high risk settings as they do with other infectious diseases.
39. **From 24 March**, the COVID-19 provisions within Statutory Sick Pay and Employment and Support Allowance regulations will end. People with COVID-19 may still be eligible, subject to the normal conditions of entitlement.
40. **From 1 April, the Government will update guidance setting out the ongoing steps that people with COVID-19 should take to minimise contact with other people.** This will align with the changes to testing set out later in this chapter.

## Testing, tracing and certification

41. Testing and tracing have been important throughout the response to COVID-19. The Government's provision of LFDs enabled people to take a test before meeting family, friends and colleagues, allowing them to protect themselves and others, and breaking chains of transmission. This was particularly important during the period of exceptionally high prevalence driven by the Omicron variant towards the end of 2021. Access to LFDs also enabled contacts of positive cases to test daily in lieu of isolation, reducing the workforce impacts of isolation while identifying positive cases.
42. However, the Government's free provision of testing at scale has come at a very significant cost to the taxpayer during the pandemic response. The Testing, Tracing and Isolation (TTI) budget in the financial year 2020-21 exceeded that of the Home Office, and the programme cost £15.7 billion in the financial year 2021-22. This level of spending was necessary due to the severe risk posed by COVID-19 when the population did not have a high level of protection.
43. The population now has much stronger protection against COVID-19 than at any other point in the pandemic, due to the vaccination programme, natural immunity,

access to antivirals, and increased scientific and public understanding about how to manage risk. For this reason, the Government now assesses that it is time to transition to focus its COVID-19 response towards guidance, while targeting protection on individuals who are most at risk from the virus. Government spending on COVID-19 will reduce significantly in line with this change.

### *Testing*

44. As immunity levels are high, testing and isolation will play a less important role in preventing serious illness. Some changes to testing have already begun. In January, the recommendation for a confirmatory polymerase chain reaction (PCR) test following a positive LFD was changed, and the testing regime in adult social care was also changed to a LFD regime.
45. The Government will implement further changes to the availability of testing in the coming months.
46. **From 21 February, the Government is removing the guidance for staff and students in most education and childcare settings to undertake twice weekly asymptomatic testing.**
47. **From 1 April, the Government will no longer provide free universal symptomatic and asymptomatic testing for the general public in England.**
48. Over 2 billion lateral flow tests have been provided across the UK since 2020. UKHSA continues to have good stock levels and will manage these to provide flexibility in future. Ahead of the end of free universal testing in England, it will be necessary for UKHSA to cap the number of tests distributed each day to manage demand. Given that advice to test has and continues to reduce, the Government urges people only to order what they need.
49. The Government will help enable COVID-19 tests to be made available for those who wish to purchase them through the private market. Private markets are established in many European countries - including France, Germany, Italy and Spain - and the United States of America. The Government is working with retailers and pharmacies to help establish the private market in testing.
50. **From 1 April, there will be some limited ongoing free testing:**
  - a. **Limited symptomatic testing available for a small number of at-risk groups - the Government will set out further details on which groups will be eligible.**
  - b. **Free symptomatic testing will remain available to social care staff**

*Contact tracing*

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

*COVID-status certification*

53. **From 1 April, the Government will remove the current guidance on domestic voluntary COVID-status certification and will no longer recommend that certain venues use the NHS COVID Pass.** The NHS COVID Pass will remain available within the NHS App for a limited period, to support the use of certification in other parts of the UK. The NHS App will continue to allow individuals access to their vaccination status for international travel, as well as their recovery status for travel to those overseas destinations that recognise it.

**Safer behaviours**

54. Throughout the pandemic, Government advice and information has been informed by the best scientific evidence available from health agencies, academics, and experts.<sup>48</sup>
55. People will continue to be advised that there are safer behaviours they can adopt to reduce the risk of infection. Precautions remain particularly important to those who are at higher risk if they catch COVID-19, although due to advances in vaccination and therapeutics, this group is now better protected. The majority of people previously considered clinically extremely vulnerable are now advised to follow the same general guidance as everyone else as a result of the protection they have received from vaccination.
56. Individuals can still reduce the risk of catching and passing on COVID-19 by:
  - a. Getting vaccinated;
  - b. Letting fresh air in if meeting indoors, or meeting outside;

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<sup>48</sup> SAGE, [Scientific evidence supporting the government response to coronavirus \(COVID-19\)](#), 18 February 2022.



- c. Wearing a face covering in crowded and enclosed spaces, especially where you come into contact with people you do not usually meet, when rates of transmission are high;
  - d. Trying to stay at home if you are unwell;
  - e. Taking a test if you have COVID-19 symptoms, and staying at home and avoiding contact with other people if you test positive; and
  - f. Washing your hands and following advice to 'Catch it, Bin it, Kill it'.
57. **From 1 April, guidance to the public and to businesses will be consolidated in line with public health advice.** There will continue to be specific guidance for those whose immune system means they are at higher risk of serious illness from COVID-19 despite vaccination.

*Businesses and other organisations*

58. Employers and businesses have also taken significant steps over the pandemic to mitigate the risks of COVID-19 within their settings. The Government has lifted the majority of legal requirements on businesses, and continues to provide 'Working Safely' guidance setting out the steps that employers can take to reduce risk in their workplaces.
59. **From 24 February, workers will not be legally obliged to tell their employers when they are required to self-isolate.** Employers and workers should follow Government guidance for those with COVID-19.
60. **From 1 April, the Government will remove the health and safety requirement for every employer to explicitly consider COVID-19 in their risk assessments.** The intention is to empower businesses to take responsibility for implementing mitigations that are appropriate for their circumstances. Employers that specifically work with COVID-19, such as laboratories, must continue to undertake a risk assessment that considers COVID-19.
61. **From 1 April, the Government will replace the existing set of 'Working Safely' guidance with new public health guidance.** Employers should continue to consider the needs of employees at greater risk from COVID-19, including those whose immune system means they are at higher risk of serious illness from COVID-19. The Government will consult with employers and businesses to ensure guidance continues to support them to manage the risk of COVID-19 in workplaces.

### *Ventilation*

62. The Government will continue to promote and support good ventilation. Employers and businesses should continue identifying poorly ventilated spaces and take steps to improve fresh air flow.
63. There is increasing evidence of the importance of circulating fresh air in reducing the risk of COVID-19 transmission. Ventilation also helps with reducing transmission of other respiratory infections such as influenza, with some research showing that being in a room with fresh air can in some cases reduce the risk of airborne transmission of COVID-19 by over 70%.<sup>49</sup> There are also potential wider benefits of good ventilation, for health, concentration, and lower absence rates.<sup>50</sup> The Government has responded to this evidence through:
- a. Public communications campaigns and comprehensive business guidance on ventilation and fresh air;
  - b. Providing over 350,000 CO<sub>2</sub> monitors to state-funded education settings backed by £25 million of funding,<sup>51</sup> and up to 9,000 high efficiency particulate air (HEPA) cleaning units for the small number of education settings where poor ventilation could not be quickly rectified;<sup>52</sup>
  - c. Enabling local authorities to use their allocations from the £60 million Adult Social Care Omicron Support Fund, at their discretion, to audit and improve fresh air in adult social care;<sup>53</sup> and
  - d. Completing a ventilation audit of the central government estate.
64. The Government is also carrying out further ventilation research and the Government's Chief Scientific Adviser has commissioned a report from the Royal Academy of Engineering on how our built environment could be made more infection resilient, to be published this May. The Government will carefully consider its recommendations, alongside the ongoing research.

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<sup>49</sup> Based on modelled risks within Table 3, SAGE EMG paper, [Role of Ventilation in Controlling SARS-CoV-2 Transmission](#).

<sup>50</sup> SAGE, [EMG: Simple summary of ventilation actions to mitigate the risk of COVID-19, 19 October 2020](#).

<sup>51</sup> CO<sub>2</sub> monitors act as a proxy to measure ventilation. Gov.uk, [All schools to receive carbon dioxide monitors](#), 21 August 2021.

<sup>52</sup> Gov.uk, [More support for schools and students as plan B comes to an end](#), 24 January 2022.

<sup>53</sup> DHSC, [Adult Social Care Omicron Support Fund](#), 10 January 2022.

## Changes at a glance

**Today, 21 February** the Government is:

- Removing the guidance for staff and students in most education and childcare settings to undertake twice weekly asymptomatic testing.

**From 24 February** the Government will:

- Remove the **legal** requirement to self-isolate following a positive test. Adults and children who test positive will continue to be advised to stay at home and avoid contact with other people for at least 5 full days and then continue to follow the guidance until they have received 2 negative test results on consecutive days.
- No longer ask fully vaccinated close contacts and those aged under 18 to test daily for 7 days, and remove the legal requirement for close contacts who are not fully vaccinated to self-isolate.
- End self-isolation support payments, national funding for practical support and the medicine delivery service will no longer be available.
- End routine contact tracing. Contacts will no longer be required to self-isolate or advised to take daily tests.
- End the legal obligation for individuals to tell their employers when they are required to self-isolate.
- Revoke The Health Protection (Coronavirus, Restrictions) (England) (No. 3) Regulations.

**From 24 March**, the Government will:

- Remove the COVID-19 provisions within the Statutory Sick Pay and Employment and Support Allowance regulations.

**From 1 April**, the Government will:

- Remove the current guidance on voluntary COVID-status certification in domestic settings and no longer recommend that certain venues use the NHS COVID Pass.
- Update guidance setting out the ongoing steps that people with COVID-19 should take to minimise contact with other people. This will align with the changes to testing.

- No longer provide free universal symptomatic and asymptomatic testing for the general public in England.
- Consolidate guidance to the public and businesses, in line with public health advice.
- Remove the health and safety requirement for every employer to explicitly consider COVID-19 in their risk assessments.
- Replace the existing set of 'Working Safely' guidance with new public health guidance.

## 4. PROTECTING PEOPLE MOST VULNERABLE TO COVID-19

65. Since March 2020, the medical and scientific community has learned a lot more about COVID-19, what makes someone more or less vulnerable to it, and how to manage the virus in higher risk settings.
66. At the start of the pandemic very little was known about risk factors from COVID-19 and vaccines were unavailable, so the Government took a precautionary approach and advised 'clinically extremely vulnerable' groups to follow shielding advice. These measures were extremely restrictive and often had a significant impact on individuals' lives and their mental and physical wellbeing, meaning people and their families made considerable sacrifices to stay safe.
67. Data on COVID-19 related deaths and admissions between December 2020 and June 2021 showed that COVID-19 mortality increased with age (when controlled for vaccination status and other key factors). This same analysis showed that the risk was higher for people with specific clinical conditions such as Down's syndrome, solid organ transplantation, Dementia, Parkinson's disease, and neurological conditions. Those living in more deprived areas and from certain ethnic minority groups were also at higher risk of COVID-19 mortality.<sup>54</sup>
68. As a result of the success of the Government's strategy to invest in scientific and medical innovation, the Government has been able to rely more on vaccines and medical treatments, and gradually remove restrictive guidance for those at an increased risk of COVID-19. The shielding programme ended on 15 September 2021.
69. The Government prioritised those at highest risk from COVID-19 for vaccination by following JCVI advice, and using the COVID-19 Population Risk Assessment. Vaccination has proved to be the most effective way to protect those at increased risk from COVID-19 and everybody should be encouraged to get all doses of the vaccination and boosters for which they are eligible. The Government and UKHSA will continue to communicate to people most vulnerable to COVID-19 about

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<sup>54</sup> Hippisley-Cox, J. et al. [Risk prediction of COVID-19 related death and hospital admission in adults after COVID-19 vaccination: national prospective cohort study](#), 17 September 2021.

available clinical interventions, including vaccination and treatments, and also testing and public health advice (see previous chapter).

