Thursday, 13 March 2025

(10.00 am)

LADY HALLETT: Mr Stoate.

MR STOATE: My Lady, good morning. Before we start the evidence today, there are a number of witness statements relating to Week 1 evidence that we ask your permission to adduce into evidence, and for publication on the Inquiry's website.

LADY HALLETT: Certainly.

MR STOATE: If I could ask that the list of documents be brought up, please.

There they are, my Lady. There's a second page. Yes, thank you very much.

They provide important additional contextual information and background which will assist you, my Lady, when considering the evidence you have heard in this investigation and in your report. Thank you.

My Lady, the first witness today is Helen Whately. May the witness please be sworn.

MS HELEN WHATELY (sworn)

Questions from COUNSEL TO THE INQUIRY

MR STOATE: Thank you, good morning.

Could you please give the court your full name.

A. Helen Whately.

Q. You very helpfully provided the Inquiry with a witness

statement, the Inquiry reference for which is INQ000535015, dated 23 January 2025. Is that statement true to the best of your knowledge and belief?

A. Yes.

Q. Thank you very much.

Ms Whately, you are and have been the Member of Parliament for Faversham and Mid Kent since 2015?

A. Yes.

Q. And you are, I think, currently the shadow Secretary of State for Work and Pensions?

A. Yes.

Q. You have, in the past, held various positions within the Conservative Party and ministerial roles, but in terms of the relevant position you held in relation to the scope of this, the procurement module of this Inquiry, you served as Minister of State for Care from 13 February 2020 to 16 September of 2021; is that correct?

A. Yes.

Q. You are, of course, aware that Module 6 of this Inquiry is investigating the impact of the pandemic on the public and privately funded adult social care sector, so the focus of my questions this morning is about the procurement of key medical equipment -- procurement and description of key medical equipment and supplies during

the pandemic for the care sector?

A. Yes.

Q. In terms of the scope of your ministerial brief, that's as Minister of Care, you say that when you were first appointed in that role, your portfolio, as agreed by the Secretary of State, Mr Hancock, consisted of, amongst a number of other things, adult social care; is that right?

A. Yes.

Q. You say that from early March of 2020, your ministerial role was focused predominantly on the Covid-19 response; is that right?

A. Yes.

Q. Perhaps understandably so.

A. Mm-hm.

Q. You say, as your portfolio included adult social care, during the pandemic you were involved in decisions to ensure that systems and processes were in place so that key healthcare equipment and supplies were distributed and available to the social care sector; is that right?

A. Sorry, could you just repeat that?

Q. Yes, of course. You say in your statement that you were not involved in direct operational decisions about procurement?

A. Yes.

Q. That's, I think, the distinction you draw; is that right?

A. Correct, yeah.

Q. But that you were involved in decisions to ensure that the systems and processes enabled the distribution of the key healthcare equipment supplies into the social care sector; is that correct?

A. Yes.

Q. You say you provided strategic direction on policy which included liaising with various individuals and bodies, that's within the social care sector, is it?

A. Mm-hm.

Q. On issues such as the prioritisation of the social care sector when decisions were made in respect of those medical equipment supplies, yes?

A. **(The witness nodded)**.

Q. Just for completeness, you do tell us that from September of 2021 to July 2022 you were Exchequer Secretary to the Treasury; is that right?

A. Yes.

Q. But during that time and in that role you were not involved in any decisions concerning PPE, healthcare equipment or supplies?

A. That's correct.

Q. Thank you. I want to turn first, please, to the issue

1 of pandemic preparedness.
2 In your witness statement you say that in common
3 with many other countries, adult social care is
4 a devolved -- in your words, a devolved and diverse
5 sector which you say provided a difficult starting point
6 for a pandemic that needed a rapid and coordinated
7 response to make the most of limited resources, like
8 Covid-19 tests and PPE; is that right?
9 **A.** Yes.
10 **Q.** You say in your statement that while in England, the NHS
11 has NHS England and a substantial team at the Department
12 of Health and Social Care to develop, implement and
13 monitor policy and activity, at the start of the
14 pandemic, the Adult Social Care Team was rather
15 different to that; is that right?
16 **A.** Yes, and I can give a little more insight into that.
17 **Q.** Yes, please.
18 **A.** Although could I just take a moment as this is my first
19 appearance at this Inquiry following the pandemic.
20 **Q.** Of course.
21 **A.** To say that I know that many thousands of people lost
22 their lives during the pandemic, including many
23 thousands who received social care, and for me as Care
24 Minister, that's something I spend much time thinking
25 about, and I would like to say to the loved ones of

1 those people who died how sorry I am for their loss and
2 how particularly sorry I am that I know how hard it was
3 that many people didn't get to spend time with their
4 loved ones during the pandemic and never got to say
5 good bye.
6 And I would also like to say a thank you to the many
7 healthcare and social care workers who were at the front
8 line, some of whom did also lose their lives, but who
9 I know went above and beyond, and also to many
10 colleagues in the Civil Service who I know worked
11 incredibly hard during that time.
12 **Q.** Thank you very much.
13 **A.** Shall I give a little more -- on the point that you were
14 just making about the difference between -- it's
15 something I was very conscious of, because my brief was
16 across health and social care, so I was -- so social
17 care was in my portfolio, but also the NHS workforce,
18 and that was clearly a substantial responsibility, and
19 something I was spending in the early time
20 particularly -- actually no, throughout my time as
21 a minister, a significant amount of time on the NHS
22 workforce side.
23 But there's a significant difference between the
24 infrastructure and capacity at the centre to support the
25 NHS relative to social care, where you had a very

1 significant number of civil servants in the Department
2 of Health and Social Care on the NHS side but also the
3 organisation of NHS England with its operational
4 capabilities and oversight capabilities whilst social
5 care, the Department of Health was a relatively small
6 team, very focused on policy, in particular at that time
7 on the charging form policy, and just was not set up nor
8 was it intended to have that kind of operational reach
9 out into the social care sector, so that was a very
10 different starting point for the social care compared to
11 the NHS.
12 **Q.** Yes.
13 You say in your statement that, I think as
14 a consequence of that, DHSC had to devote significant
15 resources and time into creating what you describe as
16 communication channels at scale and obtaining data to be
17 able to target the support where you thought it was
18 needed, together with redeploying and recruiting people
19 to build up that adult social care side of the team; is
20 that right?
21 **A.** Exactly correct, so in the early part of the pandemic
22 some of my conversations with the senior civil servants
23 in the department, and particularly the director at the
24 time, Ros Roughton, was how can we make sure we've got
25 the people to be able to respond to social care's needs,

1 and the team we had was working around the clock to
2 support social care, and so one of the -- yeah, the
3 early things was, well, how can we build up that team
4 with people with capabilities either from outside the
5 Civil Service or from other departments? So that was
6 one of the earlier things. And how do we structure it
7 so that it shifts from being a group of people who focus
8 on policy to a group of people with an area -- with
9 operational oversight coupled with, because of the
10 nature of social care with around 25,000 different care
11 providers and they're not managed from the centre, in
12 fact the majority are privately-run organisations, to
13 the extent that there's a contractual relationship with
14 care providers, that will be held by local authorities
15 who are commissioning their services, so that very
16 disparate system, and the Department didn't, for
17 instance, have a list of all of those care providers,
18 where the data existed, was with CQC to the extent that
19 they had the data of all the CQC-registered care
20 providers, so in fact that's not the entirety of the
21 care sector, there are also care providers who are not
22 CQC-registered as they're not providing what's described
23 as personal care. You will also have people who employ
24 their own care worker directly, you will have unpaid
25 carers who we considered part of the care system, so to

1 speak, supported housing, shared (unclear). So many
2 different models.
3 So it's a hugely varied sector, as I said, and at
4 the centre we didn't have a list of everybody who was
5 involved in it to reach out to.
6 **Q.** So a complex landscape and a small team that you had to
7 build at speed?
8 **A.** Yes. The other thing which is probably helpful context,
9 because I think -- certainly for me it's been helpful in
10 preparation or this Inquiry, looking back at my diary
11 and messages around that time, is actually, in the
12 initial few weeks after I was appointed, I was appointed
13 on February 13, first went into the Department on the
14 14th, and in that early time, there was a lot of
15 business as usual going on in government, that the view
16 was, well, the pandemic might or might not really come
17 to the UK, and if it does, well, we're very well
18 prepared for a pandemic, that was very much the
19 briefings we were receiving, the consensus was that the
20 UK was one of the best prepared countries in the world.
21 And my job, when first appointed as a minister, was
22 to deliver on our manifesto commitments, most
23 conspicuously, for instance, having 50,000 more nurses
24 in the NHS and taking forward social care charging
25 reform, and if I look at my diary at the time, those

1 were the things I was spending significant amounts of
2 time on, along with business as usual in Parliament like
3 going and speaking in debates and (unclear) debates in
4 the chamber. So there was a lot else going on.
5 And then it's clear from my records that then, as we
6 get into March, it does really start ramping up on the
7 pandemic, but there still were also other things going
8 on that ministers and other officials had to manage as
9 well.
10 **Q.** In respect of pandemic planning for the adult social
11 care, your concerns arose quite quickly, didn't they?
12 **A.** Mm-hm.
13 **Q.** You say, just by way of background:
14 "... the responsibility for planning for adult
15 social care was seen to lie with local authorities."
16 As opposed to the department, presumably.
17 **A.** Yes, so this was one of the things I started asking
18 questions about as -- you know, given the risk the
19 pandemic would hit us in that way. And my
20 responsibilities is, well, you know, who is responsible
21 for what, for social care, and how is this going to
22 work? And the initial understanding, advice I was given
23 was very much that local authorities would be leading
24 the response for social care, because they were the
25 organisations that had the relationship with care

1 providers. And in legislation, for instance, in the
2 Care Act 2014, that sort of sets out the local authority
3 role, while the department's role for social care is
4 much more to do with oversight and policy and then some
5 oversight of local authorities performing their
6 statutory duties. But yeah, so the -- very much
7 expectation was that local authorities would be the lead
8 organisation.
9 And in fact, looking back at some of the record in
10 the early conversations, for instance, about how PPE
11 should get to social care, again you can see the records
12 that that was expected to be, to some extent, social
13 care providers continuing to get it from their
14 wholesalers but the local authorities very much being
15 the point of contact.
16 This is not to attribute blame; it's just to kind of
17 explain how the situation evolved. And then there came
18 a point, which you may well have come to, where we took
19 a view, I took a view, in the sense of, "Hold on, we
20 need to do this differently."
21 **Q.** Yes, absolutely.
22 **LADY HALLETT:** Can I ask you to slow down. I'm sorry, like
23 many of us, me included, you speak quite quickly and I'm
24 just worried about the stenographer.
25 **THE WITNESS:** I will do my best.

1 **MR STOATE:** You say this about the plans for pandemic
2 planning, you say:
3 "The small number of plans I saw showed that they
4 [the local authorities, you've explaining where that
5 lay] in turn looked to care providers to have their own
6 plans. But I don't believe that local authorities in
7 general checked those plans, nor did I identify any
8 [Public Health England] process for assuring themselves
9 of the pandemic preparedness of care providers."
10 Is that right --
11 **A.** So this is true, and again I don't want to attribute
12 blame, and some of what you're referring to, taken from
13 my WhatsApp messages at the time, which are the records
14 of many of the conversations I've seen myself, for
15 instance, the Secretary of State for MHCLG at the time,
16 Robert Jenrick, and also the Health Secretary,
17 Matt Hancock at the time, and you can see from our
18 messages, and I recall the conversations where we wanted
19 to assure ourselves that given that -- as I described,
20 the role of local authorities, we wanted to be assured
21 that they were ready to support social care, and care
22 homes and domiciliary care through the -- what was
23 coming.
24 And so one of the things that I wanted to see was
25 I said, "I want to see those pandemic plans, because

1 until I've seen one, how will I know that it's any
2 good?"
3 **Q.** Yes, could --
4 **A.** And it was quite a struggle to get them.
5 **Q.** Yes, if we just pause there briefly, I'll give you
6 absolutely a chance to give your full evidence there,
7 but if we just look briefly at one passage of those
8 messages you've referred to, it's INQ000475068.
9 Ms Whately, these are WhatsApp messages between you and
10 the Health Secretary, Matt Hancock, which you've very
11 helpfully provided to the Inquiry and referred to. On
12 3 March we can see there, in the evening, Mr Hancock
13 sends a message to you saying:
14 "Lots of questions about how social care will cope
15 with covid19.
16 "Are you on it?"
17 And your response, very soon afterwards:
18 "I am chasing it. Have got hold of what I'm told
19 are two [local authorities] plans (Herts & Essex). My
20 opinion is that they are inadequate. Have asked for
21 someone to brief me tomorrow on a plan for getting these
22 and other plans into shape."
23 Shortly afterwards you say:
24 "Was literally about to message you to flag my
25 concern."