## Vaccines

70. COVID-19 vaccines remain the most important and effective way the public can protect themselves and others from becoming seriously ill or dying from the virus. Vaccines have built a wall of defence around communities across the country, saving countless lives and allowing a phased return to normality. A recent review by UKHSA also showed that people who have had one or more doses of a COVID-19 vaccine are less likely to develop long COVID symptoms than those who remain unvaccinated.<sup>55</sup>
71. The UK's vaccination programme, which prioritised the most vulnerable to COVID-19 for early receipt of vaccines, has now protected tens of millions of people and prevented many hospitalisations and deaths.<sup>56</sup> The programme continues to be extended. The NHS has already given a first dose to 60% of 12 to 15 year olds in England and is now offering second doses.<sup>57</sup> Vaccinations have also started to be offered to at-risk 5 to 11 year olds since week commencing 31 January (2 doses, 8 weeks apart). From April, all 5 to 11 year olds will be able to come forward for a course of COVID-19 vaccine (2 doses, 12 weeks apart). Every parent will have the opportunity to make an informed choice.
72. The Government will continue to be guided by JCVI advice on the deployment of the vaccination programme. Subject to JCVI advice, further vaccinations (boosters) may be recommended for people who are most vulnerable to serious outcomes from COVID-19 this autumn and, ahead of that, a spring booster for groups JCVI consider to be at particularly high risk.
73. For people who have yet to take up their initial vaccine offer, the NHS continues to make vaccines available across the UK to ensure that every eligible person who wants a vaccine can get one. The Government will continue to provide flexible delivery models to ensure vaccines remain accessible.
74. The Government will continue to support communities with lower rates of COVID-19 vaccine uptake, particularly in areas of deprivation and for ethnic minority groups. In

<sup>55</sup> UKHSA, [The effectiveness of vaccination against long COVID](#), February 2022.

<sup>56</sup> The number of hospitalisations directly averted by vaccination. In total, around 261,500 hospitalisations have been prevented in those aged 45 years and over up to 19 September 2021. UKHSA, [COVID-19 vaccine surveillance report](#), 21 October 2021. Furthermore, around 105,600 hospitalisations have been prevented in those aged 25 years and over in England from 13 December 2021 to 6 February 2022 inclusive.

UKHSA, [Boosters prevented over 105,000 hospitalisations. UKHSA analysis estimates](#), 10 February 2022.

<sup>57</sup> NHSE, [COVID-19 weekly announced vaccinations](#), 17 February 2022.

December 2021, the Government announced a further £22.5 million in funding for the Community Vaccine Champions Scheme to support 60 local authorities with the lowest COVID-19 vaccine uptake.<sup>58</sup> Community Champions work with local councils to address barriers to accurate vaccine information and encourage individuals to get vaccinated.

## Deploying treatments

75. The Government has moved quickly since the onset of the pandemic to ensure that those at risk of and suffering from COVID-19 have early access to safe and effective treatments.

### *Antivirals*

76. In April 2021, the Prime Minister launched the Antivirals Taskforce (ATF), in order to identify, procure and deploy novel antiviral treatments for UK patients with COVID-19. Antivirals can be used at the earliest stage of infection to help reduce the development of severe COVID-19 by blocking virus replication.
77. The ATF has secured a supply of almost 5 million courses of antivirals - more per head than any other country in Europe.<sup>59</sup> These antivirals are the first medicines which can be given at home to treat people whose immune systems mean they are at higher risk from COVID-19.
78. In company trials, Paxlovid (nirmatrelvir + ritonavir) reduced the relative risk of COVID-19-associated hospitalisation or death by 88% in unvaccinated patients who received treatment within 5 days of symptoms appearing.<sup>60</sup> Results from Lagevrio (molnupiravir) company trials show around 30% relative reduction in the rate of hospitalisation in unvaccinated patients.<sup>61</sup> Both antivirals have now received conditional marketing authorisation from MHRA, making the UK the first country in the world to approve an oral antiviral that can be taken at home for COVID-19.<sup>62</sup>
79. People at highest risk of developing severe COVID-19 can now access antivirals should they test positive for COVID-19. UKHSA has sent priority PCR tests to around 1.3 million people to support rapid turnaround of results so they can access the treatments as soon as possible after symptoms begin.<sup>63</sup> In England, around 14,000 people with weakened immune systems have already been treated with the

<sup>58</sup> Gov.uk, [£22.5m of funding announced in new community push to get nation boosted now](#), 19 December 2021.

<sup>59</sup> DHSC, [Second ground-breaking antiviral to be deployed to country's most vulnerable](#), 28 January 2022.

<sup>60</sup> Pfizer, [Additional Phase 2/3 Study Results Confirming Robust Efficacy of Novel COVID-19 Oral Antiviral Treatment](#), 14 December 2021.

<sup>61</sup> Merck, [Merck and Ridgeback Announce Publication of Phase 3 Study of Molnupiravir](#), 16 December 2021.

<sup>62</sup> MHRA, [First oral antiviral for COVID-19, Lagevrio \(molnupiravir\), approved by MHRA](#), 4 November 2021.

<sup>63</sup> DHSC, [Second ground-breaking antiviral to be deployed to country's most vulnerable](#), 28 January 2022.

new antivirals, Lagevrio (molnupiravir) and Paxlovid (nirmatrelvir + ritonavir), and the new monoclonal antibody treatment, Xevudy (sotrovimab).

### *Therapeutics*

80. The Therapeutics Taskforce was quickly established in April 2020 to ensure that COVID-19 patients in the UK had access to safe and effective treatments as soon as possible. Effective therapeutics have played a vital role in lessening the severity and impact of COVID-19.
81. The UK has led the way in the testing and deployment of life-saving treatments, which have been made available to patients in the UK and across the world. World-leading clinical trials such as RECOVERY - the world's largest randomised controlled clinical trial for COVID-19 treatments have helped to discover new effective treatments for COVID-19.
82. In June 2020, the UK was the first in the world to discover that dexamethasone - a low-cost corticosteroid - reduced the risk of mortality in hospitalised COVID-19 patients requiring oxygen or ventilation by up to 35%.<sup>64</sup> UK Government-funded trials demonstrated tocilizumab and sarilumab - monoclonal immunomodulatory antibody treatments - reduced the relative risk of mortality by up to 24% when administered to patients within 24 hours of entering intensive care.<sup>65</sup>
83. New therapeutics like Xevudy (sotrovimab), a monoclonal antibody, have been authorised for use in people who have mild to moderate COVID-19 infection and at least one risk factor for developing severe illness. In a clinical trial, a single dose of the monoclonal antibody was found to reduce the risk of hospitalisation and death by 79% in high-risk adults with symptomatic COVID-19 infection.<sup>66</sup>

## Supporting the NHS and social care

84. Throughout the pandemic the Government has provided health and social care services with resources and support to respond to the unique challenges they have faced.
85. The approach to managing COVID-19 in NHS and adult social care services will continue to evolve in the coming months, but will continue to focus on providing care for those that need it and supporting people who are most vulnerable to COVID-19, including people receiving social care and people receiving treatment in hospitals.

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<sup>64</sup> [Statement from the Chief Investigators of the Randomised Evaluation of COVID-19 thERapY \(RECOVERY\) Trial on dexamethasone](#), 16 June 2020.

<sup>65</sup> Gov.uk, [NHS patients to receive life-saving COVID-19 treatments that could cut hospital time by 10 days](#), 7 January 2021.

<sup>66</sup> Gov.uk, [MHRA approves Xevudy \(sotrovimab\)](#), 2 December 2021.



*NHS*

86. A key objective for the NHS over the last two years has been to keep patients and staff safe and limit the spread of COVID-19 within hospitals. Enhanced Infection Prevention Control (IPC) measures have been required in NHS settings, including:
- a. Asymptomatic testing for patients and for staff;
  - b. Enhanced personal protective equipment (PPE) to protect healthcare workers and the patients they come into contact with;
  - c. COVID-19 specific bed management and clinical pathways; and
  - d. Evaluation of ventilation in line with the latest guidance.<sup>67</sup>
87. In the next phase of managing COVID-19, the NHS will continue to:
- a. Deliver and support specific programmes to manage the risk of COVID-19, including the deployment of vaccines (see chapter 4).
  - b. Support patients with Long COVID, where the UK is leading the way in research, treatment and care. Specialist services have been established throughout England for adults, children and young people experiencing long-term effects of COVID-19 infection, underpinned by a £100 million plan for 2021-22, and further investment for 2022-23.
  - c. Work to better understand COVID-19 and the long-term health impacts it may have, supported by £50 million in research funding.
  - d. Use and develop measures to restore and recover elective services and reduce backlogs for treatments.
  - e. Providing access to free PPE to the end of March 2023, or until the IPC guidance on PPE usage for COVID-19 is amended or superseded (whichever is sooner).

*Adult social care*

88. Care home residents, and those in receipt of adult social care at home and other care settings, are often among the most vulnerable in society to COVID-19. To protect these people, the Government introduced additional protective measures, including:
- a. Free PPE for adult social care workers;
  - b. Prioritisation of staff and residents for vaccinations;

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<sup>67</sup> NHSE, ([HTM 03-01 Specialised ventilation for healthcare buildings](#)), 22 June 2021.

- c. Designated settings to ensure that those who need residential care but are still likely to be infectious with COVID-19 at the point of discharge from hospital can complete a period of isolation before moving to their care home;
  - d. Introducing visitor restrictions at times of particularly high risk; and
  - e. In recognition of the challenges facing the sector, the Government published its first ever set of winter plans for adult social care.
89. The Government will continue to support the adult social care sector with the following protections:
- a. Supporting and encouraging the take-up of vaccines amongst care recipients and staff, including any further doses that may be recommended by JCVI for COVID-19 and other infections;
  - b. Guidance on precautions for visitors and workers in adult social care; and
  - c. Providing access to free PPE to the end of March 2023 or until the UK IPC guidance on PPE usage for COVID-19 is amended or superseded (whichever is sooner).
90. The role of the Government in managing the COVID-19 response in adult social care has been unprecedented. As a part of living sustainably with COVID-19, by 1 April the Government will publish updated IPC guidance. This will replace current COVID-19 IPC guidance for care homes, home care and other adult social care services. The Government will continue to work with local authorities and care providers to respond to outbreaks in care settings and manage local workforce pressures.

## Tackling health inequalities

91. COVID-19 has also exacerbated pre-existing socio-economic and health inequalities, driving poorer outcomes amongst those who were already disadvantaged. Since the start of the pandemic, the NHS has accelerated its preventative health programmes which proactively engage those at greatest risk of poorer health outcomes to address health inequalities.
92. The Government will continue to support communities with lower rates of COVID-19 vaccine uptake, particularly in areas of deprivation and for ethnic minority groups as part of its approach to both reducing health disparities as and living with COVID-19, but also to support the wider health and social care system.
93. The recent 'Levelling Up the United Kingdom' white paper also aims to reduce geographical inequalities by investing in health, local infrastructure and leadership,

and improving education and skills.<sup>68</sup> The Government will set out a strategy to tackle the core drivers of inequalities in health outcomes in a new white paper on health disparities in 2022.

94. The Government has provided significant additional funding to respond to the pandemic on an emergency basis through additional borrowing. As the country moves to living with COVID, the Government must ensure that the cost of resilience and contingency measures are met in a responsible and sustainable manner. The Government is already asking taxpayers to make an additional contribution through the Health and Care levy. The Government will meet the cost of living with COVID-19 within this and other existing funding streams.

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<sup>68</sup> DLUHC, [Levelling Up the United Kingdom](#), 2 February 2022.

## 5. MAINTAINING RESILIENCE

95. As set out in the introduction, the future path and severity of the virus is uncertain and it may take several years before the virus becomes more predictable. During this period further resurgences will occur, it is possible more severe variants will emerge and there will sadly be more hospitalisations and deaths. As a result, the Government is taking steps to ensure there are plans in place to maintain resilience against significant resurgences or future variants and remains ready to act if a dangerous variant risks placing unsustainable pressure on the NHS.
96. The Government's aim is to manage and respond to these risks through more routine public health interventions. As such, the NHS has developed a range of interventions to respond to COVID-19 demand while protecting NHS activity to the fullest possible extent. In future, pharmaceutical capabilities will be the first line of defence in responding to COVID-19 if risk threatens to place unsustainable pressure on the NHS.
97. The Government will retain surveillance to monitor the virus, understand its evolution and identify changes in characteristics, enabling the Government to make informed decisions. The Government will prepare and maintain the capabilities to ramp up testing and other tools such as laboratory infrastructure to be used as a line of defence against a new variant.

### Monitoring and mitigating risks

98. The UK has been a global leader in sequencing and monitoring, at times uploading the highest number of sequences of any country on the Global Initiative on Sharing Avian Influenza Data (GISAID) platform.<sup>69</sup> UKHSA will continue to sequence some infections and monitor a range of data.

#### *Domestic surveillance*

99. The Government will continue to monitor cases, in hospital settings in particular, including using genomic sequencing, which will allow some insights into the evolution of the virus. UKHSA will maintain scaled down critical surveillance capabilities including the COVID-19 Infection Survey (CIS) population level survey,

<sup>69</sup> [GISAID Submission Tracking](#) (19 November 2021 - 16 February 2022 the UK uploaded 30% of global sequences).

genomic sequencing and additional data. This will be augmented by continuing the SARS-CoV-2 Immunity & Reinfection Evaluation (SIREN) and Vivaldi studies.

## UK monitoring mechanisms during the pandemic

The Office for National Statistics (ONS) has continued to keep pace with the changing evidence needs of the Government and the public in tracking the spread of COVID-19 and understanding its impact. This includes official statistics on health, society, the labour market and the economy.

The COVID-19 Infection Survey was established in April 2020 to measure:

- How many people across England, Wales, Northern Ireland and Scotland test positive for a COVID-19 infection at a given point in time, regardless of whether they report experiencing symptoms;
- The average number of new positive test cases per week over the course of the study; and
- The number of people who test positive for antibodies.

The results of the survey contribute to UKHSA's estimates of the rate of transmission of the infection, often referred to as "R". The survey provides important information about the socio-demographic characteristics of the people and households who have contracted COVID-19.

The SIREN study was established in June 2020. The purpose of this study is to understand whether prior infection with SARS-CoV2 (the virus that causes COVID-19) protects against future infection with the same virus.

The [Vivaldi Study](#) was also established in June 2020. The purpose of this study is to investigate COVID-19 infections in care homes, to find out how many care home staff and residents have been infected with COVID-19, and inform decisions around the best approach to COVID-19 testing in the future.

## Preparing to respond

100. In order to be prepared for further resurgences and new variants, the Government will maintain resilience and infrastructure required to scale up a proportionate response.

*NHS and social care resilience*

101. The NHS has developed a range of interventions to respond to COVID-19 demand while protecting urgent and elective care activity to the fullest possible extent, including during the peaks of demand seen in April 2020, January 2021, and at the present time. These interventions include:
- a. Tried and tested plans to expand general and acute and critical care bed capacity as needed, learning the lessons from previous waves of COVID-19. This includes surging capacity within hospital trusts' existing footprints, across Integrated Care System footprints and clinical networks, and patient transfers between regions if required.
  - b. Maximising patient discharge, working with local authorities and partners to ensure that all medically fit patients can be safely discharged as soon as possible, supporting improved patient outcomes and freeing up beds for elective surgery.
  - c. Making full use of non-acute beds in the local health and care system as necessary, including in hospices, hotels, community beds and the independent sector. At points throughout the pandemic NHS England has contracted with independent providers to secure additional surge capacity and prevent the NHS from becoming overwhelmed due to COVID-19 infections. The Increasing Capacity Framework streamlines central procurement processes and allows the NHS to effectively secure the capacity it needs to meet patient needs on a local level.
  - d. The use of 'virtual wards' and 'hospital at home' models of care have ensured that patients can be safely cared for in their own homes and that additional bed capacity can be freed up in hospitals. The NHS operational planning guidance sets out that, by December 2023, systems should complete the comprehensive development of virtual wards towards a national ambition of 40 to 50 virtual beds per 100,000 population.
  - e. Implementing a range of workforce interventions, including increasing staffing numbers, temporary local adjustments to staffing ratios, with flexible redeployment of staff including training for roles in critical or enhanced care.
  - f. Ensuring continued improvements to the urgent and emergency care pathway to avoid emergency department crowding. Interventions include using NHS 111 as the first point of triage for urgent care services, which increases the ability to book patients into the full range of local urgent care services, including urgent treatment centres; same day emergency care; speciality clinics; and urgent community and mental health services.

102. While significant uncertainty remains, the NHS will continue to closely monitor COVID-19 demand and keep the use of these interventions under review, deploying them as necessary to protect the delivery of health services to the fullest extent possible.
103. Local authorities will have their own contingency plans for maintaining care services in the event of acute workforce supply challenges. In the event that a local authority – having deployed all its contingency measures – is unable to cope, a request for further support could be made via the Local Resilience Forums (LRFs).
104. The Government will continue to work closely with the health and care sectors to identify and understand capacity risks, in the event of another challenging winter and/or new variant of concern.

#### *Pharmaceutical interventions and medical countermeasures*

105. The Government already has experience in successfully deploying a contingency response based on medical countermeasures. During the response to the Omicron variant, the NHS administered a booster programme to all adults and met the surge in demand for vaccines at short notice. The Government will ensure that there are sufficient procurement plans in place to make certain that the UK has access to the most effective vaccines on the market, and that these are available to the health care system and the public when needed.

#### *Testing: Contingency capabilities*

106. The Government will retain core infrastructure and capabilities in England to scale up testing in the case of a new dangerous variant.

#### *Local outbreak management*

107. Local partners have significantly stepped up to support local outbreak management. In future the Government expects COVID-19 to be managed regionally and locally as part of a wider all hazards approach, using existing health protection frameworks.
108. The Government will revise current COVID-19 outbreak management advice and frameworks, to set out the support that local authorities and other system partners (such as LRFs, regional health protection teams, the NHS and others) can expect from regional and national stakeholders and the core policy and tools for contingency response. The Government will continue to provide guidance via UKHSA engagement with local partners.

*Approach at the borders*

109. Last month the Government announced its new system for international travel, underpinned by a commitment to see a return to unrestricted travel and to support recovery across all sectors. There are now no requirements on eligible vaccinated travellers apart from the need to complete a simplified Passenger Locator Form. Travellers who do not qualify as eligible vaccinated also need to take a pre-departure test and an arrival test on or before day 2, but no longer need to isolate or take a day 8 test.
110. The Government also committed to developing a contingency toolbox of options. The Government recognises that border measures have carried very high personal, economic, and international costs. The Government will only consider implementing new public health measures at the border in extreme circumstances where it is necessary to protect public health.
111. Contingency measures would only be used where they are proportionate to the threat faced by a COVID-19 variant and effective in slowing ingress to avert pressure on public services such as the NHS. There may be scenarios where border measures are not appropriate and will not form part of a contingency response. The approach will be underpinned by three important principles:
- a. The bar for implementation of any measures is very high;
  - b. Any measure will be tailored and proportionate to the threat posed and will seek to minimise economic and social impacts; and
  - c. In the event any measures were deemed necessary they would be time limited and not be in place any longer than needed.
112. Given the current state of the pandemic and a move towards global travel volumes returning to normal, the infrastructure for hotel quarantine will be fully stood down from the end of March and the Government is developing options to increase compliance with home isolation in its place should quarantine measures need to be reintroduced. Previous global responses to variants of COVID-19 that targeted travel from specific countries may not always be appropriate given how quickly the virus can spread, and tailoring measures to the nature of the threat can improve their effectiveness and proportionality. As such, the Government will have in reserve a more agile toolbox tailored depending on the nature and source of the threat, and deployed only where that high bar is crossed. The default will be to first consider whether less stringent measures are appropriate so as to minimise the impact on general travel where possible.
113. The Government will set out the contingency approach and toolbox of measures in more detail ahead of Easter when reviewing The Health Protection (Coronavirus,



International Travel and Operator Liability) (England) Regulations 2021. The Government will continue to work with industry on contingency planning.

## 6. SECURING INNOVATIONS AND OPPORTUNITIES FROM THE PANDEMIC

114. The COVID-19 pandemic has been a unique challenge for governments, communities and businesses across the world. These challenges have brought with them opportunities for innovation, as new approaches were developed and deployed at scale and pace. The Government is committed to securing the innovations and opportunities which have emerged during the pandemic, where there is long term benefit to wider Government priorities.
115. In addition, the COVID-19 public inquiry chaired by Baroness Hallett starts this spring and is intended to enable the Government to learn lessons about its response.
116. The Government will also remember those that have lost their lives during the COVID-19 pandemic, and commemorate the enormous efforts and sacrifices of all those who have supported the country throughout. On 12 May 2021, the Prime Minister announced that a UK Commission on COVID Commemoration would be established to consider how the country should remember those who have lost their lives and recognise those involved in the response. The Government will set out the Commission's membership and terms of reference in due course.