1 Moving on a bit, you say:
2 "The Essex doc says providers are required by the
3 CQC to have plans in place to provide safe care in the
4 event of a pandemic. And, during a full pandemic,
5 Directors of Adult Social Services need to know the
6 effectiveness of providers plans, emerging risk and
7 capacity to meet demand. That's basically it. Their
8 plan."
9 Mr Hancock replies:
10 "Can you possibly put some serious drive into
11 getting them to a credible position? [The Chief Medical
12 Officer] tells me there's guidance to social care being
13 developed to publish. Seems to me that we need to do
14 a lot of work here."
15 Your response:
16 "Yes, absolutely. It has taken me a week to even
17 get these 2 example plans and to get meeting in diary
18 with Chief Social Worker (tmr). You are right, it needs
19 a rocket under it."
20 And Mr Hancock replies with a rocket emoji.
21 Much as you said, you've summarised this in your
22 statement:
23 "There did not appear to be a plan in place to make
24 sure care providers would be able to supply their staff
25 with PPE in the event of a pandemic."

1 Is that right?
2 **A.** Yes, that is true.
3 So, I mean, as set out in that message, that,
4 I think, brings to life the experience at the time,
5 looking at the first -- those two plans, which were hard
6 to get hold of, and when I looked at them, I said, "This
7 doesn't really look like a plan." Whether it was to the
8 extent that they did articulate some local authority
9 responsibility and sense of their responsibility, or
10 looking into the care providers and saying, "We expect
11 you guys to have a plan", but neither was particularly
12 robustly established, including, therefore, no detailed
13 plan of, that level, how PPE would be distributed to --
14 **Q.** Yes, you summarise it like this in your witness
15 statement:
16 "... care providers were expected to have their own
17 stocks of PPE available ... the national PPE supply was
18 officially for NHS and social care ..."
19 But you say:
20 "... [you] don't believe material work had been done
21 to work out how to distribute PPE social care providers
22 from that stock in the event of a pandemic ..."
23 Is that right?
24 **A.** Yes, so on -- so, in the early days, I remember
25 receiving the reassurances that the UK is very well

1 prepared for the pandemic, and part of that is we have
2 our national stock of PPE. And I wanted to be assured
3 that wasn't just for the NHS; that was for social care
4 as well, and I recall being told yes, it was for the NHS
5 and social care, there is a national stock.
6 What became clear, then, when I started hearing from
7 care providers that they were not getting the PPE they
8 needed, didn't have the PPE they needed, was that there
9 was a problem with getting that PPE to them. And one of
10 the things that in fact transpired is, you know, the
11 difficulty of distributing from, I think, the single
12 national warehouse, actually, to the around 25,000
13 different care providers.
14 And that was one of the reasons why one of the
15 things we did early on in the pandemic was a drop of
16 face masks to every single care provider, which I know
17 has some under criticism because it was insufficient for
18 larger care providers, and some providers said they
19 didn't get their stock, but it was, in the
20 circumstances, a reaction: we've got to get something
21 out there, and this is a way of doing it.
22 **Q.** Yes, I'll be asking you some questions about that aspect
23 shortly, but just to sort of conclude this aspect of
24 preparedness, you've arrived in the job really with the
25 pandemic looming.

1 **A.** Mm-hm.
2 **Q.** You've been briefed that pandemic readiness is there,
3 but the plans you found are not adequate, and you've
4 already spotted, have you, these potential issues around
5 PPE supply?
6 Reflecting on it, do you think, on a national level,
7 that the Department of Health and Social Care should
8 have been responsible for preparedness for a pandemic
9 within the adult social care sector? You think that's
10 something, looking forward, that should be the case?
11 **A.** I think, so one of the things I think is important is
12 for there to be clarity about who is going to be
13 responsible for what and then, to the extent that at any
14 level there is responsibility, including, for instance,
15 responsibilities of local authorities or, indeed, care
16 providers themselves, then some system of assurance
17 that, actually, where a plan is needed, that that plan
18 has been made. Because I think that was part of the
19 problem, is there was expectation at many levels that
20 there would be plans, but I haven't seen any evidence
21 that it was anyone's job to go and check that those
22 plans existed.
23 You could have a system in which every care provider
24 would have some kind of plan, I recognise the burdens on
25 them, the difficulties, challenges they face, and then,

1 you know, as part of the CQC assurance process to ensure
2 that there is some kind of plan there, and there is
3 always a balance between the cost and regulatory burden
4 and that, but given that what we found is we believed
5 there would be plans and there weren't, a system for
6 making sure that plans existed would be worthwhile.
7 What should be done at different levels and to what
8 extent national versus local, again, is something that
9 is worth thinking through. You won't necessarily have
10 the same answer for everything, but certainly what felt
11 to be the case, and at the point at which I realised or
12 felt that there weren't a set of local authority plans
13 and the system wasn't ready at the front line, I took
14 a view, in discussion with the Health Secretary, we are
15 going to need to do this from the centre. And it very
16 much felt everybody was also looking to government at
17 the centre to take charge.
18 In other countries, things might work differently,
19 but in this country people do look to the government to
20 take hold of things and I think that expectation would
21 most likely remain.
22 **Q.** Just before we get to that aspect, the taking charge,
23 one other aspect you refer to in your statement about
24 the preparedness and the task that faced you is about
25 data and the availability of data.

1 **A.** Mm-hm.
2 **Q.** These are your words, you say that early on in March of
3 2020 you identified that there was a stark lack of data
4 from the social care sector to inform your pandemic
5 response; is that right?
6 **A.** Yes.
7 **Q.** You say:
8 "... particularly a lack of timely data on COVID-19
9 cases and deaths and access to PPE ..."
10 Was one of those parts of the data --
11 **A.** Yes.
12 **Q.** -- that was absent.
13 **A.** So gaps in data, I mean, we didn't have a list of care
14 providers. We were able to go to CQC for the registered
15 care providers, but that took time to establish. Then
16 yeah, one of the very early challenges was not having
17 timely information about the number of Covid cases. So
18 I was saying, have we got Covid in care homes? I'm
19 hearing rumours. I'm looking at the news and I can see,
20 for instance, in countries like Spain that many people
21 were dying in care homes, wanting to know what's going
22 on in England, that was my responsibility, and not
23 having the data about Covid cases, then not having data
24 about Covid deaths, and in fact I can see in the records
25 that, you know, there was a point in April where we

1 start getting that data, but I remember some really
2 quite robust conversations, shall I say, between me and
3 the public health colleagues saying that, like, I need
4 to have the data about how this is hitting care homes
5 and where.
6 And then also, yes, PPE. One of the problems of --
7 I'm hearing from stakeholders about the PPE shortages,
8 and we know very well both, I should say the shortage in
9 the NHS as well as social care, but how bad is it? Is
10 it comprehensive? Is it everywhere, or is it just some
11 places? And not having the data at the very beginning
12 of the pandemic in order to be able to focus supplies
13 was also a challenge.
14 **Q.** You, if I may say, have conveyed that in your answer,
15 but you do say in your statement that you were extremely
16 concerned about the lack of data?
17 **A.** Mm-hm.
18 **Q.** In terms of addressing that, you say you commissioned
19 work that led to the development of a new data tool for
20 the Department of Health and Social Care which was to
21 prove central to the response ultimately to Covid-19.
22 It was something that was -- became called the Capacity
23 Tracker, the adult social care Capacity Tracker; is that
24 right?
25 **A.** Yes, this was something I personally very specifically

1 commissioned because of this frustration, how could we
2 effectively respond without data which told us what was
3 going on at the front line? And I remember civil
4 servants going on a mission to look at what was there
5 that we could work with, and identifying something
6 called the Capacity Tracker which was already used in
7 part of the country between social care and the NHS to
8 establish availability of places in care homes, and, in
9 essence, an Excel spreadsheet was used to store that
10 data inputted by care providers and we decide that was
11 the best system to build up to become a national set of
12 data, and to add the fields to it that, for instance,
13 included access to PPE, Covid cases, deaths, and over
14 time, we added additional information to it, staffing.
15 Actually, one of the important things, one of the
16 particular worries earlier in the pandemic was what
17 would happen to social care staffing, reflecting, for
18 instance, that we saw in Spain, very sadly, people died
19 in care homes not necessarily of Covid but because all
20 the staff left and there was no one to look after care
21 home residents, and they actually died of neglect.
22 That was one of the biggest worries at the early
23 stage of the pandemic was how would we make sure there
24 would be staff?
25 We didn't have that situation in this country, for

1 which my gratefulness to the social care staff who stuck
2 there, but as context, that was actually one of the
3 biggest worries early on.
4 Anyway, we built up the Capacity Tracker and it
5 became -- it became something that I looked at every
6 day, and we used it to also gain a greater
7 understanding, for instance, of what was driving Covid
8 rates, and it became a very useful tool.
9 **Q.** Yes, focusing on access to PPE in terms of how that came
10 into this Capacity Tracker, you say that was something
11 that was developed and built up over time. By when, in
12 your recollection, was the Capacity Tracker providing
13 the kind of visibility on PPE supplies and shortages
14 that you thought you would need to drive the response?
15 **A.** Yes, and I know this, I know that in my statement I say
16 the Capacity Tracker was up and running in June, by
17 which point we had 98% of care providers filling it in
18 regularly, though actually we started using it earlier
19 than that, and checking the Corporate Statement for this
20 module. In April it starts providing us information
21 that we're using, and I noted that we were using that to
22 brief the Prime Minister in May on the situation.
23 So it started providing us useful information at
24 some point during April, I don't have the exact date,
25 and we built it up into May, and by June it was properly

1 established.
2 **Q.** So that's the Capacity Tracker. It's giving you that
3 visibility by June, is it, on PPE?
4 **A.** On PPE. So yes, and we had a system that a care
5 provider could say if they were about to run out of PPE,
6 for instance, they didn't have enough stock to last, for
7 instance, 48 hours or so. It was dependent, clearly, on
8 care providers filling it in accurately, and there's
9 a range of capabilities in the sector to, for instance,
10 do that. But in general, we did use it, and we'd used
11 it, for instance, to inform the PPE distribution system
12 of where we saw there were shortages, can they go out
13 and address those.
14 **Q.** All right. That's what I want to look at now, some of
15 the ways you say you sought to address the challenges of
16 getting emergency channels of supply into the care
17 sector.
18 You've talked vividly, if I may say, about the
19 reports you were hearing in March of 2020 about concerns
20 and shortages of PPE in the NHS and care sector,
21 I presume.
22 **A.** Yes.
23 **Q.** You say the reports included not just that but also
24 concerns that something called the National Supply
25 Distribution Response hotline, that was something

1 I think the DHSC put in place in March of 2020 to
2 respond to care providers who had an urgent need; is
3 that right?
4 **A.** Mm-hm. That was across health and social care.
5 **Q.** Health and social care, yeah.
6 **A.** Okay.
7 **Q.** You say in your statement in March there were concerns
8 that that hotline was being overwhelmed with calls?
9 **A.** Mm-hm.
10 **Q.** Was that a justified concern? Did that hotline become
11 overwhelmed?
12 **A.** That is what I heard from the care providers. I wasn't
13 operating the hotline, therefore, I can't give you the
14 view of the hotline operators -- (overspeaking) --
15 **Q.** No, but that's what you heard from the sector?
16 **A.** But that is certainly what I heard from the sector,
17 that -- and in terms of how the system worked. So at
18 first, the social care sector was pointed towards
19 getting their PPE from their usual wholesalers, then
20 there was a system that was pointing towards local
21 resilience forums, essentially local authority groups,
22 to get PPE and then we move on to the PPE Portal or the
23 Clipper system which I'm sure you'll come to.
24 But in the -- so the first two phases of that, the
25 back-up was to access the national hotline and the

1 national stockpile, which was for the NHS and social
2 care and, indeed, I did hear frustration from social
3 care providers about them not managing to get stock from
4 that. So I raised that with officials, for instance,
5 the relevant director general, Jonathan Marron who
6 I know has given evidence to this Inquiry already, and
7 I was assured that service was responding to social care
8 providers, although they weren't able to give me the
9 data saying what had been distributed to social care
10 providers.
11 Q. Mm. Can we look at, please, at another message. This
12 is in early April between you and Mr Hancock. It's
13 INQ000475068. So we're now on 5 April. You messaged
14 Mr Hancock to say:
15 "Please can I have someone in the supplies team
16 dedicated to overseeing PPE to social care. It is still
17 all over the place, they have sent me contradictory info
18 in recent days and cannot answer [questions] about flow.
19 I am also told clipper system looks NHS focused (and
20 again, no one can tell me whether it will cope with
21 [20,000] social care providers ordering stock day 1).
22 There's only so long I can keep saying to the social
23 care sector we're working on it, without losing all
24 credibility."
25 Just unpacking that somewhat, you were asking for