### Innovation, opportunities and learning

#### *Life sciences*

117. Over the course of the pandemic the scientific community has made extraordinary scientific advances. The Government directly supported several vaccine manufacturers in their research and development. The first COVID-19 vaccines were ready for clinical trials in under a month, which then led to the deployment of the first safe and effective wide-scale COVID-19 vaccination programme. These vaccines have now been used more widely around the world than many medicines, with extraordinarily successful results.
118. Innovations in vaccines, antivirals and therapeutics will likely play a vital role in the Government's response against COVID-19 in the future. A number of vaccine suppliers are already trialling new bi-valent vaccines, which would provide

protection against COVID-19 variants. The Vaccine Taskforce (VTF) will continue to ensure that the UK has access to effective vaccines on the market. The Therapeutics Taskforce will continue to support the eight national priority clinical trial platforms run by the National Institute for Health Research, focused on prevention, novel treatments, and treatments for Long COVID.

119. The UK remains an attractive prospect for companies to invest in the UK's life sciences sector, whether it be as part of an established research and innovation network or in the growing biologics manufacturing industry. At the recent Autumn Budget, the Chancellor announced a further £354 million for UK life sciences manufacturing as part of the Global Britain Investment Fund to support investment into the UK economy. The Vaccine Taskforce's investment into facilities at UKHSA Porton Down has increased the UK's capacity to test the efficacy of vaccines against emerging variants.

#### **Vaccine Taskforce (VTF)**

The Vaccine Taskforce was set up in April 2020 to drive forward the development, procurement, and production of a COVID-19 vaccine as quickly as possible, bringing together the Government, academia, industry and international cooperation in science and research. Since then, the VTF has had unprecedented success. Using experience and expertise from the private sector has enabled the UK to build a diverse portfolio of vaccines and secure assured supply through to 2023. This has allowed the NHS to run the largest vaccination campaign in its history.

The Government's longer-term approach to vaccine procurement will seek to build upon the legacy of innovation from the success of the VTF and look to apply the wider lessons from the past two years to other vaccination programmes.

#### *NHS and social care*

120. The Government will implement lessons learnt from the pandemic in the Health and Social Care sector, drawing on what worked well, and on future clinical advice. In particular, the Health and Social Care Integration white paper sets out the Government's plans to make integrated health and social care a reality for everyone

across England and to level up access, experience, and outcomes across the country.<sup>70</sup>

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<sup>70</sup> DHSC, [People at the Heart of Care: adult social care reform](#), 1 December 2021

### **Improving NHS data**

In March 2020, the NHS COVID-19 Data Cell (a partnership between NHS England and NHS Improvement (NHSEI) and NHSX) worked with partners to provide a data analysis and modelling platform that brought together multiple complex data sources from across the health and care system into a single, secure location.

The platform proved invaluable in providing a single version of the truth to support data driven decisions. In a matter of months, this system achieved what would have taken years to develop under non-crisis circumstances.

### **Virtual Wards**

To enable patients to be safely discharged as quickly as possible the NHS established “virtual wards”. This allowed clinicians to use technology to remotely monitor COVID-19 and non-COVID-19 patients while communicating with them at home.

### **Oximetry@Home**

This NHS service provides pulse oximeters to patients with COVID-19 who are at a higher risk, along with supporting information to monitor their oxygen saturation levels at home, with 24/7 access to advice and support. It is usually led by general practice working alongside community teams. The service can help ensure more timely hospital treatment if required.

### **Emergency registers for health professionals**

Section 2 of the Coronavirus Act 2020 has enabled thousands of nurses and other healthcare professionals who no longer work for the NHS to be placed on temporary registers, allowing them to work in NHS services to alleviate workforce pressures during times of emergency.

Following the success of these registers, the Department for Health and Social Care (DHSC) will amend legislation to enable the Nursing and Midwifery Council (NMC) and the Health and Care Professions Council (HCPC) to establish temporary registers to support emergency response arrangements in future.

*Strengthening health security at home and abroad*

121. The Government is committed to supporting future health security and resilience.

**UK Health Security Agency (UKHSA)**

UKHSA was set up in April 2021 to prepare for, prevent and respond to all hazards to public health. UKHSA has been instrumental in delivering the UK's response to COVID-19:

- **Testing capacity and diagnostics** including the largest network of diagnostic testing facilities in British history. The UK has now registered over 467 million COVID-19 tests.<sup>71</sup>
- **Genomic sequencing capabilities** where the UK has uploaded over 2 million genome sequences to the international GISAID database, accounting for a quarter of all SARS-CoV-2 genomes shared globally to date.<sup>72</sup>
- **Innovation and technology:** the development of the Rosalind Franklin laboratory, and use of innovative new techniques - such as reflex assay technology - strengthened our ability to rapidly detect COVID-19 mutations and support the assessment of variants of concern. At its peak, in December 2021, the Rosalind Franklin Laboratory was processing over 400,000 PCR tests a week.<sup>73</sup>

UKHSA will continue to lead the wider health protection emergency planning and response system, championing health security across the UK.

## International learning and innovation

122. Epidemics and pandemics are not new, but the rate at which they have occurred has increased during the last 20 years. This increase is thought to be driven by a combination of changes to land use and human behaviours that bring people into closer contact with wild animals, coupled with unprecedented levels of global movement of people and trade.

<sup>71</sup> UKHSA, [Testing in the UK](#), 17 February 2022.

<sup>72</sup> Gov.uk, [UK completes over 2 million SARS-CoV-2 whole genome sequences](#), 10 February 2022.

<sup>73</sup> UKHSA, [Rosalind Franklin laboratory processes 5 million PCR tests](#), 10 February 2022.

*Supporting global COVID-19 recovery*

123. The UK remains committed to equitable global access to COVID-19 tools to help reduce the risk and frequency of variants of concern, and to contribute to global COVID-19 recovery. The UK has played a leading role in global vaccine access and has committed up to £1.4 billion of UK aid to address the impacts of COVID-19 and to help end the pandemic as quickly as possible. The UK's commitment included £548 million to support the COVAX Advanced Market Commitment (AMC) to deliver COVID-19 vaccines for up to 92 low- and middle-income countries.
124. The UK's G7 Presidency delivered a shared commitment to provide one billion doses to vaccinate the world over the next year. As part of this commitment, the Government committed to donate 100 million surplus COVID-19 vaccine doses by June 2022, at least 80% of which will go to COVAX to enable it to further support those in need. The Government exceeded its target of 30 million doses donated by the end of 2021.

*Building resilience to global health threats*

125. The Government continues to invest in and develop resilience to global health threats via improved health and biosecurity and pandemic preparedness, examples include:
- a. **Biological Security Strategy:** Later this year, the Government will publish a refreshed biological security strategy. COVID-19 has reinforced the need for effective preparation for future biological threats to protect the UK against naturally occurring infections, accidental release and potential deliberate misuse by state and non-state actors, in particular through surveillance, risk monitoring and response planning.
  - b. **The 100 Days Mission and Early Warning Systems:** The 100 Days Mission is a global public-private ambition to harness scientific innovation to reduce the impact of future pandemics by making available safe and effective diagnostics, therapeutics, and vaccines within the first 100 days of a future pandemic threat being identified. The Mission was launched as part of the UK's G7 Presidency in 2021 and the UK is working domestically, with the G7, G20, and international partners to ensure sustainable implementation of the 25 recommendations to ensure the Mission is achieved by 2026.
  - c. **Pandemic preparedness:** The UK is hosting a global pandemic preparedness summit in March 2022, (the Coalition for Epidemic Preparedness Innovations (CEPI) Summit) which will explore how the world can better prepare for pandemics by harnessing the power of science to

revolutionise how new vaccines can be developed, manufactured, and equitably distributed to end pandemics.

- d. **Engagement and reform of the WHO:** The UK is supporting work underway to harness the lessons learnt from the COVID-19 pandemic. A stronger architecture for pandemic preparedness and response includes: sustainably financing the WHO; supporting improvements to the way outbreaks are investigated and the establishment of a Scientific Advisory Group for Origins of Novel Pathogens; and considering amendments to the International Health Regulations (2005) to improve management of public health emergencies.

*Improved international consistency on global travel health policies*

126. International travel has been severely disrupted throughout the pandemic, causing difficulties for businesses and passengers. The Government will work further with international partners to discuss how cooperation and alignment of border and travel health policies can be improved. This approach will identify opportunities for standardisation to support global efforts to detect, manage, and respond to new health threats as well as seek to deliver as smooth an experience as possible for passengers, helping to support the recovery of the international travel sector.



## 7. LEGISLATION

127. During the pandemic, the Government has had to introduce regulations and legislation involving unprecedented government intervention in order to protect public health, and support individuals, businesses and public services. As part of the implementation of the living with COVID-19 strategy, the Government will make the following legislative changes, subject to appropriate parliamentary scrutiny.

### *Domestic Restrictions under the Public Health (Control of Disease) Act 1984*

128. The Government has always said that restrictions would not stay in place a day longer than necessary, and is now able to proceed with removing the last domestic restrictions:
- a. The Health Protection (Coronavirus, Restrictions) (England) (No. 3) Regulations 2020 (“No.3 Regulations”) have been in place since 18 July 2020. These powers will be revoked on 24 February. Local authorities will now be required to manage outbreaks through local planning, and pre-existing public health powers, as they would with other infectious diseases.
  - b. The Health Protection (Coronavirus, Restrictions) (Self-Isolation) (England) Regulations 2020 have been in place since 28 September 2020, and impose a legal duty on individuals who test positive and certain close contacts to self-isolate. As set out in chapter 3, the legal duty to self-isolate will be lifted on 24 February and be replaced by guidance.

### *Statutory Sick Pay and Employment and Support Allowance*

129. In light of the Government’s decision to end the legal duty to self-isolate from 24 February, on 24 March:
- a. The Statutory Sick Pay (General) Regulations 1982 and the Statutory Sick Pay (Coronavirus) (Suspension of Waiting Days and General Amendment) Regulations 2020 will be amended to remove COVID-19 provisions. From

this date, Statutory Sick Pay (SSP) will no longer be payable from day 1 if people are unable to work because they are sick or self-isolating due to COVID-19. Pre-pandemic SSP rules will apply.

- b. The COVID-19 Employment and Support Allowance provisions within The Employment and Support Allowance and Universal Credit (Coronavirus Disease) Regulations 2020 will automatically expire. From this date, people will no longer be eligible for Employment and Support Allowance because they are self-isolating due to COVID-19. Anyone infected with COVID-19 may, subject to satisfying the conditions of entitlement, still be eligible for Employment and Support Allowance on the basis that they have a health condition or disability that affects their ability to work under the general Employment and Support Allowance regulations.

### *Vaccines as a Condition of Deployment Regulations*

- 130. The Health and Social Care Act 2008 (Regulated Activities) (Amendment) (Coronavirus) Regulations 2021 making vaccination a condition of deployment were introduced in Care Quality Commission (CQC) registered care homes from 11 November 2021. These regulations require that individuals entering the premises are fully vaccinated, unless otherwise exempt. Regulations to extend vaccination as a condition of deployment to health and wider social care settings were approved by Parliament in December 2021, and its main provisions were set to come into force on 1 April 2022. These regulations would require that anyone providing a CQC regulated activity would also be required to be fully vaccinated, unless otherwise exempt.
- 131. After reviewing the latest clinical and scientific evidence, the Government announced its intention to revoke both of the above regulations, subject to consultation and appropriate parliamentary procedure. Whilst vaccination remains the country's best line of defence against COVID-19, the balance of opportunities and risks of the policy have now changed with the dominance of the Omicron variant. The Government therefore assesses that it is no longer proportionate to require vaccination as a condition of deployment through statute. Professional bodies, the Royal Colleges, the Chief Medical Officer, Chief Nursing Officer and others consider it is a professional responsibility for health and care staff to be vaccinated. The Government has asked the professional regulators to review how this responsibility could be strengthened through their guidance, and will also be consulting on doing so through the Government's guidance for CQC regulated providers.

132. A public consultation on revocation concluded on 16 February 2022, and the Government will publish its response shortly. Subject to the outcome of the consultation, the regulations will be revoked ahead of 1 April 2022.

#### *International travel regulations*

133. With the intention to continue to facilitate safe travel and sector recovery, and in the context of having significantly reduced travel restrictions, the Government will review The Health Protection (Coronavirus, International Travel and Operator Liability) (England) Regulations 2021 before Easter and ahead of their expiry date of 16 May.

#### *The Coronavirus Act 2020*

134. The Coronavirus Act 2020 was first introduced in March 2020 and has enabled the Government to support individuals, businesses, and public services during the pandemic.

#### *Temporary provisions*

135. The Government will expire all remaining non-devolved temporary provisions within the Coronavirus Act 2020. Half of the original 40 temporary non-devolved provisions have already expired, as the Government has removed powers throughout the pandemic which were no longer needed. Of the 20 remaining non-devolved temporary provisions, 16 will expire at midnight on 24 March 2022. These are:
- a. **Section 2:** Emergency registration of nurses and other health and care professionals.
  - b. **Section 6:** Emergency registration of social workers: England and Wales.
  - c. **Section 14:** NHS Continuing Healthcare Assessments: England.
  - d. **Section 18:** Registrations of deaths and still-births.
  - e. **Section 19:** Confirmatory medical certificate not required for cremations: England and Wales.
  - f. **Section 22:** Appointment of temporary Judicial Commissioners.
  - g. **Section 38:** Temporary continuity: education, training and childcare.

- h. **Section 39-41:** Statutory Sick Pay: funding of employers' liabilities; power to disapply waiting period limitation; modification of regulation making powers.
  - i. **Section 45:** NHS pension schemes: suspension of restrictions on return to work: England and Wales.
  - j. **Section 50:** Power to suspend port operations.
  - k. **Section 58:** Powers in relation to transportation, storage and disposal of dead bodies.
  - l. **Section 75 (2) and (3):** Disapplication of limit under section 8 of the Industrial Development Act 1982.
  - m. **Section 81:** Residential tenancies in England and Wales: protection from eviction.
  - n. **Section 82:** Business tenancies in England and Wales: protection from forfeiture
136. The remaining four provisions will be expired within six months. These provisions have enabled innovations in the delivery of public services and the Government is seeking approval to make them permanent through other primary legislation currently before Parliament and due to come into force over the spring and summer. In each case, a final six-month extension is necessary in order to ensure there is no gap in the legislation that enables public service delivery. The relevant provisions are:
- a. **Section 30:** has supported coronial services throughout the pandemic in England and Wales by enabling inquests, where COVID-19 is suspected as the cause of death, to take place without a jury, helping reduce pressures and backlogs. This provision will be made permanent via the Judicial Review and Courts Bill.
  - b. **Sections 53 to 55:** have allowed thousands of court hearings to take place using audio and video links. Over 12,000 hearings per week have taken place using remote technology across 3,200 virtual courtrooms, helping courts reduce the backlog in cases and bring more people to justice. The provision for remote hearings will be made permanent via the Police, Crime, Sentencing and Courts Bill.

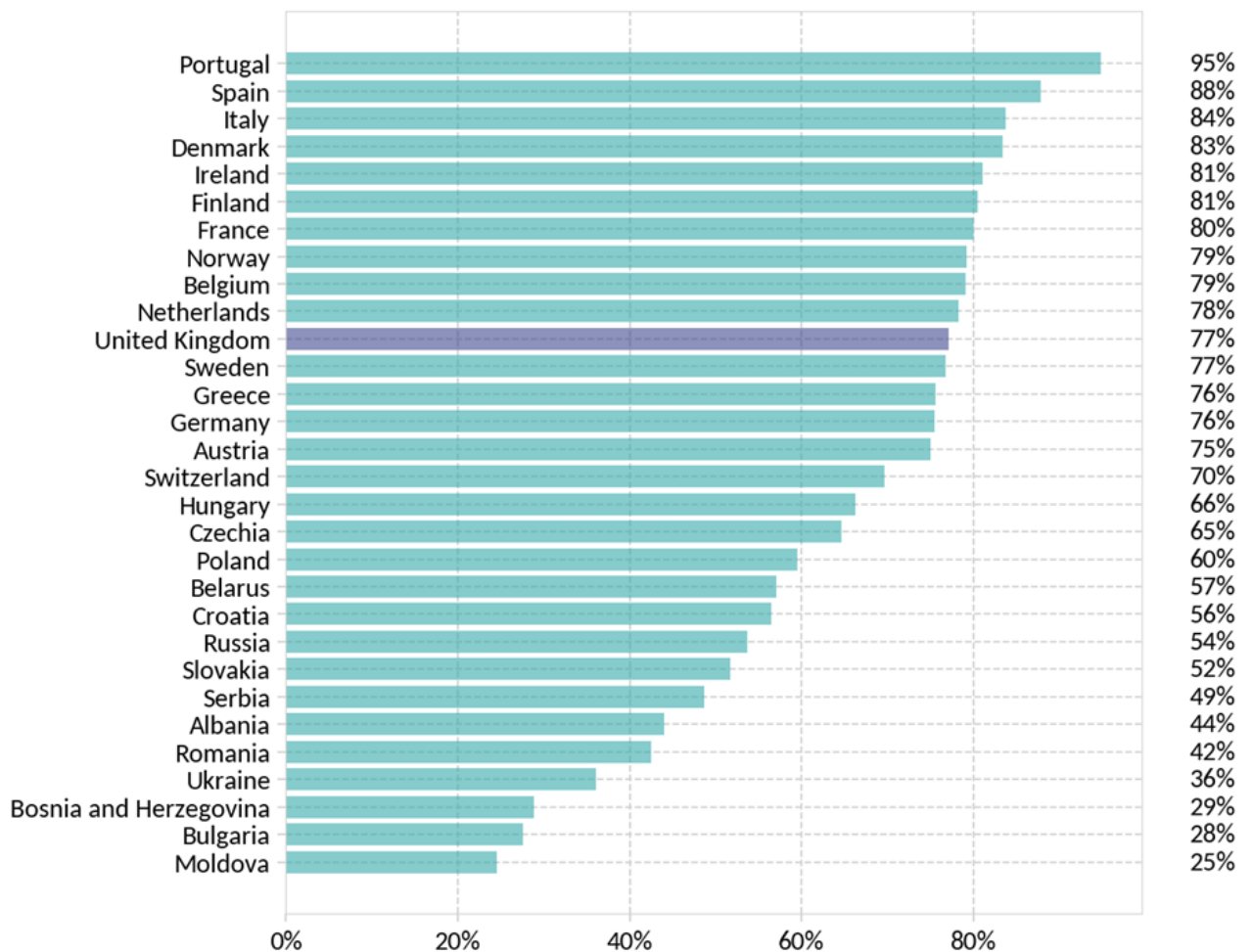
*Permanent provisions and devolved governments*

137. There are a number of permanent provisions within the Coronavirus Act 2020 which would require new primary legislation in order to repeal. Some of these provisions are still necessary to support the recovery from the pandemic, including:
- a. **Section 11:** Indemnity for health service activity: England and Wales. This provision ensures that any gaps in indemnity cover for NHS clinical negligence do not delay or prevent ongoing care. Without this, NHS Resolution would be unable to pay legitimate clinical negligence claims, leaving clinicians exposed to the full cost and patients without compensation.
  - b. **Section 75(1):** Disapplication of limit under section 8 of the Industrial Development Act 1982 (IDA). This provision ensures that the financial limits set out in section 8 of the IDA do not hinder the allocation of vital Government schemes for businesses such as the Help to Grow scheme, the Automotive Transformation Fund, and the Offshore Wind Manufacturing Investment Scheme (OWMIS).
138. The Government is committed to removing unnecessary provisions from the statute book as soon as possible and will look for opportunities to do so as the Government's legislative programme proceeds.
139. Once the Government has received the conclusions of the COVID-19 public inquiry, it will consider whether further changes to public health legislation are needed. The Public Health (Control of Disease) Act 1984 and any outstanding provisions in the Coronavirus Act 2020 would be in scope for this work.
140. The Government will also work with the Devolved Administrations, who have used their specific powers within the Coronavirus Act during the pandemic, to help transition provisions into devolved legislation where necessary.

# ANNEX: INTERNATIONAL COMPARATORS

**Figure 4: Proportion of total population of European countries who have received one dose of COVID-19 vaccine<sup>74</sup>**