1 someone who would focus, I think, a dedicated person to
2 focus on PPE supplies and social care. It might be
3 obvious; why were you asking for that?
4 A. So one of my worries was that while the national
5 stockpile was intended for distribution to the NHS and
6 social care, I felt that more of the people involved in
7 it were from the NHS side, it was being run out of
8 NHS England. There was greater understanding, in
9 general, of how the NHS works, the NHS Supply Chains,
10 getting PPE to hospitals, compared to -- I was concerned
11 less knowledge of how the social care system worked, the
12 fact you had so many thousands of different social care
13 providers, big ones, small ones, and the complexity. So
14 I was asking at that point that could somebody be in the
15 room who would really understand the social care bit of
16 it, so that social care wasn't let down because of
17 somebody just not knowing how it worked, relative to
18 that knowledge about the NHS.
19 Q. Did you get that person?
20 A. So one of the things that happened was David Pearson who
21 subsequently chaired our adult social care taskforce, he
22 had an involvement in being a voice for social care
23 behind the scenes then. Also -- so some of these
24 conversations were with Jonathan Marron who'd previously
25 been the director general with oversight of social care,

1 so he did have knowledge of the social care system and
2 I was very much assured that social care was being
3 considered during that.
4 Then we went on to the second part of the comment
5 you referred to was about the Clipper system.
6 Q. Yes.
7 A. And again, you can see me at first saying, well, this
8 looks like they've got it all worked out for the NHS. I
9 would say in response to some of that --
10 Q. Just pausing there --
11 A. -- (overspeaking) --
12 Q. I'll absolutely let you make this point -- no, not at
13 all, but just so we're all clear, and my Lady is clear
14 as well. So when you're talking about the Clipper
15 system, so you've asked for this person to be dedicated
16 to social care PPE supply. You then refer to the
17 Clipper system, is that shorthand for what became the
18 online portal for the health and social care sectors to
19 order PPE stocks?
20 A. Yes, it is.
21 Q. Thank you. And when we see Clipper, that's the
22 logistics company that was engaged to run that?
23 A. I think so. It was just the colloquial terminology --
24 Q. That was the shorthand --
25 A. -- we were using then, was people were calling it the

1 Clipper system, but yes, it was the PPE Portal, and
2 which, as I'm saying here, my concern was it looks like
3 they've worked out how they were going to get it to the
4 NHS and I was pushing on the social care side.
5 Q. Yes.
6 A. It did get developed for social care, and actually,
7 I think they did a very good job of doing that. It took
8 a little while to ramp up, but actually, I think the
9 work on it started in April and within a matter of weeks
10 often that, it was distributing to a significant number
11 of care providers and during the course of the summer
12 and by the autumn it was getting very large volumes of
13 PPE out to thousands and thousands of care providers,
14 and feedback I got from care providers over that time
15 was that once it was up and running it actually was
16 a good system, and if you consider how long people think
17 things take in government, it was probably quite
18 a remarkable thing to get that going that quickly even
19 though at the time, for me and working with care homes,
20 it all felt like you wanted everything to go quicker.
21 Q. Yes.
22 A. It had felt too slow. On reflection it was --
23 Q. You have, sort of, completed the circle, as it were. So
24 by the time the Clipper system is up and running, you
25 say in your statement, and you've just told us, you

1 believe it worked well. And by the winter of 2020 to
2 2021, you say, "I can't remember receiving many
3 complaints from providers about the distribution of
4 PPE", and you say that the Capacity Tracker by then was
5 showing that most of the suppliers did in fact have PPE?
6 **A.** Yes.
7 **Q.** I want to just ask you in a little bit more detail about
8 the development of it and, as you've alluded to there,
9 the time that it took. At one point, as you were
10 building this up, and you've alluded to this as well,
11 there was an emergency drop of PPE, wasn't there?
12 **A.** Mm.
13 **Q.** This was 4 April?
14 **A.** Yes.
15 **Q.** By DHSC and the Ministry of Housing, Communities & Local
16 Government of a number of items of PPE, was this right,
17 every CQC-registered care home?
18 **A.** Yes.
19 **Q.** That was to be done through the local resilience forums,
20 which I think you've said are multi-agency partnerships
21 made up of representatives from local public services,
22 including the NHS and others?
23 **A.** So the initial distribution of the -- it was 7 million
24 facemasks to 26,000 care providers. I don't believe
25 that was done through the local resilience forums.

1 **Q.** Okay.
2 **A.** I think that was organised more directly by the national
3 stockpile system.
4 **Q.** All right, but that was -- the idea was 300 masks and
5 other items to every CQC-registered care home.
6 **A.** Yes, which was done because it was facemasks that were
7 the particular issue in part, and I remember receiving
8 this advice from my officials at the time, because care
9 providers would tend to have a good stock of gloves and
10 aprons and things like that, but were less likely to
11 have facemasks because they didn't use them so much
12 day-to-day, so that was the particular challenge. So --
13 and I remember discussing, well, could we not do
14 something more sophisticated with more facemasks to the
15 bigger organisations, clearly? And was advised, and I
16 agreed with the approach, which was: actually, we
17 can't -- a more sophisticated approach would take much
18 longer and is going to be very hard to do, so, actually,
19 at this point let's just do something that we can do.
20 **Q.** Yes.
21 **A.** And this was what was therefore done.
22 **Q.** I want to look just briefly some of the challenges this
23 did create.
24 Can I please bring up INQ000517172. Thank you.
25 This a briefing by civil servants within the

1 ministry for local government regarding the rollout of
2 the PPE Portal being, as it says, being developed by
3 DHSC. This is dated 15 May, so we are some weeks on now
4 from that initial drop, as you've said.
5 Can you see where it says, "Context" --
6 **A.** Mm-hm.
7 **Q.** -- halfway down the page:
8 "1. Drops to [local resilience forums] have become
9 the main distribution route for emergency PPE supplies
10 since the first deliveries at the start of April. The
11 continuation of what was originally intended to be
12 a one-off drop has put strain on our relationships ..."
13 That's presumably the Ministry of Housing and Local
14 Government.
15 "... with [local resilience forums] and local
16 authorities, poses a threat of reputational damage to
17 the government that falls on [the local government
18 ministry] and carries significant operational risk.
19 Additionally as [local resilience forums] turn their
20 attention to restart, it is essential their resource
21 capability is used as effectively as possible.
22 "2. DHSC had expected their PPE Portal to be
23 operational by mid-May. They have confirmed that [local
24 resilience forums] will continue to be the main route
25 for emergency supplies until the PPE Portal is fully

1 operational. DHSC have indicated that they may complete
2 roll-out by mid-June."
3 Just asking you about that. Do you say recognise
4 some of those challenges that seem to be flagged up here
5 by the local government department?
6 **A.** Yes, so I know that ministers in MHCLG, the local
7 government department, were hearing from LRFs about how
8 difficult LRFs were finding it, and also the challenge
9 for LRFs to make sure that they had PPE in a situation
10 where there were general widespread shortages, as we
11 know, for supplying the NHS, supplying social care and
12 in -- clearly globally, not just something --
13 a situation that the UK faced. So there was a supply
14 challenge.
15 And I also know that LRFs were being asked to
16 provide PPE not just to, for instance, social care but
17 to many different organisations and sectors that wanted
18 to have PPE, and had an expectation for it, even though
19 there was clearly the general shortage.
20 **Q.** Mm.
21 I want to bring up briefly, please, a witness
22 statement of Penelope Hobman, who is the director of the
23 Covid-19 Response Unit at the Ministry of Housing,
24 Communities and Local Government.
25 It's INQ000538191.

1 It should be on the screen there for you. If you
2 look at paragraph 163 --
3 A. Yeah.
4 Q. So we've seen where it got to in -- we've had the drop
5 in May -- sorry, in April. We've seen where it got to
6 in May. Here we are at June. According to the local
7 government ministry:
8 "During June [it says] the Department continued to
9 relay concerns to DHSC from LRFs, particularly about the
10 shifting timelines of the full PPE portal roll out."
11 Then it references here an early meeting in June,
12 2 June, between you and the minister Simon Clarke, for
13 social care.
14 I don't want to press you in terms of specifics but
15 just in that time and we're now in June, were you still
16 hearing that kind of concern about the timescale for the
17 rollout of the PPE Portal?
18 A. So, yes, as evidenced by the fact that Simon sought
19 a meeting with me and we talked about it. There were
20 clearly still demands coming through from the front line
21 and through local authorities for PPE, so that was
22 likely not only care providers but also others who
23 wanted PPE. I remember that being a factor in the
24 situation.
25 Q. If we could just go up, please, to page 7 of the same

1 document. This is paragraph 17. So this is still
2 Ms Hobman's statement.
3 Referring to the April drop in the last sentence of
4 this paragraph here, she says:
5 "Following this drop, LRFs still reported shortages,
6 and a series of subsequent drops followed, with this
7 eventually becoming the main route by which LRFs
8 received PPE through weekly drops taking place until
9 September of 2020."
10 Then the next paragraph, please, paragraph 18, this
11 is the sentence I wanted to ask you about:
12 "The portal was not fully operational until
13 September of 2020."
14 Is that right? Does that accurately reflect your --
15 A. So my recollection is it gradually ramped up, both the
16 number of providers, and the size of the orders they
17 could make, and what items of PPE they could order.
18 There will be somewhere a timeline that says the number
19 of providers that were accessing it, as of May, June,
20 July. I just remember it ramping up. One of the things
21 that I recall doing was pushing to say, "Well, can
22 you -- can you ramp up faster? And also, can you make
23 sure that you are allowing providers to order the
24 sufficient volume?" Because I think some of them said
25 to me that, "The problem is we can't get enough volume

1 off it or enough PPE, sort of, in advance." So it took
2 time to get there.
3 Q. Just turning up very briefly, please, INQ000574777.
4 This is the witness statement of the Care Provider
5 Alliance.
6 A. Mm-hm.
7 Q. If we look -- yes, at page 8. Where it says, "In
8 March 2020".
9 So we can see that:
10 "In March 2020, DHSC provided 300 facemasks to each
11 CQC registered care provider ..."
12 What's said there is:
13 "... far from enough to support the response to the
14 pandemic or operationalised guidance."
15 I mean, I'm assuming --
16 A. Yes --
17 Q. -- you've said that it was, sort of, the best you --
18 A. That was the point, it was a best efforts, as I said,
19 and not enough for larger providers.
20 Q. "Questions by [Care Provider Alliance] colleagues
21 quickly arose regarding the appropriate timing for mask
22 usage and what other types of masks could offer staff
23 protection. Guidance on addressing these enquiries was
24 issued by Public Health England ... in early autumn
25 2020, several months after the ... distribution of

1 masks.
2 "This followed months of engagement by [the Care
3 Provider Alliance] with [the Department of Health and
4 Social Care] PPE task and finish groups."
5 And then this:
6 "PPE supplies continued to be slow to get to the
7 sector throughout the first wave and the summer/autumn
8 of 2020, however [the Care Provider Alliance] continued
9 to work with and advise DHSC on the launch of [the]
10 portal from Spring/Summer ... The launch date ... was in
11 May 2020, however access to this portal for the entire
12 sector took a significant amount of time -- non-CQC
13 registered providers were unable to access PPE from the
14 portal initially and therefore were directed [back] to
15 the Local Resilience Fora ... The level of support from
16 the LRFs was inconsistent across the country."
17 From your recognition in March of how bad you were
18 hearing things were, through to the build-up of the
19 Capacity Tracker -- and that's iterative, isn't it,
20 it's --
21 A. Mm-hm.
22 Q. -- you're adding fields and you're getting the data
23 back -- to the emergency drops through the LRF and the
24 challenges that posed, and what seems to be, finally,
25 this becoming operational by September 2020, did that

1 timeline cause you any concern or frustration?
2 A. I mean, yes, from -- from the initial drop, as I said,
3 I wanted to do something which was much more
4 comprehensive and essentially more sophisticated, giving
5 care providers the volume that they required, but the
6 reality was, in the early stage of the pandemic, we both
7 didn't have the systems, the ability, to have a more
8 sophisticated distribution to care providers. And of
9 course there was also that shortage of actual stock,
10 hence there were stories, whether it was in social care
11 or in the NHS, of staff kind of finding their own PPE
12 and finding other ways of getting hold of it.
13 So, clearly, I was -- I was frustrated and wanted us
14 to do better, but there was -- the constraint was the
15 reality of both the system and the quantity of stock.
16 I do think, and looking at this, and I clearly read
17 it in advance, the point about the guidance is there was
18 guidance on the use of, I'll say, infection prevention
19 and control (IPC) earlier than the autumn, including the
20 use of PPE, because I remember having -- and I was --
21 I looked at it much earlier than that, some of the
22 guidance, to try to make sure that it was clear for care
23 staff how to use PPE effectively.
24 I think one of the things that this extract flags
25 is, again, the situation with CQC versus non-CQC