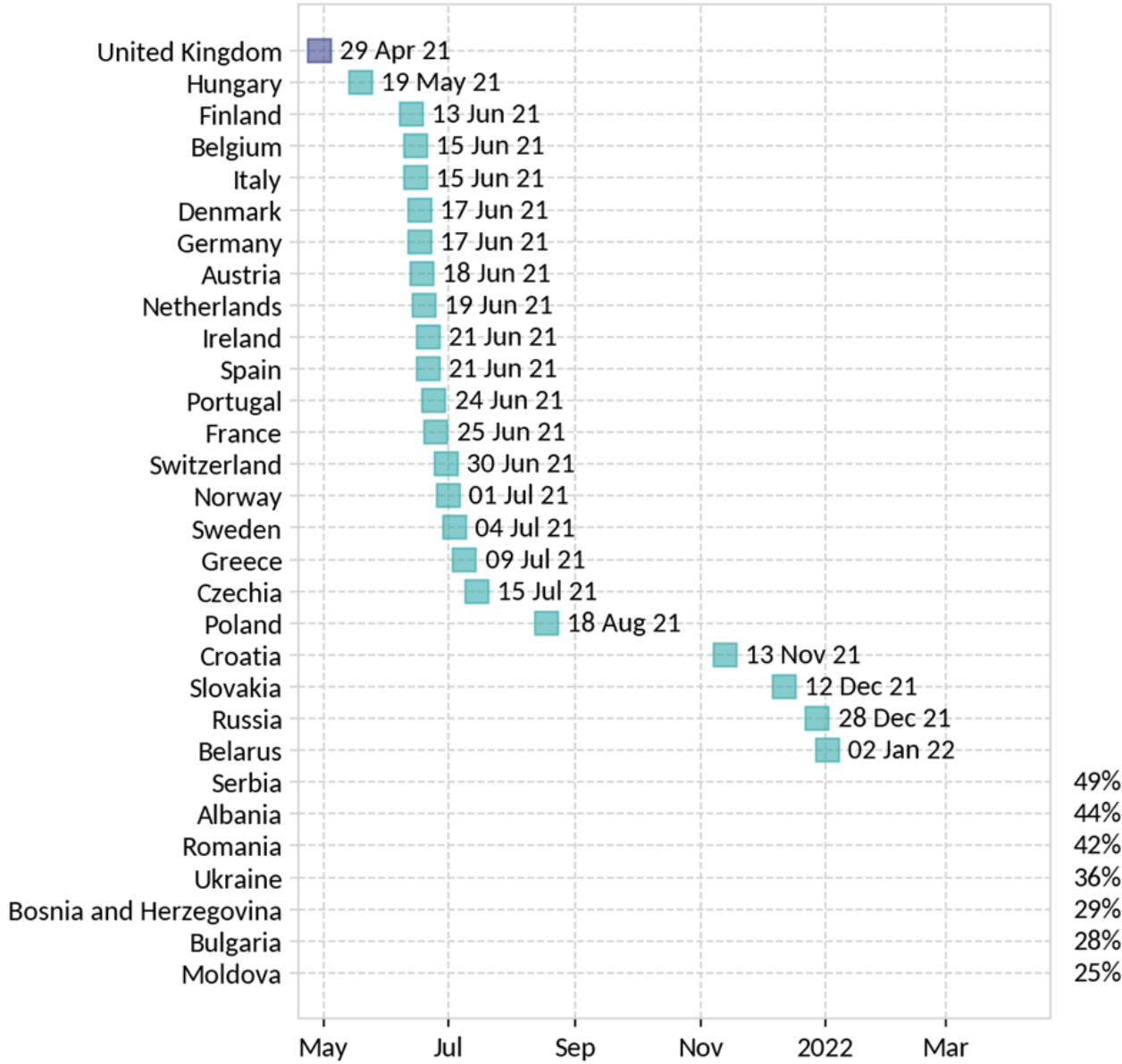
*European countries filtered to the top 30 largest by population*



<sup>74</sup> Our World in Data, [Share of people vaccinated against COVID-19](#). 19 February 2022.

**Figure 5: Date at which 50% of the total population of European countries received their first dose of COVID-19 vaccine<sup>75</sup>**

*European countries filtered to the top 30 largest by population*

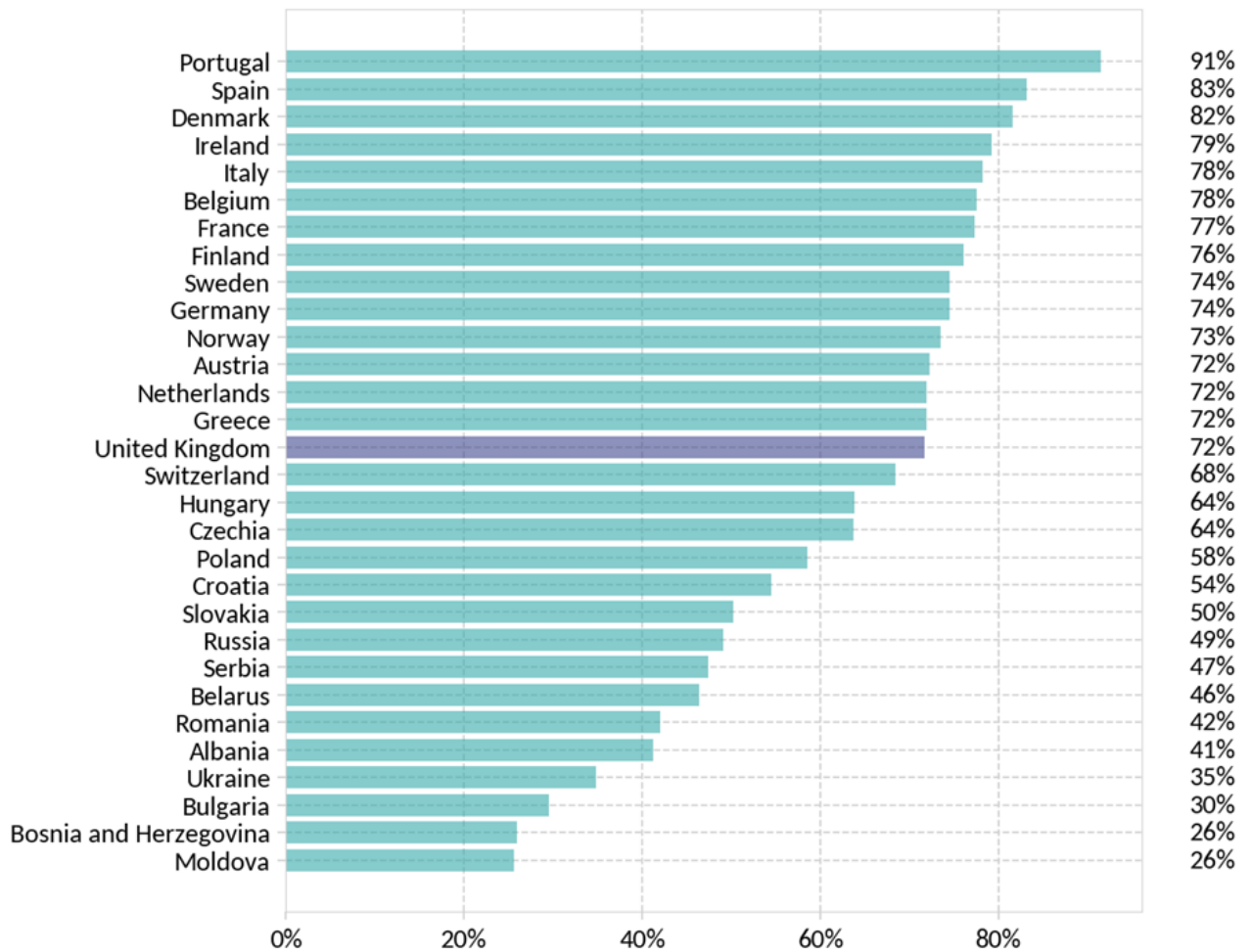


The speed of the UK’s initial vaccine rollout in early 2021 had a direct impact on the ability to open up the economy, and ease social restrictions sooner than other comparator countries last summer. The success of the rollout also meant that the UK maintained a lower level of restrictions than most other European comparator countries this winter.

<sup>75</sup> Our World in Data, [Share of people vaccinated against COVID-19](#), 20 February 2022

**Figure 6: Proportion of total population of European countries that are fully vaccinated with a COVID-19 vaccine<sup>76</sup>**

*European countries filtered to the top 30 largest by population*



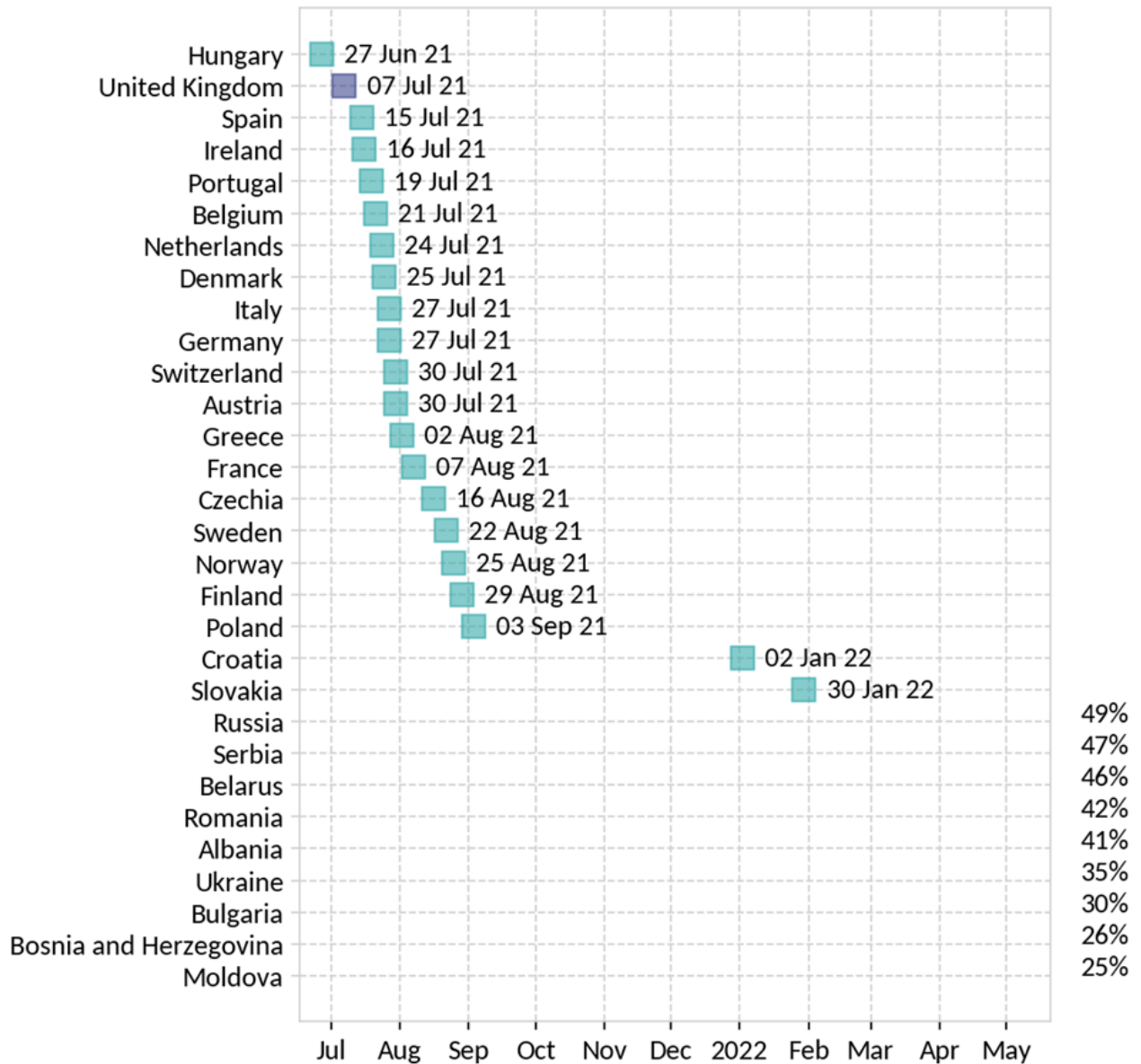
*Data extracted on 20 January 2022, however, differences in reporting mean dates of underlying data vary by a few days.*

<sup>76</sup> Our World in Data, [Share of people who completed the initial COVID-19 vaccination protocol](#), 20 February 2022.