1 registered, where the portal was set up and worked
2 better for providers that were registered with CQC who
3 were giving personal care and therefore known to need
4 PPE. The situation was harder with providers that
5 weren't CQC registered, therefore not giving personal
6 care, because, by law, if you're giving personal care,
7 you're -- in the sense of, sort of physical personal
8 care -- you're required to be CQC registered. And
9 therefore, at the centre it wasn't possible to know
10 which of those organisations did actually really need
11 PPE or not. Hence that was one reason for it being
12 delegated more locally, is at a local authority level,
13 those staff would be better placed to judge whether
14 organisation (a) really needed PPE, or wanted it, but
15 actually, given that there was a shortage of supply, it
16 shouldn't be receiving it because they weren't doing
17 close contact care.
18 Q. In those crucial early months of such difficulty and
19 such high demand for PPE, do you think that a lack of
20 preparedness and/or a lack of proper data contributed to
21 a delay in the ability of providers to access PPE
22 through the portal by the time it was set up?
23 A. The fact that we didn't have sufficient stocks, and the
24 issues with the central logistics in terms of the
25 difficulty they had actually getting the stock out the

1 door -- and I heard literally one of the problems was
2 this "one door" situation -- coupled with the fact that
3 I don't think there'd been any testing of and working
4 out in advance of how would we get PPE out to many
5 thousands of care providers.
6 So that had to be worked out in real time. Had
7 those things been worked out in advance, we would have
8 been in a better position, albeit clearly one of the
9 fundamental constraints was the supply.
10 Q. Yes.
11 A. So you might have hit that bottleneck even if you had
12 all the systems up and running.
13 Q. Just want to move briefly, please, to another matter,
14 and this is about the cost of PPE to the care sector.
15 You say, this is your paragraph 136, you say that:
16 "Early in the pandemic care providers flagged the
17 high cost of PPE to [you at the department] as one of
18 the problems they faced."
19 A. Mm-hm.
20 Q. You say:
21 "That's why I argued for PPE-funding for social care
22 from the Treasury. I did not want to see staff or
23 people receiving care put at risk because their employer
24 could not afford [it] ..."
25 How was that concern ultimately addressed, the cost

1 aspect of PPE?
2 A. So, yeah, that's correct. So one of the challenges --
3 and it's no secret about the financial pressures on care
4 providers, and one of the things I heard from providers
5 was how expensive this is, all -- both the increased
6 volume of PPE needed and prices going up for PPE they
7 were securing from wholesalers. Therefore, together
8 with the Health Secretary, who was lobbying the Treasury
9 for funding for social care, there was, early in the
10 pandemic, some funding distributed to local government,
11 which was intended in part to go on through to care
12 providers. However, the care providers were telling me
13 that they didn't get a material share from that funding.
14 Q. Mm.
15 A. That's why we created what's called the Infection
16 Control Fund, which was a completely new method getting
17 funding to care providers. The government had no
18 established way of directly funding care providers,
19 we've since legislated to enable that to happen should
20 it be needed in the future, but at the time it didn't
21 exist so this was a difficult thing for the Treasury,
22 quite understandably, because they have to be careful of
23 taxpayers' money, but -- and during the pandemic
24 I recall over a billion pounds was distributed through
25 that fund to the care sector for use on a range of

1 things, including extra staffing costs, but also to
2 support, say, with PPE costs.
3 **Q.** Yes.
4 **A.** However, through the portal, as you'll know, that, then,
5 became a method of giving PPE completely free to the
6 sector so that cost was not a barrier at all.
7 **Q.** So you say this: social care infection fund introduced
8 in May of 2020, extended in October 2020. By March it
9 was providing 1.1 billion of ring-fenced funding for the
10 sector?
11 **A.** Mm-hm, correct. It was substantial. And I did hear
12 from the sector that that made a really big difference.
13 **Q.** Yes, if we bring up INQ000513190, the witness statement
14 of Melanie Weatherley, director of the Care Association
15 Alliance, 3.1 -- forgive me, 3.3, she says this:
16 "It is difficult to overestimate the impact of
17 making PPE available to the care sector at no cost and
18 more importantly in a reliable way. This enabled care
19 providers, particularly small and medium sized care
20 providers to be reassured that they could meet their IPC
21 responsibilities."
22 So --
23 **A.** Yes --
24 **Q.** -- a dip sample, but one organisation telling us exactly
25 that, this make a really significant difference. Did

1 that reflect your --
2 **A.** Yes, I mean, I heard from many providers that when we
3 had the system up and running and working and providing
4 PPE for free, at no cost, then that made a great
5 difference to --
6 **Q.** Yeah.
7 **A.** -- to them. One of the things in my note says that the
8 portal distributed 1.8 billion PPE items to adult
9 domiciliary care, so home care, and nearly 2.7 billion
10 items to residential care, to just give a sense of the
11 scale, it was a huge operation. Clearly, there was
12 frustration, we talked about the pace, it was actually
13 a huge operation in terms of scale and quantity of PPE,
14 and as it says here and I heard that generally,
15 particularly come the winter and the second wave, care
16 providers said they, you know, for the vast majority of
17 the time they had the PPE that they needed.
18 **Q.** Yes.
19 Just to complete this paragraph, what Ms Weatherley
20 says is:
21 "It was not the cost of the additional PPE that was
22 the main concern, but the general lack of availability,
23 the challenges in sourcing correct sizes and the
24 variability in quality."
25 Do you recognise those as challenges that remained?

1 **A.** Um, I mean, definitely, um, and particularly in the
2 early part -- well, amongst the challenges was, well, is
3 this PPE up to the job? There were concerns about PPE
4 being out of date. There was one particular exchange
5 about some distribution of PPE stocks that had a label
6 that said they were out of date, I remember going back
7 and investigating and being told: no, those have been,
8 sort of, re-tested and they are good to use. But
9 understandably, the organisations that had received that
10 PPE with an older label on, were really worried about
11 whether it was okay to use. So quality was one of the
12 concerns, as well as general supply.
13 **Q.** A theme of your witness statement, which is obviously to
14 be published in full, and if I may say, a theme of your
15 evidence today, is that you personally -- and possibly
16 officials around you -- were having to lobby quite hard
17 to achieve any sense of parity or prioritisation, to use
18 your word, for the care sector within procurement of
19 these things like PPE, key things like PPE.
20 Does that reflect your experience?
21 **A.** Yes, and it's something that I reflect on and try and
22 unpick, you know, how much is ... unsurprisingly the
23 experience of -- as a minister representing a sector,
24 whether it's in a pandemic or in normal times, you lobby
25 on behalf of your sector, and you're always fighting

1 their corner, and it wouldn't be uncommon for a minister
2 to feel: oh, you know, my area is not getting the
3 attention it needs, because, if you're lobbying
4 a Secretary of State, they've got a much wider brief or
5 the Prime Minister's considering a lot of things, so
6 you're always going to fight your corner.
7 **Q.** Mm.
8 **A.** But the thing that I was certainly conscious of, and as
9 I said at the beginning, is the difference with social
10 care and the NHS in terms of both the quantity of people
11 with experience and working in that sector, and also the
12 extent to which, I guess, they were or weren't in the
13 room. So NHS had the power of NHS England, and Simon
14 Stevens was the chief executive, who had
15 a well-established relationship with the Prime Minister,
16 Treasury, Number 10, and social care didn't have the
17 same place in government, and government didn't have,
18 historically, the same responsibilities in the same way
19 for social care.
20 Therefore, I felt yes, I was fighting every step of
21 the way for social care.
22 **Q.** Yes. Everyone's fighting their corner but we're in
23 a pandemic now, these are very vulnerable residents,
24 aren't they, often?
25 **A.** Mm.

1 **Q.** Very vulnerable workers --
2 **A.** Mm-hm.
3 **Q.** -- from different backgrounds and all the rest. Did
4 social care ever achieve the proper prioritisation
5 within the procurement of supplies, and as well as that,
6 can you reflect on how that might be achieved, looking
7 forward, in the event of anything in the future?
8 **A.** So on procurement specifically, I don't think I would
9 see a disparity because the same sort of items were
10 needed in healthcare as in social care. So my focus or
11 thoughts would be more on distribution. If you have
12 evidence to the contrary, then, I guess, I wasn't at all
13 close to procurement anyway.
14 On distribution, and one of the concerns I had at
15 the time and have expressed, is whether people really
16 understood social care. So was social care in the room?
17 Did people -- were there people there arguing for social
18 care, you know, considering that there were definitely
19 voices in the room for the NHS, were people arguing the
20 same over social care? I wasn't in the room. In fact,
21 one of the reasons why I asked for the director for
22 social care at the time, Ros Roughton, for that to
23 become a director general role was because I thought if
24 we had a director general dedicated to social care then
25 you would have somebody in the room in certain meetings

1 who, the sole thing they were speaking up for was social
2 care.
3 I also worked to get a new role of a chief nurse for
4 social care. Again, to give another voice for social
5 care, particularly for the social care workforce. So
6 some of what I did was getting voices of social care in
7 the room.
8 I do feel from the conversations I had with many
9 people as I've mentioned, whether it was Jonathan
10 Marron, Emily Lawson, or clearly the Health Secretary,
11 you know, social care, was being thought about, although
12 I have read something from -- it's an NAO report, which
13 therefore there's some issues with referring to that,
14 but that indicates that in some parts of the system
15 people believed that social care had other routes for
16 getting PPE, for instance. So I think some of the
17 problem was to do with understanding the system and
18 believing that there was a different answer for social
19 care when in fact, for instance, the national supply
20 system was meant to be there supporting social care.
21 **MR STOATE:** My Lady, thank you. Those are my questions.
22 There are some others.
23 **Questions from THE CHAIR**
24 **LADY HALLETT:** Can I -- just before I ask the -- I think
25 Mr Weatherby is going first. You've said number of

1 times that you were being told about concerns from the
2 care sector but from care providers. How were you
3 getting that information? Was that coming from your
4 constituents? Was it coming from briefings from
5 officials? How were you -- you were obviously being
6 told what's going on on the ground somehow. How did you
7 do that?
8 **A.** It's a good question, okay, and through multiple
9 channels. When I joined the Department of Health as
10 minister there were already very well-established
11 stakeholder communication forums between officials and
12 the care sector. In my early briefings as a new
13 minister, I had introductions to some of the key
14 representatives, organisations, like the CPA, whose
15 statement is here, and Nadra, who is a fantastic
16 advocate, Vic Rayner, another person who was a great
17 advocate, so I got to meet some of the representatives
18 of the sector, and so -- and officials would give me
19 briefings as well as me, and I increasingly established,
20 having my own direct call -- so I had regular virtual
21 meetings with representatives.
22 Also, I'd have other sources -- so clearly, I had
23 care providers in my own constituency who would be
24 contacting my offices, other MPs would contact me saying
25 they had heard from care providers. And obviously,

1 I could read the media and, occasionally, I would get
2 a direct contact from a care provider as well. So
3 multiple sources to form a picture of what was going on.
4 **LADY HALLETT:** Thank you very much.
5 It is you, Mr Weatherby.
6 **Questions from MR WEATHERBY KC**
7 **MR WEATHERBY:** Thank you.
8 Good morning, I ask just a few questions on behalf
9 of the Covid Bereaved Families for Justice Group, which
10 represents about 7,000 bereaved families members, many
11 of whom were lost in care homes under adult social care,
12 and some of whom worked, and some of the bereaved still
13 work in adult social care.
14 So just two short topics from me. Mr Stoate
15 referred you to one of your WhatsApp messages from
16 5 April and I just want to put up on screen
17 INQ000569777, page 15, please, which is the published
18 diaries of Mr Hancock. And the entry for the date that
19 Mr Stoate was asking you about, which was 5 April.
20 And presumably, from the WhatsApp and other contact
21 with you on that date -- and again, presumably,
22 a contemporaneous diary entry -- Mr Hancock records
23 this:
24 "A cri de coeur from Helen Whately, who is under
25 massive pressure over PPE shortages in care homes: 'It

1 is still all over the place', she said. Apparently she
2 is getting contradictory information from officials who
3 can't seem to answer any questions about supplies."
4 And again he quotes:
5 "'There is only so long I can keep saying to the
6 social care sector that we are working on it without
7 losing all credibility', she said miserably. I promised
8 to do everything I can."
9 So is that an accurate account from your
10 recollection of your contact with Mr Hancock at that
11 time?
12 **A.** Yes, and that diary entry is referring to the same
13 exchange that Mr Stoate spoke about earlier.
14 **Q.** Yes, that's right, yes.
15 **A.** And I also have it in front of me, so it is pretty
16 accurate.
17 **Q.** Yes. But it conveys the depth of concern from you at
18 that point?
19 **A.** Yes, it does.
20 **Q.** Yeah. Can I put up another document, which is
21 INQ000083702. And can we start at page 1, please.
22 And this is a minute of the Health Ministerial
23 Implementation Group meeting, just two days later on
24 7 April. And from page 1, I'm not sure it's up in front
25 of you, I hope it is, it should be on screen.

1 **A.** The front page is, yes.
2 **Q.** Good. And that's chaired by Mr Hancock, and there's
3 number of senior ministers there, and representatives
4 from each of the devolved administrations, and a number
5 of other people, including senior civil servants.
6 And the minutes of this meeting show that
7 Matt Hancock chaired it, but you provided an update
8 regarding social care.
9 **A.** Mm-hm.
10 **Q.** And I'm not going to take you through all of it, but on
11 page 4, if we could just have a look at page 4,
12 Mr Hancock introduces the meeting and there's a review
13 of the current situation of adult social care. And then
14 you provide an update. And you refer to PPE a number of
15 times, but without mentioning the concerns that you'd
16 raised in such stark terms two days earlier. So for
17 example, in the second paragraph, your first paragraph,
18 there's a reference about halfway down:
19 "RAG ratings across admission status".
20 RAG ratings, that's, red, amber, green, I presume:
21 "RAG ratings across admission status, workforce and
22 PPE were being collected from care homes and could
23 potentially be shared with Local Authorities",
24 et cetera.
25 And then the bottom paragraph on that page, again,

1 from you:
2 "The Minister ... said that ensuring parity in the
3 approach between NHS and social care for PPE and testing
4 was important. PPE was being delivered to social care
5 providers from national stocks, they could contact the
6 National Supply Distribution Response hotline in
7 emergencies."
8 Et cetera.
9 Looking at this minute, there's no reflection at all
10 of the degree of concern that you had at that time, is
11 there?
12 **A.** I would agree that the minute does not reflect that.
13 **Q.** Yes.
14 **LADY HALLETT:** Sorry, does that mean that the minute is not
15 completely full, because you weren't responsible for it
16 being prepared, or are you saying that you didn't
17 reflect it in what you said?
18 **A.** The problem is, going back to the 7 April five years
19 ago, nearly, I cannot be sure what I exactly said in
20 that meeting and whether I did or didn't articulate some
21 of the challenges, and the minute doesn't reflect that,
22 or whether it was the formality of the meeting meant
23 that I just gave an update on the process that was meant
24 to be happen. Unfortunately I don't have a more
25 detailed record of it.

1 **LADY HALLETT:** Sorry to interrupt, Mr Weatherby.
2 **MR WEATHERBY:** No, that's very helpful, thank you.
3 Okay, I've started the question by orienting it to
4 5 April and the cri de coeur, and this is very shortly
5 afterwards. So it would be a surprise, wouldn't it, if
6 the minutes were wrong, and you had actually expressed
7 the level of disquiet that you'd expressed to
8 Mr Hancock?
9 **A.** I don't want to suggest that the minutes are wrong, but
10 the situation is that I don't have a more detailed
11 record of exactly what was or wasn't said in that
12 meeting.
13 **Q.** Okay, well, I mean, if the minute is right, the effect
14 of it would be that the people, the other senior
15 ministers, the devolved administration, other senior
16 people from the Civil Service and different departments,
17 they would all have left that meeting with a wrong
18 impression of what was going on, wouldn't they?
19 **A.** So I have no doubt that there were senior ministers who
20 also knew, at that time, the challenges with PPE
21 distribution. I had conversations with other ministers
22 about it. So I think there was widespread awareness in
23 government --
24 **Q.** Yeah. Okay --
25 **A.** -- about the PPE --

1 **Q.** Was this actually an example of DHSC saving face across
2 government with other ministers about what was actually
3 going on on the ground?
4 **A.** As I said, the problem I have is beyond these minutes,
5 I don't have a more detailed record of what was or
6 wasn't said at that meeting.
7 **Q.** My second point, moving on, supply to care homes. We
8 know from the same statement that Mr Stoate put to you
9 from Penelope Hobman, I don't need to take you to it,
10 I think, but we know from that statement and, just for
11 the record, it's paragraph 127, from that statement, we
12 know that on 13 April, DHSC informed the Ministry of
13 Housing, Communities and Local Government that due to
14 gowns and other -- certain other items being in short
15 supply, they wouldn't be provided in the next drop to
16 local resilience forums, which as, you've described,
17 would be distributing to the social care sector.
18 So by 13 April, that's an example, isn't it, of
19 a serious problem arising with the lack of PPE?
20 **A.** Yeah, I remember there was -- and this may be (unclear)
21 there was a particular window when gowns became in
22 desperately short supply across the system, and, yeah,
23 so there was a particular problem at a particular point
24 in time with gowns.
25 **Q.** Yes.

1 **A.** In general the problem was more with facemasks, I would
2 recollect --
3 **Q.** Yes, sure.
4 **A.** -- but there was a particular gowns crisis --
5 **Q.** I'm just using it as an example of acute shortages which
6 led to simply no supply at various points during this
7 period?
8 By 5 May there was a deep dive ministerial meeting
9 on care homes, which acknowledged that the situation in
10 care homes was a national emergency.
11 **A.** Mm-hm.
12 **Q.** Can we just put that up, just so you can orient it.
13 It's INQ000146701. And that meeting was chaired by
14 Dominic Raab --
15 **A.** Mm-hm.
16 **Q.** -- who I think at that point would have been filling in
17 for the Prime Minister.
18 **A.** Yes, when the Prime Minister --
19 **Q.** When he was ill --
20 **A.** -- had Covid.
21 **Q.** And you were there and, again, senior ministers. So by
22 that stage there was a very clear understanding that the
23 situation generally in care homes was the national
24 emergency. That -- we get that from page 3.
25 **A.** Mm-hm.

1 **Q.** If we can flick through to the bottom of page 3.
2 Then if we could jump to page 8. And, again, this
3 is you, and it's towards the bottom of the page, it's
4 the second-to-bottom paragraph. And you're explaining
5 the problems, and the last sentence, you said that the
6 biggest challenge for PPE in care homes was the supply,
7 and there'd been ongoing discussions with Lord Deighton
8 on this.
9 **A.** Mm-hm.
10 **Q.** So at this point, it's all out in the open, the general
11 position in care homes was a national emergency as
12 described.
13 **A.** Mm.
14 **Q.** You're setting out here in this ministerial meeting that
15 there's a problem not only with distribution but in fact
16 with inadequate supply. And is it right that this is
17 a problem that was evident in March, April, May, and
18 continued through the first wave?
19 **A.** Yes, so we -- I started hearing about problems with PPE
20 in mid to late March, and challenges continued through
21 into April, and into May, yes.
22 **MR WEATHERBY:** Yes, thank you very much that's all I ask.
23 **LADY HALLETT:** Thank you Mr Weatherby.
24 Mr Stanton. Mr Stanton is over there, Ms Whately.
25 **Questions from MR STANTON**

1 **MR STANTON:** Thank you, my Lady. Good morning, Ms Whately.
2 **A.** Good morning.
3 **Q.** I appear and ask questions on behalf of the British
4 Medical Association. I have just one question which
5 relates to a proposal to reduce the levels of PPE, and
6 the context is set out in part at paragraph 124 of your
7 witness statement, which I don't think we need to bring
8 up, but there you talk about the impact on health and
9 care workers. You describe how some tragically lost
10 their lives, others caught Covid-19 and are living with
11 the consequences of Long Covid, and in the final
12 sentence you say:
13 "Care workers and NHS staff looked to PPE to protect
14 them from Covid-19 but in the early days when we faced
15 shortages, like so many other countries, the PPE they
16 needed wasn't always there to protect them."
17 And I should say the BMA entirely agrees with your
18 statement there.
19 **A.** Mm.
20 **Q.** You also say at paragraph 49, and I think it might help
21 if we bring this up on the screen, although I can see
22 you might have it within your paper bundle.
23 This is at INQ000535015_0015. At paragraph 49 you
24 talk about the downsides of PPE.
25 **A.** Mm.

1 **Q.** You talk about discomfort, and also some problems with
2 people who have difficulties with hearing. And in the
3 final sentence you say:
4 "Mitigating these disadvantages and looking at
5 when/where we could safely reduce use of PPE, therefore
6 also became objectives."
7 **A.** Mm-hm.
8 **Q.** And appreciating that you refer to the need to safely
9 reduce PPE, this does nevertheless seem to be at odds
10 with the priority of preventing infection from a deadly
11 disease.
12 And therefore, please can I ask: who set this
13 objective, how was it implemented, and when did the
14 implementation take place?
15 **A.** So what this reflects is conversations that I'd be
16 having with care providers and indeed with staff when
17 I did what's called virtual visits to care homes, and
18 also actually family representatives of people receiving
19 care, in care homes and home care, who talked to me
20 about the challenges they were finding with the use of
21 PPE and the problems. So for instance, for staff, the
22 discomfort of wearing facemasks for many, many hours,
23 and the difficulties communicating with the people they
24 cared for.
25 So whether that was working age adults or, as people

1 often will think of in care homes and nursing homes or
2 home care, older people who may be hard of hearing, may
3 be suffering with dementia, and therefore wearing a face
4 mask makes communication much harder. Really hard for
5 somebody who, for instance, relies on lipreading to
6 understand, therefore, someone talking with the
7 a muffling of their facemask. And also individuals with
8 dementia getting really upset, and, you know, "What's
9 going on? Why are all these people surrounding me
10 wearing masks?" Whether they could articulate that or
11 not. And family members talking about that being
12 a problem as well.
13 So one of the things which I will have spoken to
14 public health officials about is, well, how can we
15 mitigate this negative impact that PPE is having. One
16 of the things that we looked at and trialled was the use
17 of clear masks, although those weren't very popular in
18 practice. And one of the things I would have been
19 asking is, is all -- "When will it be safe for masks not
20 to be used?" So that reflects the problems that I was
21 hearing, as I said, from the front line on the downside
22 of masks.
23 **Q.** Yes, thank you.
24 Can I just quickly ask, did any downgrade actually
25 occur?

1 **A.** Not in the sense of -- well, you said "downgrade", like
2 moving to a less effective form of PPE. Not like that.
3 So, as I said, we trialled the use of clear masks and
4 was that an alternative. And then what you will see in
5 published guidance was that, at various times, there was
6 a point at which the guidance will have said: well, you
7 don't need to use so much PPE, though that was a long
8 time later in my recollection when PPE stopped being
9 used.
10 **MR STANTON:** Thank you very much.
11 Thank you, my Lady.
12 **LADY HALLETT:** Thank you, Mr Stanton.
13 Mr Thomas. Oh no, it's Mr Dayle. Mr Dayle, they've
14 misled me again. My apologies.
15 **Questions from MR DAYLE**
16 **MR DAYLE:** Thank you, my Lady.
17 Ms Whately, I ask questions on behalf of FEMHO, the
18 Federation of Ethnic Minority Healthcare Organisations,
19 I just have two short topics.
20 Firstly, at your paragraph 36 -- and you don't need
21 to bring it up -- I see that you have your paper bundle,
22 you say, and I quote:
23 "I identified early on in the pandemic, in
24 March 2020, that there was a stark lack of data from the
25 social care sector to inform our pandemic response,

1 particularly a lack of timely data on COVID-19 cases and
2 deaths, access to PPE and availability of staff."
3 Now, I know you touched on this more generally with
4 Mr Stoate, but just to confirm, did this stark lack of
5 data that you referred to also include data on race and
6 ethnicity?
7 **A.** For instance, of staff -- so, we had very little data
8 for social care staff in the sense of -- because it's --
9 it's, in general, an unregistered profession. So, for
10 instance, if you're a registered nurse, they have
11 a register of all the nurses working in and registered
12 to work in this country. You don't have the equivalent
13 for social care, other than some subsets like social
14 workers. And therefore you don't have an official
15 dataset about the social care workforce. You have, for
16 instance, you know, broad numbers from Skills for Care.
17 I know that I had an understanding that
18 a significant number, a proportion of the social care
19 staff, would be staff from ethnic minorities, as you
20 say, but we wouldn't have -- I wouldn't have accurate
21 figures and who was working where.
22 **Q.** Right. And having an awareness of the difficulties, as
23 you've described it, can you say what steps you took to
24 address this issue? And I mean, specifically as it
25 regards procurement of PPE?