**Figure 7: Date at which 50% of the total population of European countries were fully vaccinated with a COVID-19 vaccine<sup>77</sup>**

*European countries filtered to the top 20 largest by population*



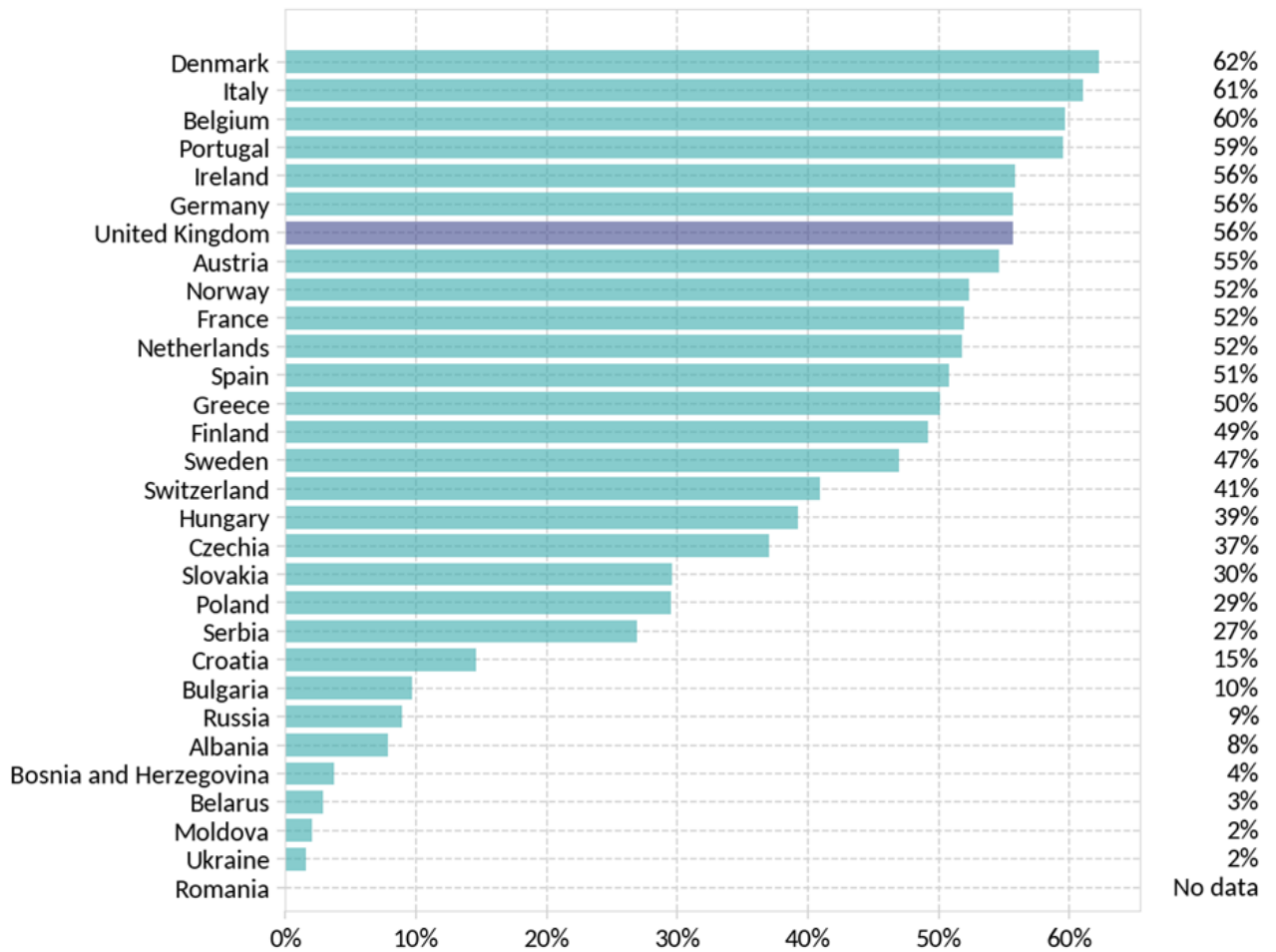
*Vaccine protocols vary by country due to use of different manufacturers. Although the initial protocol (full vaccination) is 2 doses for most vaccines, for a few manufacturers this can be 1 or 3 doses.<sup>78</sup>*

<sup>77</sup> Our World in Data, [Share of people who completed the initial COVID-19 vaccination protocol](#), 20 February 2022.

<sup>78</sup> Our World in Data, [Coronavirus \(COVID-19\) Vaccinations](#), 20 February 2022.

**Figure 8: Proportion of total population of European countries who have received a booster dose of COVID-19 vaccine<sup>79</sup>**

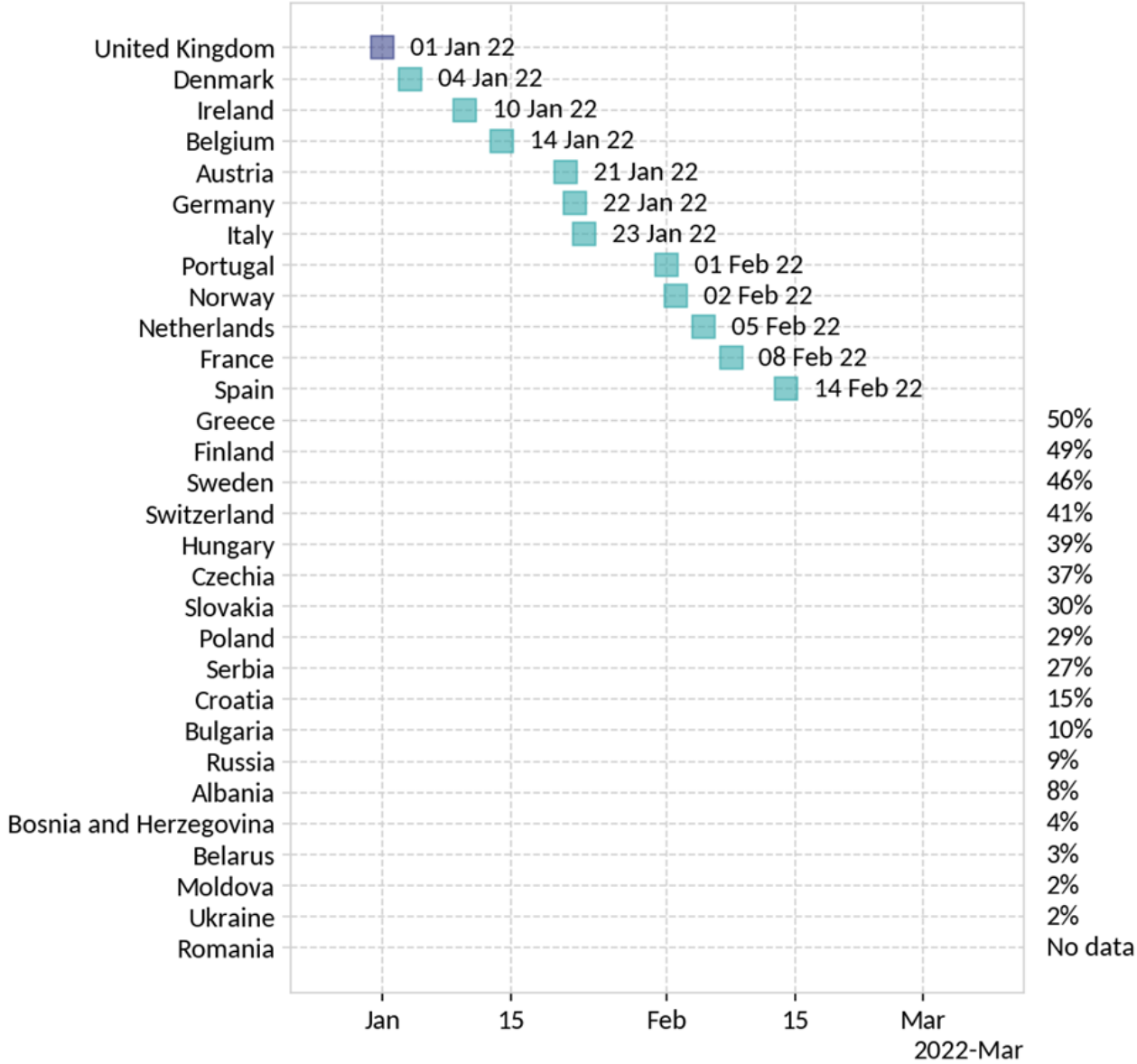
*European countries filtered to the top 30 largest by population*



<sup>79</sup> Our World in Data, [COVID-19 vaccine boosters administered per 100 people](#), 20 February 2022.

**Figure 9: Date at which 50% of the total population of European countries received a booster dose of a COVID-19 vaccine<sup>80</sup>**

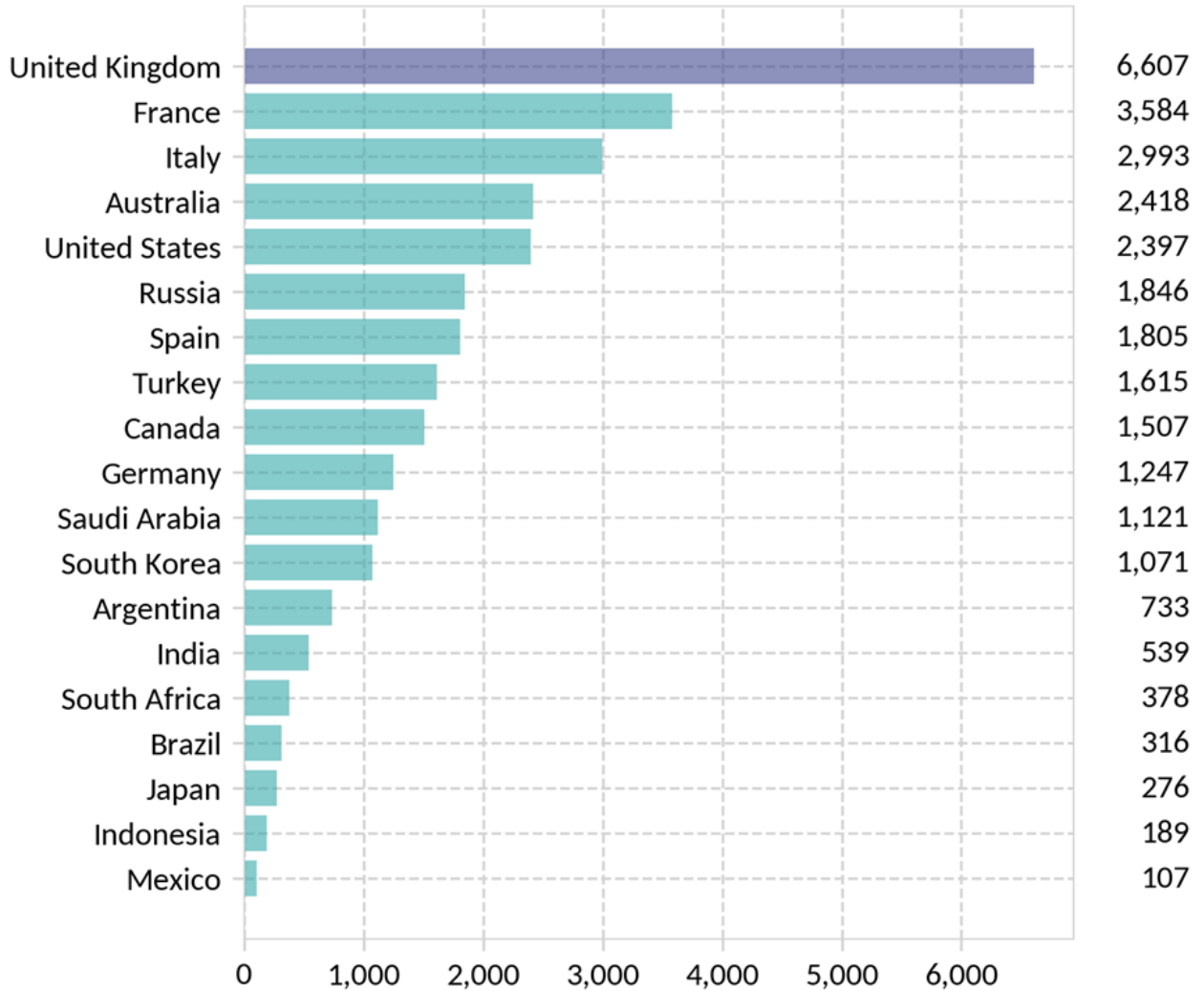
*European countries filtered to the top 30 largest by population*



<sup>80</sup> Our World in Data, [COVID-19 vaccine boosters administered per 100 people](#), 20 February 2022.

**Figure 10: COVID-19 tests administered per 1,000 people: G20 countries<sup>81</sup>**

*The UK has administered more tests per 1,000 people than any other G20 country since 13 February 2020 (noting that there is no publicly available testing data for China).*



*The methodology for recording daily testing figures varies from country to country. The UK testing figures display the number of PCR and antigen tests conducted across pillars 1 and 2.<sup>82</sup>*

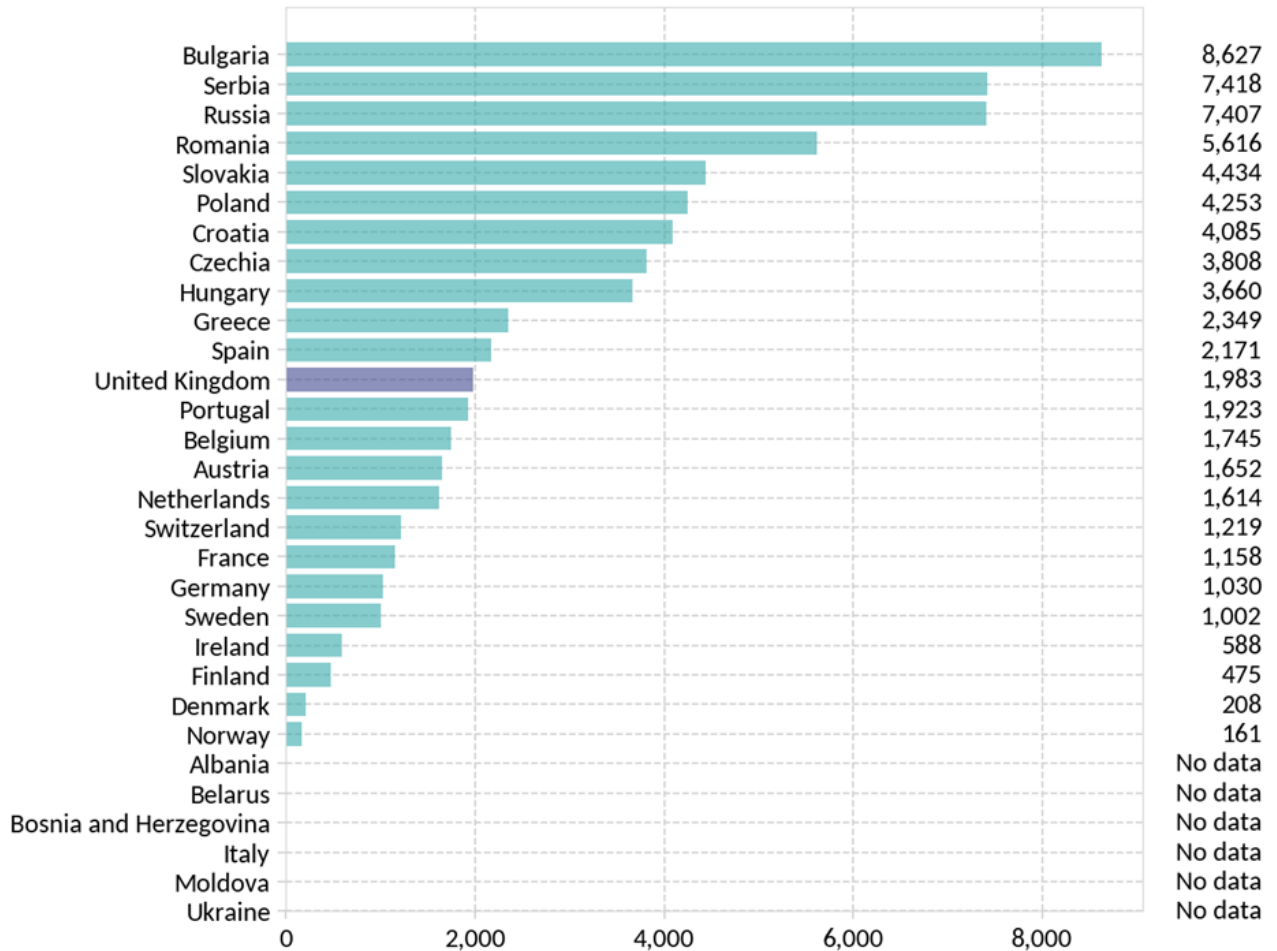
<sup>81</sup> Our World in Data, [Daily new COVID-19 tests per 1,000 people](#) 18 February 2022.

<sup>82</sup> Our World in Data, [The Our World in Data COVID-19 Testing dataset](#). 20 February 2022.

### Figure 11: Excess deaths per million in European countries<sup>83</sup>

Excess deaths are defined as the difference between total deaths during a crisis and the expected number of deaths in 'normal' conditions.<sup>84</sup>

*European countries filtered to the top 30 largest by population*

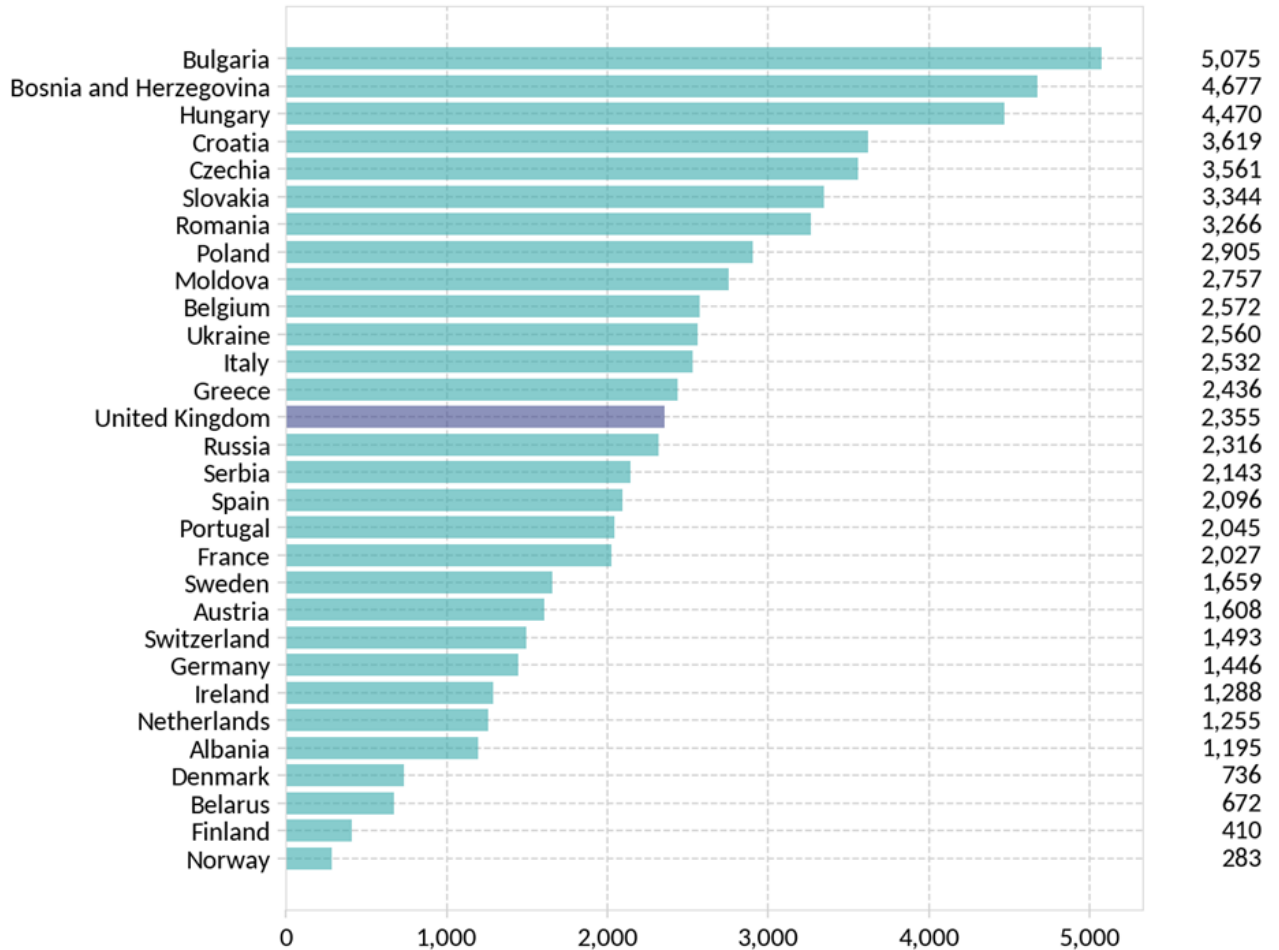


<sup>83</sup> Our World in Data, [Excess mortality: Cumulative number of deaths from all causes compared to projection based on previous years, per million people](#), 20 February 2022.

<sup>84</sup> Our World in Data, [Excess mortality during COVID-19](#), 20 February 2022.

**Figure 12: Recorded COVID-19 deaths per million in European countries<sup>85</sup>**

*European countries filtered to the top 30 largest by population*



*This chart shows the number of deaths recorded with COVID-19 on the death certificate. The guidance for including COVID-19 on death certificates varies between countries. It is anticipated that the true number of COVID deaths is higher than the number recorded so excess deaths can provide a more well rounded picture of the impact of the pandemic<sup>86</sup>*

<sup>85</sup> Our World in Data, [Weekly confirmed COVID-19 deaths per million people](#), 20 February, 2022.

<sup>86</sup> Our World in Data, [Coronavirus \(COVID-19\) Deaths](#). 20 February 2022.



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