1 **A.** So I was not involved in the procurement of PPE. What
2 I think is relevant to this is, as we learnt that people
3 from some ethnicities were at greater risk from Covid,
4 we took steps to try to mitigate that risk and make sure
5 that staff were supported. As I said at the outset,
6 I had oversight both of NHS workforce as well as social
7 care, and one of the things that the NHS did, working
8 with the BMA, was a risk assessment framework that
9 looked at the different risk levels of staff, and
10 expected all employers to consider the individual risk
11 that any staff member faced. And we then got that
12 adapted for the social care sector and required social
13 care providers to adopt that framework and risk assess
14 their staff.
15 **Q.** Very well.
16 At paragraph 54 of your statement, you wrote:
17 "On 19 March 2020 my private office sent me an
18 update on the supply of PPE in response to my concerns.
19 The update confirmed that there were PPE shortages."
20 Did you also anticipate issues concerning
21 suitability of PPE, especially as it regards those from
22 ethnic minority backgrounds?
23 **A.** I don't believe at that time, or at least not in any
24 advice that was sent to me, was there any suggestion
25 that different staff would need different sorts of PPE,

1 whether that was, you know, by gender or ethnicity.
2 I don't remember it being a factor. The concern
3 I remember at the time was just how can we get PPE out
4 of, you know, any sort of PPE to the front line.
5 **Q.** Next topic. You say at paragraph 65 that:
6 "One of my concerns was that the national PPE
7 supply, which was already struggling, was geared towards
8 the NHS."
9 **A.** Mm-hm.
10 **Q.** I should say that many FEMHO members work in the social
11 care sector, community health, or combine their paid
12 employment with work as unpaid carers. So my question
13 is: how did the structural separation between health and
14 social care impact PPE supply and support for social
15 care and community health organisations?
16 **A.** So I think I risk repeating some of what I've said
17 earlier, where social care was meant to be able to
18 access those supplies, and some supplies did go to
19 social care from that national stockpile, however
20 I think there were greater challenges in getting it out
21 to social care, particularly because of the nature of
22 the social care sector, there were many thousands to
23 different providers, and potentially greater experience
24 working with the NHS as well.
25 **Q.** What accounts for government's failure to anticipate

1 procurement needs outside the NHS?
2 **A.** Okay, that is a big question about the pandemic
3 planning, and the extent to which there had been
4 effective planning for social care's needs as well as
5 the NHS. And I think, you know, why did there not seem
6 to be a plan that was in place for social care? And
7 I think this is one of the significant gaps -- and
8 I would imagine we'll explore it more in the social care
9 module to come -- which is: although the view was that
10 we were well prepared for a pandemic, in practice, it
11 turned out we weren't, it didn't feel -- certainly from
12 my position, at least -- that we were very well prepared
13 to support social care. And I think also part of the
14 problem being that, to the extent that we were prepared
15 for a pandemic, it was for a flu pandemic rather than
16 for what actually -- the Covid pandemic.
17 **Q.** Very well. And finally from me, you say at paragraph 49
18 that:
19 "As the pandemic progressed, I heard about PPE not
20 being used effectively. Therefore, making sure PPE was
21 used properly at all times in social care became an
22 additional objective of the PPE policy."
23 Can you identify any policy that you developed in
24 response to the issue of PPE and its suitability for
25 black, Asian and minority ethnic workers?

1 **A.** So I recall when there started to be awareness of, you
2 know, facemasks, for instance, not fitting so well for
3 staff of different ethnicities or if staff had facial
4 hair or a beard, for instance, that there were
5 discussions about what was the right kind of PPE or
6 facemasks for that. I think that was particularly
7 a case of some of the respirators that were used in the
8 NHS. So I do recall that that was an area that the
9 public health teams were looking at, to see what
10 different PPE would be appropriate to be distributed to
11 people when there was problems with fit. That applied
12 for ethnicity and also, I think -- I heard from, you
13 know, women saying it that the PPE didn't fit them so
14 well.
15 **MR DAYLE:** Thank you, Ms Whately.
16 Thank you, my Lady.
17 **LADY HALLETT:** Thank you, Mr Dayle.
18 That completes our questions for you for this
19 module, but I've got a horrible feeling, Mrs Whately,
20 that I'm going to be calling on you again, aren't I, in
21 another module. So I do appreciate the burden that the
22 Inquiry places on people, especially busy people like
23 you, so I am really grateful to you for your help. I'm
24 grateful for the attempts you made to raise the profile
25 of care homes. I know you appreciated, obviously, the

1 importance that that kind of raising of a profile was to
2 the residents or recipients of social care, and to their
3 loved ones, so thank you very much.
4 **THE WITNESS:** Thank you.
5 **LADY HALLETT:** I shall return, I'll give slightly longer for
6 a break. Quarter to.
7 **(11.27 am)**
8 **(A short break)**
9 **(11.45 am)**
10 **LADY HALLETT:** Ms Gardiner.
11 **MS GARDINER:** My Lady, the next witness is Ms Collins.
12 **MS SARAH COLLINS (sworn)**
13 **LADY HALLETT:** I hope you told you weren't first on, the
14 plan is to try and finish you before lunch though, even
15 if that means taking a later lunch.
16 **THE WITNESS:** That's fine. Thank you.
17 **Questions from COUNSEL TO THE INQUIRY**
18 **MS GARDINER:** Please state your full name for the Inquiry.
19 **A.** Sarah Hojgaard Collins.
20 **Q.** Thank you. You've provided a witness statement to the
21 Inquiry. It's 90 pages and it's signed and date
22 3 December 2024.
23 The INQ ref is 000521972. Is that your witness
24 statement?
25 **A.** That's correct.

1 **Q.** And is that witness statement still true to the best of
2 your knowledge and belief?
3 **A.** Yes, it is.
4 **Q.** Ms Collins, I'd like to begin just by covering some of
5 your professional background. You have been a civil
6 servant since 2008, I believe?
7 **A.** Yes.
8 **Q.** And you were previous previously at the Department of
9 Transport. What did you do there?
10 **A.** I worked in Transport for 10 years, buying trains and
11 letting rail franchises and I was the interim commercial
12 director there before I joined the Cabinet Office.
13 **Q.** And you joined the Cabinet Office in May 2018. What was
14 your role at that time?
15 **A.** So I had the title of Delivery Director and my
16 responsible was to lead on functional strategy,
17 efficiency and government spend controls.
18 **Q.** And in what capacity did you first get involved in NHS
19 Test and Trace?
20 **A.** So I joined NHS Test and Trace in September 2020, and
21 that was when Jacqui Rock had become the chief
22 commercial officer and she was putting together a team
23 of commercial directors to lead the new commercial
24 function in test and trace.
25 **Q.** And what was your job title at that point?

1 **A.** So at that time, I was the commercial director for
2 sourcing and delivery. For context, this was -- we were
3 building a massive commercial function at a very short
4 timescale so there were five directors, commercial
5 directors. I had initially the responsibility for
6 common goods and services, so all the districts and
7 professional services and arrangements around
8 establishing the test and trace programme and then from
9 April 2021, I then also together over the procurement of
10 new testing technologies and lab capacity and
11 consumables, reagents and equipment.
12 **Q.** And then since January 2022 you've been the commercial
13 director of UKHSA?
14 **A.** Yes, that's correct.
15 **Q.** It might be helpful at the outset, because you're the
16 first witness in this module of the Inquiry to deal
17 specifically with testing, just to explain what UKHSA
18 is. It came into being in October 2021, and could you
19 just briefly outline the purpose and some of the
20 predecessor organisations that we might discuss as well?
21 **A.** Yes, certainly. So UKHSA was established, as you say,
22 October 2021 and was basically a combination of what was
23 Test and Trace, Public Health England, and the Joint
24 Biosecurity Centre and subsequently also the Vaccines
25 Taskforce that joined late on, and UKHSA is basically

1 here to fight or protect the public from infectious
2 diseases as well as CBRN threat, so it's health
3 security, and building on the lessons from Covid in
4 terms of making sure that we are able to protect the
5 public from new threats that comes up.
6 If you want a little bit of background about PHE and
7 the other organisations, do you want me to give that,
8 or?
9 **Q.** I think that's good for now, but we might ask further
10 questions as they come up and as they're relevant.
11 **A.** Okay.
12 **Q.** Specifically about Public Health England, in
13 January 2020 when we first began to hear about
14 coronavirus as the general public, what was Public
15 Health England's role in relation to testing at that
16 point?
17 **A.** Yes, so Public Health England had -- I guess, because
18 this is a commercial model, I'll cover the commercial
19 element to it as well, but the organisation had public
20 health protection in their remit. It did not have the,
21 sort of, remit to scale up the level of testing that we
22 saw through the pandemic, the mass testing.
23 What they did really well was developing the first
24 PCR tests, the first assay, and in the early days, did
25 the testing almost sort of in-house within the -- in the

1 labs. But then, when there was a need to scale up the
2 size that -- you know, the political -- (unclear)
3 direction, then it was quite clear that a new
4 organisation needed to be set up or a new programme
5 needed to be set up to deal with the scale at
6 significance.
7 The commercial function within PHE, I would, sort
8 of, call it a classic procurement function with a small
9 group of individuals that did a really good job but
10 their role was to source, you know, sort of corporate
11 services as well as they had established a framework,
12 a microbiology framework, but it was only there to
13 support the organisation in buying, sort of, reagents
14 and supplies, but at a very small scale.
15 **Q.** Okay. So you've said that Public Health England didn't
16 at that point have the remit to scale up. When you say
17 remit, do you mean that that they -- that wasn't within
18 their role as defined by statute, or that they didn't
19 have the capacity to do that?
20 **A.** So I think if you've -- if you read their remit letter
21 it was quite clear there was a certain amount of roles
22 that they had in terms of the scientific elements, but
23 they did not have the capacity nor the remit to scale up
24 what was required in terms of rolling out this scale of
25 testing programme that was then decided. That wasn't

1 part of their remit.
2 **Q.** So if a pandemic had hit, and indeed it did, where did
3 that responsibility lie? What was the plan for mass
4 testing, if there was one?
5 **A.** So I don't think there was a plan for mass testing at
6 the scale, I think that's the -- there's the lessons
7 that we're learning now through this Inquiry. And
8 I think it's -- what's really important, and we'll come
9 into lessons learnt throughout this session here -- is
10 that also while it's important to recognise that testing
11 was a real focus, diagnostics is a core part of pandemic
12 preparedness but there might also be other initiatives
13 that are needed going forward.
14 So -- but at the time it was a scientific
15 recommendation as well as a political direction to
16 establish a mass-scale programme as was decided. That
17 may not be the decision next time.
18 **Q.** You've said in your witness statement that as of
19 March -- 1 March 2020, PHE could process about 2,000 PCR
20 tests a day. And at that point we're just talking about
21 PCR tests.
22 **A.** Yes.
23 **Q.** And by the end of March, PHE and the NHS were able to
24 process about 10,000. So that's quite a significant
25 scale up already.

1 **A.** Yes.
2 **Q.** But did you have to go beyond PHE at some point?
3 **A.** Yes, so -- and just to say, obviously, I wasn't in the
4 organisation at the time, but this is all set out in the
5 statement.
6 So what happened was -- so, remember the context, we
7 didn't have a Covid test, that was developed at rapid
8 pace in January, and PHE stood up testing stuff -- left
9 other work and supported this.
10 NHS labs helped as well, but when the ministerial
11 decision was to scale up to 100,000, that was -- they
12 were not, you know, equipped to do that at all. And
13 that is why the Lighthouse labs came on board in early
14 April, where we started -- and also tests could be
15 commercialised.
16 **Q.** And the National Testing Programme was established at
17 that point in mid-March; is that correct?
18 **A.** Yes.
19 **Q.** And that was a predecessor to what became known as NHS
20 Test and Trace?
21 **A.** **(Witness nodded)**
22 **Q.** Which was later, as you have already explained --
23 **A.** Correct.
24 **Q.** -- involved in the UKHSA?
25 So going back to when it was the National Testing

1 Programme at the very beginning, whose responsibility
2 was setting up the National Testing Programme? And
3 specifically thinking about the commercial function,
4 where did that lie?
5 **A.** So I think it's important to break this up in the time
6 phases. So initially, I believe DHSC decided to
7 establish the testing programme and then at that point
8 very early on there was a team in the Cabinet Office,
9 Complex Transactions Team, and I believe you're seeing
10 Bev Jandziol after me, and she -- a group of commercial
11 specialists from the Complex Transactions Team joined
12 the efforts in March, literally sort of from one day to
13 another was -- came in to support this.
14 Of what was, in the early days -- I think it wasn't
15 particularly clear what the sort of the journey was --
16 what was going to happen, so they rolled their sleeves
17 up and supported efforts in contracting with labs to get
18 the testing capacity up.
19 If you want me to explain a little bit further or --
20 **MS GARDINER:** That's very helpful for now, thank you --
21 **LADY HALLETT:** Before either of you go on -- sorry -- where
22 does this all fit in with the ending of community
23 testing, temporary ending of community testing -- on
24 8 March, was it?
25 **A.** So that's the following year.

1 **LADY HALLETT:** Oh, so you're talking about
2 -- (overspeaking) --
3 **A.** We're talking about.
4 **LADY HALLETT:** -- 21.
5 **A.** So 2020 when --
6 **LADY HALLETT:** Sorry, of course, so 8 March was 2020. The
7 end of community testing was in 2020.
8 **A.** No, my Lady --
9 **LADY HALLETT:** I thought you were talking about -- you
10 talked about, 1 March 2020, PHE could do 2,000 a day,
11 end of March up to 10, early April -- I thought you were
12 2020 -- Lighthouse labs --
13 **A.** Yes.
14 **LADY HALLETT:** -- and the National Testing Programme
15 established mid-March.
16 **A.** Yes.
17 **LADY HALLETT:** But also I thought, and I don't know whether
18 any of the Core Participants who were with me in any of
19 the other modules can help, I thought community testing
20 was stopped on 8 March, because we asked questions of
21 Dame Jenny Harries whether it was because of a lack of
22 tests or some other policy decision. But that was
23 March 2020, I think, wasn't it? Am I going mad,
24 Mr Weatherby -- sorry, I won't embarrass you,
25 Mr Weatherby.

1 I'm pretty confident it was.
2 **A.** So it might be a confusion about what we mean by
3 community testing.
4 **LADY HALLETT:** Basically testing went to the healthcare
5 sector.
6 **A.** Ah, apologies. What I was referring to was the
7 community testing programme that was established in the
8 autumn to roll out testing in -- through the local
9 authorities. Apologies.
10 **LADY HALLETT:** Okay. Can we start again?
11 End of March, PHE could do 10,000 a day.
12 **A.** That's correct.
13 **LADY HALLETT:** Early April, Lighthouse labs. Mid-March,
14 National Testing Programme. What was the National
15 Testing Programme?
16 **A.** So the National Testing Programme was the programme
17 established by the Department of Health and Social Care
18 to scale up testing.
19 **LADY HALLETT:** Testing whom?
20 **A.** So there were different phases of who was in scope. So
21 initially, obviously, it was the sort of the vulnerable,
22 the people who were -- it's actually set out in the
23 statement, but let me sort of get to it. Sort of -- it
24 was the --
25 **LADY HALLETT:** It's paragraph 3.14.

1 **A.** Yes. Forgive me --
2 **LADY HALLETT:** So it's the vulnerable and those needing
3 management of pneumonia admitted to hospital.
4 **A.** So there was a whole -- obviously testing was rolled out
5 to -- as soon as they became available -- to various
6 groups, and that was decided by -- well, there was
7 a group of scientists advising government on which
8 groups they should be rolling out testing to from, you
9 know, people in the healthcare sector, and then
10 obviously that increased in scope.
11 **LADY HALLETT:** Sorry to interrupt, Ms Gardiner.
12 **MS GARDINER:** Could we please bring up on screen
13 INQ000514384. And at page 1.
14 Just going back to what you were saying about where
15 the commercial function lay at each point in the history
16 of the National Testing Programme, or NHS Test and
17 Trace, you've explained that when the National Testing
18 Programme was first set up, as my Lady has pointed out,
19 in the middle of May, and took over that responsibility
20 for testing from PHE, that was an action that was
21 initiated by DHSC, and at that point the commercial
22 function was provided by the Cabinet Office, and we're
23 going to hear from another witness later on about that.
24 **A.** Yes.
25 **Q.** As you've also explained, you came on board in September

1 of 2020, and this is from -- this email is from just
2 before that, in August 2020.
3 And if we go just to the bottom of page 1, and the
4 penultimate paragraph, we can see this is a draft email
5 which is going to be sent to the workforce of NHS Test
6 and Trace, announcing the appointment of a new chief
7 commercial officer, Jacqui Rock, and also a new chief
8 financial officer. And we read here:
9 "We recognise this has been an area of concern
10 across the programme which needs improvement and have
11 put is place a series of measures to streamline
12 approvals in the past few weeks."
13 So are we to understand from this that, at the point
14 when you and also Jacqui Rock, who has also provided
15 a statement to the Inquiry, came on board, there had
16 been some concerns up until that point about where the
17 commercial function lay in relation to testing?
18 **A.** Yeah. So, for context, when Bev and the colleagues from
19 Cabinet Office joined, we -- it wasn't really
20 a function; it was commercial people joining to support,
21 still under the reins of the Department of Health and
22 Social Care, so they couldn't sign the contracts, for
23 instance, they were sort or part of that, so it wasn't
24 really a function. They were just sort of embedded
25 within the team supporting. What became --

1 Q. Would you describe that as akin to consultancy or
2 secondees or --
3 A. No, I think they were very much part of the teams but,
4 for instance, there wasn't a commercial director sitting
5 at, sort of, exco level, part of those discussions, it
6 was very much -- I don't even think they sort of
7 appeared on the org chart. They were part of the effort
8 supporting, but what was quite clear, it became clear
9 that this was establishing a, sort of, very large
10 organisation as well as a very big commercial
11 organisation and it required that commercial leadership
12 and that was why the decision was made to appoint Jacqui
13 Rock as the chief commercial officer, to then establish
14 a function with the right level of governance, the
15 right, also number of staff as well.
16 So we ended up being around 378 at the peak of
17 this -- of the organisation. And that just gives you
18 a sort of indication of the scale and complexity and
19 what was required to support this programme.
20 Q. And just to give us an idea, what difference did that
21 make at that point to the teams actually doing the
22 procurement on the ground?
23 A. In terms of scaling up? Well -- (overspeaking) --
24 Q. Well, in terms of who could sign contracts, approvals,
25 and did the process become more streamlined, as this

1 email indicates?
2 A. So -- absolutely. So what we did, so the Complex
3 Transactions Team had to get DHSC staff to sign
4 contracts. When we established the test and trace
5 commercial function, we established governance, an
6 investment board, and we had delegation to sign
7 contracts. So I would have it, and my direct reports as
8 well, the category leads, but only the civil servants.
9 And a lot of the staff that joined the commercial
10 function, there was a combination of people that were,
11 there were qualified commercial staff from the
12 Government Commercial Organisation that were parachuted
13 in as well as contractors and staff from elsewhere, but
14 under the leadership of Jacqui.
15 We had the assurance processes, we implemented
16 business case templates, and the whole rigour that was
17 required to be able to take all these procurements and
18 cases through to procure. So it made a huge difference.
19 Personally, I will also say I joined at that time
20 and realised my goodness, this was what the team -- the
21 30 people had been doing was -- it's heroic in terms of
22 actually just trying to support, but it was quite clear
23 that there was needed to be a rebalance in terms of
24 having more staff on the ground and to support the
25 organisation that didn't have the commercial capability

1 and understanding of procurement regulations, that was
2 really important.
3 Q. Thank you, and we're going to explore that period before
4 the appointment of Ms Rock with our later witness.
5 But to give us an idea of how the procurement for
6 the testing operation actually worked, could you explain
7 how suppliers came into the testing programme?
8 A. Yes, in the early days?
9 Q. At the point where you began to work in the testing
10 programme.
11 A. Okay. So -- perhaps I probably should just explain a
12 little bit what happened before I joined.
13 Q. Yes.
14 A. Because in the early days of test and trace there was
15 a call to arms, and because the procurement function in
16 PHE didn't have relationship with industry, and I think
17 there's a theme emerging around the importance of having
18 those engagements and established relationships with
19 industry, various efforts were put into place to engage
20 with industry so -- and that's why there were webinars
21 and calls and sort of active contacting potential
22 suppliers that could support that.
23 There was also no sort of right routes to market, as
24 well. So there weren't those established relationships
25 in place. So when I joined, we had, you know, various

1 calls to arms and engagement but we focused really on
2 establishing frameworks that could help us to have more
3 a sort of standard approach to procuring tests and
4 equipment from -- so particularly the DPS and their
5 Microbiology Framework, which had started a little bit
6 earlier, the development of that, but those were
7 establishments that it was important for us to have
8 faster ways of procuring.
9 Q. Thank you, and we're going to come and look at the
10 framework and the DPS in more detail later on.
11 You mentioned the call to arms.
12 A. Yes.
13 Q. And also industry webinars.
14 And in your statement you also set out that contacts
15 that came through, whether it was those mechanisms or
16 elsewhere, could come into a variety of mailboxes, and
17 UKHSA has done a piece of work around analysing how the
18 organisations that were contacted with came in, and were
19 contracted with.
20 So could you just briefly explain what the mailboxes
21 were, how they were categorised, and how offers were
22 triaged as they came in.
23 A. Yes. So the triage -- so I asked for this study to
24 happen, but it was a review of some mailboxes that were
25 established before, again, before even some of them even

1 before test and trace time, to understand basically had
2 there been any sort of special preference to suppliers?
3 So trying to understand, you know, what were the reasons
4 for these inboxes -- email boxes?
5 What's really, again, important to sort of recognise
6 is that, when the industry wants to in engage with
7 government, it's really important there's clarity of how
8 do they go about this. So I can understand why
9 there's -- there were four email boxes that were
10 established, as a means of suppliers or referrers to put
11 them forward to those inboxes based on the call to arms
12 and people would sort of come up. And I think, again,
13 it's important to recognise that this wasn't Joe Bloggs
14 from the street corner, this is a quite complicated
15 sector, diagnostics sector.
16 So there were companies getting in touch with
17 government to support the efforts.
18 In the review, which we did subsequently, to
19 understand, well, how -- how would -- how did they work,
20 and what did they lead to? And basically the review
21 concluded that these inboxes were sort of means of
22 people to get in touch with, it was a means of triaging
23 requests, but it didn't give a preferential treatment or
24 didn't -- it didn't circumvent the procurement process,
25 which was a really important finding. So it was a way

1 of coordinating responses.
2 The other important thing that's important to
3 recognise around the testing side is that every test has
4 to go through valuation. So with the triaging process
5 what would happen is that somebody would get in touch
6 with, you know, there's a -- might be a product here
7 whether it's PCR or whether it's lateral flows, they
8 would get in touch, but then there would be a sort of
9 a desktop sort of analysis, and then they would be put
10 forward to the scientific teams in PHE and they were
11 separate, and they would be evaluating the tests to see
12 whether they were meeting the sort of quality standards.
13 And they did that blind so they didn't know who had
14 referred them or not. They were just doing that. And
15 then if they passed the validation, then it could be
16 sort of processed and a procurement could -- or sort of
17 a -- or direct award, the majority of them in the early
18 days were direct awards -- would be established.
19 So they were sort of -- they were separate to that.
20 **Q.** Thank you. You've absolutely anticipated where I'm
21 going to go.
22 So can we get on the screen INQ000383567 and page 5.
23 This is the piece of work that you were just mentioning,
24 the commercial supplier triage analysis, which I believe
25 is from January 2022. And this is just the executive

1 summary and there is a useful summary here of the number
2 of suppliers in paragraph 9. There were 50 suppliers
3 who were identified as priority.
4 Now, how was a supplier identified as priority?
5 What did that mean?
6 **A.** So again, this is based on our reviews. So it was
7 basically whether they had had a reference from an MP or
8 a senior person in government, or it was someone who was
9 sort of a known person, it was basically -- it was not
10 about whether they should be prioritised, it was more
11 about who had referred them.
12 **Q.** So we have heard already in this module, and I'm sure
13 you've heard in the media largely before then, about
14 a VIP Lane --
15 **A.** Yeah.
16 **Q.** -- for PPE or as it's also known, the High Priority
17 Lane. And this is basically the equivalent of that,
18 not -- I'm not saying in every way, but in that you end
19 up in the -- categorised priority because you are
20 a contact of, as you've said, a minister or another
21 high-ranking person; is that correct?
22 **A.** So I don't think that's the case at all, no. So it's
23 unfortunate that they were called "priority", and I've
24 sort of -- one of our recommendations in this review was
25 not to call them "priority". What they were was a means

1 of people contacting government, saying, "We have some
2 tests, we have some products, that we would like to
3 offer."
4 What would then happen was that they would be
5 reviewed, say, "Well, is this a -- does this look like
6 a sensible thing or not?" And then it would go through
7 a separate process, the validation process.
8 **Q.** Yes, you've explained that, and not to cut across you,
9 but forgetting the fact that they were labelled
10 "priority", and I'm not saying at this point that they
11 were prioritised for this reason, but they were put into
12 that category initially, for the purpose of triage,
13 because they were a contact of the senior government
14 official; is that correct?
15 **A.** Well, I -- I think -- we didn't find any evidence of
16 them being given any special preferential treatment
17 or --
18 **Q.** Yes, you've said that and -- (overspeaking) --
19 **LADY HALLETT:** That's different --
20 **MS GARDINER:** -- we'll look at that later --
21 **LADY HALLETT:** I'm afraid we're dancing on the head of a pin
22 here, because everything you've said so far does suggest
23 to me that this is really quite similar to what we had
24 in the other procurement exercise we've analysed.
25 You say here:

1 "We have identified 50 suppliers with contracts who
2 could be considered a 'priority' or equivalent because
3 of their entry route ..."
4 **A.** Mm.
5 **LADY HALLETT:** So in other words, it's -- I think
6 Ms Mitchell came up with the expression in asking
7 Lord Feldman -- it's triaging the person as opposed to
8 the actual contact.
9 So you didn't identify 50 suppliers with contracts
10 because of their track record, or how long they'd been
11 in business, or whether they'd supplied this kind of kit
12 before, but because of how they got there, in other
13 words referred by an MP.
14 Isn't that -- I totally understand the argument that
15 once you're there you're not going to get through unless
16 you can come up with the goods. So I do understand all
17 of that, and everything has to be evaluated.
18 **A.** Yes.
19 **LADY HALLETT:** It's just this point: is it fair to say this
20 is substantially different from the other system?
21 **A.** So I don't know the detail of the other system. What
22 I know is that there were different inboxes. What we've
23 found was that we didn't feel that this particular inbox
24 was prioritised more than another one where suppliers
25 could come forward. But I'm also -- we did a review.

1 I wasn't there at the time so I can only base it on the
2 evidence that's in front of us.
3 **MS GARDINER:** Perhaps it would assist if we go to another
4 part of this document.
5 **A.** Yeah.
6 **Q.** If we go to page 11 and paragraph 25.
7 This is explaining how offers were categorised as
8 priority for the purpose of this document. It's those
9 where:
10 "'VIP' 'FASTTRACK' 'High Priority' and 'Referral'
11 [was] mentioned in [the] correspondence."
12 **A.** Mm.
13 **Q.** Those where suppliers were "involved in email
14 correspondence with a 'VIP' individual", perhaps with
15 a Parliament or Number 10 email address.
16 **A.** Yes.
17 **Q.** Or was:
18 "Involved in correspondence via the 'priority
19 contacts' mailbox."
20 And you've explained in your witness statement that
21 for the first two categories listed in those bullet
22 points, that would happen if an offer came in via
23 a senior government official or senior civil servant.
24 So we're just, at this point, my Lady's point is you
25 were talking about the point of entry to the system?

1 **A.** Yeah.
2 **Q.** And as you say, whether it's prioritised you deal with
3 in this report.
4 **A.** Yeah.
5 **Q.** So we'll look at that now.
6 If we go back, please, to page 5, where we were, and
7 paragraph 9, it's noted that of those 50 suppliers who
8 were identified as priority, that amounted to 76% of the
9 total contracted spend for this period.
10 Now, you've noted elsewhere in this report that that
11 figure might be skewed because of one contract in
12 particular, and that is detailed at page 7.
13 So if we can go to page 7, please.
14 So this the list of suppliers which had been
15 identified as priority, and we can see the original
16 referrer in the far right-hand column, and we can also
17 see the total value of the contracts.
18 I won't take us through all 50 of them because it
19 goes over three pages, but you do mention elsewhere in
20 this document that the figure, in terms of it being 76%
21 of total spend, is somewhat skewed by this first
22 contract, Innova Medical.
23 **A.** Yes.
24 **Q.** As we can see, there were nine contracts agreed with
25 Innova. In total, they value more than 3 billion. And

1 the original referrer was Dominic Cummings from
2 Number 10. And that was identified through a deep dive
3 that UKHSA carried out.
4 Can you explain why there was such
5 a disproportionately large spend on this one supplier?
6 **A.** Yes, I can. And is to say we found -- in this
7 particular one we found one reference to
8 Dominic Cummings. It's very likely that Innova would
9 have contacted the government thorough other means to
10 offer up their products. So the reason why the number
11 with Innova was so high is that there were three
12 companies in September that passing through validation
13 for lateral flow tests. And that was a really important
14 moment for government, because that meant that we could
15 roll out -- at the time it wasn't self tests but we
16 could do testing on lateral flows.
17 So, as a result, we went into contract with Innova
18 and Tanner and Abbott, the two other companies. And
19 Innova happened to have a large manufacturing capacity,
20 so we were able to contract larger amounts with them.
21 And this was in the day where we didn't have
22 a dynamic purchasing system, so we didn't have a route
23 to market, because this was a new product, so hence we
24 had to do a Regulation 32 direct award.
25 What happened was that over the course of the month

1 that, to roll out mass testing, it was required for --
2 it was -- made sense to get self use, and test and trace
3 worked with Innova because they had the capacity but
4 also were very flexible in the -- this sounds quite
5 technical, but the pack sizes actually really meant --
6 it was important from a cost perspective because if you
7 could have boxes of three and sevens, they were smaller
8 packages that could then be rolled out for testing, and
9 they were incredibly flexible in developing that, and
10 that's right why the department became the legal
11 manufacturer for that. So as a result, a bigger
12 proportion of LFTs were procured from them, but then
13 when we established the framework in March, the dynamic
14 purchasing system, we then actually had a market and we
15 could start to, we could obviously drive competition and
16 we were able to -- there were far more manufacturers on
17 board at the time and we could contract with others as
18 well.
19 **Q.** Thank you, and we're going to discuss that period of
20 time with the advent of lateral flow devices and also
21 the setting up of the DPS in more detail later on.
22 So you've explained that the total spend is somewhat
23 skewed --
24 **A.** Yes.
25 **Q.** -- because of that contract. Another way of measuring

1 whether or not priority contracts were prioritised in
2 actual fact might be by examining the number of
3 contracts which were awarded to them as compared to
4 those that had entered into other lanes.
5 So I want to take us to page 13 of this document.
6 And this is also set out in your witness statement. And
7 at the very top in the table just beneath paragraph 28,
8 we have:
9 "Successful suppliers as % of total offers."
10 And three mailboxes: Covid testing triage, Covid
11 testing priority contacts, Covid-19 innovation.
12 And as you can see, the percentage is substantially
13 higher for those that have been marked priority.
14 As you've already said, this document is at pains to
15 explain that all contracts in relation to testing went
16 through a very detailed technical assessment and that
17 was carried out by a separate team who had no knowledge
18 of how the particular supplier had entered the process.
19 However, it doesn't explain why such a significant
20 percentage of priority contacts were awarded contracts
21 as compared to those that entered through other routes.
22 Was that because those offers were, as we've heard in
23 relation to other items procured during the pandemic,
24 they were handheld through the process, or they were
25 hurried through the process quicker by virtue of having

1 a champion in the form of their priority contract?
2 **A.** So, again, I need to caveat it with the fact that this
3 was a study that we did, but we didn't find that
4 particular suppliers were being handheld. So to give an
5 example of the Innova one, where there was one reference
6 to Dominic Cummings. There was nothing -- follow-up
7 through from him subsequently.
8 Another supplier that's on there is SureScreen,
9 which became our UK Make company. We actually, if you
10 read Chris Hall's evidence, statement, is that he
11 actually had to convince them to join the efforts and
12 supply.
13 So I think I would be cautious about sort of just
14 broadbrushing, saying this is sort of evidence of them
15 being handheld. I can't say what happened outside of
16 the inboxes because these were -- we only looked at the
17 inboxes, but I haven't seen any evidence of ministers
18 pushing for specific supplies. In fact, I saw sometimes
19 the opposite. If I may, my Lady?
20 There were a couple of instances where, with
21 Lord Bethell, where he -- there were suppliers that were
22 being quite proactive and wanting to get a foot in and
23 we sort of said to him, can you deal with them so we can
24 focus on our commercial work? So, actually, shielding
25 the team. Because it was very important that the team

1 could get on with procuring the tests that had been
2 validated, and they were ready. And to be honest, in
3 the early days, it was almost like we needed to contract
4 with anyone that had the capacity. So it was -- that's
5 why we were so focused on the validation exercise,
6 because it really was important that we had the quality
7 tests.
8 So -- but that's probably as -- as far as I can sort
9 of give you on this.
10 **Q.** You say you didn't look outside of these inboxes as to
11 what was happening to these contracts outside of that.
12 Why not?
13 **A.** Well, what we didn't do is we didn't -- we looked at
14 four inboxes. What we didn't have access to was,
15 obviously, people's individual emails, email addresses,
16 or, you know, that would be sort of a cross-government
17 effort, and if you compare it to sort of normal
18 standards, there will be, we see this often where
19 suppliers will be contacting MPs or ministers and
20 saying, "Oh, please can we, you know -- can you do
21 something for us", and the answer is "Well, no because
22 we've run procurements", but there are regular sort of
23 contacts between suppliers and government.
24 So I guess the challenge was I -- it was sort of
25 looking for a needle in a haystack, it would have been

1 quite difficult, even looking at those four inboxes was
2 incredibly challenging for us to get access to them in
3 the first place.
4 **Q.** Given the much higher percentage of contacts awarded
5 contracts in the testing priority inbox, did that not
6 prompt you to say, perhaps we need to do a wider piece
7 of work to see what was happening to these contracts and
8 why they were more likely to be awarded contracts?
9 **A.** So we had a choice. I mean, we'd spent an awful lot of
10 time on this. I think from a lessons learnt
11 perspective, if -- if I can refer to again that pack --
12 it was actually more important for us to be clear on how
13 do we do proper front door going forward? So that's
14 what my focus was on establishing a new commercial
15 function in UKHSA, where we have now got a front door
16 which is managed in a very transparent manner, because
17 industry does need an access point, but it's important
18 that it's not influenced by people or that no one is
19 being handheld, but that we are following the proper
20 processes, and that's why, once we'd done this report,
21 we were like, okay, well, let's learn from this and then
22 let's make sure that there's no, you know -- I wouldn't
23 call anything like these -- what -- some of these
24 inboxes called "priority". That is not language I would
25 use, because I think that's unhelpful.

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1 **Q.** I want to turn to more generally address the involvement
2 of ministers in testing procurement. One thing you said
3 in your witness statement is that Covid-19 policy
4 decisions shaped the procurement of testing technologies
5 during the pandemic. I was wondering if you could
6 explain a little more what you meant by that.
7 **A.** Forgive me, if you could repeat?
8 **Q.** By policy decisions shaping the procurement.
9 **A.** Yes. So it's important to establish, my Lady, that
10 obviously commercial is an enabling function. So we
11 follow the direction of ministers but also policy
12 colleagues. It's really important, and I think that's
13 what's a strength of test and trace, but also UKHSA now,
14 that we have far closer collaboration between the
15 scientists and the commercial people to establish what
16 are the requirements and are they deliverable, because
17 I think in the early days of test and trace and the
18 testing programme, decisions were announced before
19 actually an assessment of whether this was possible or
20 not.
21 I think the teams did a heroic effort in scaling up
22 testing, but there was a challenge here where -- I mean,
23 when you look through the statement, there were often,
24 you know, weekly policy announcements made, and the
25 procurement teams had to be incredibly agile to support

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1 the delivery of those, and that was incredibly
2 challenging. I think they did an incredible job in
3 achieving it but when announcements are being made
4 without assessing the market -- clearly, it was also
5 about giving the public the confidence that, you know,
6 government was on it and tests would be rolled out but
7 it does create a challenge for people who need to
8 deliver it.
9 **LADY HALLETT:** Could I ask you to slow down.
10 **A.** Okay, apologies. I will.
11 **MS GARDINER:** So let's look at some examples of that that
12 you give in your statement. There was a move, around
13 about the time you came on board to the testing
14 programme, in the autumn of 2020 away from PCR -- or
15 perhaps not away from PCR but towards rapid tests,
16 lateral flow devices, and at that time the
17 Prime Minister announced on 9 September what was then
18 called Operation Moonshot and your statement sets out,
19 and if you want to see it it's at paragraph 4.132, at
20 page 47, that this was actually against the advice of
21 NHS Test and Trace.
22 Can you just explain what NHS Test and Trace advised
23 at that point from a procurement perspective and then
24 how that impacted, if at all, on the Prime Minister's
25 announcement.

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1 **A.** So I don't believe Commercial was involved in the sort
2 of decision of whether we should be doing Moonshot or
3 not, that was quite a small group of people and Dido
4 Harding was obviously the chair of NHS Test and Trace,
5 but the advice at the time was obviously that if we were
6 going to roll out lateral flow testing we needed to
7 establish a market because we didn't have a market and
8 we didn't have a product either, and that came through
9 from September onwards.
10 I believe from reading sort of various statements
11 that there was a reluctance to do Operation Moonshot in
12 the sense of doing it in a very short timescale of
13 testing people twice, was actually the recommendation
14 was to do more targeted testing programmes in the
15 various sort of groups and hence my confusion,
16 apologies, about the community testing.
17 But from a commercial perspective, this was all
18 about all the announcements, making sure that the
19 capacity was there. And that's why a lot of effort was
20 put into designing the dynamic purchasing system, but it
21 couldn't be done until we had the products, and that's
22 why -- there was a real tension there but the
23 neighbouring team, the commercial team, was there to
24 support and did what they could.
25 **Q.** So when the Prime Minister announced Operation Moonshot

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1 on 9 September, did you have the products?
2 A. So two days later the Innova test was validated, I
3 believe that was on 11 September, followed by the two
4 other products. So technically it hadn't been validated
5 yet.
6 Q. But in the quantities that you needed?
7 A. Forgive me?
8 Q. So as of the 11th --
9 A. Yeah.
10 Q. -- you had an approved test, but did you have an
11 expectation that you would be able to get it in the
12 quantities that you needed to carry out Operation
13 Moonshot?
14 A. So the challenge was -- at the time it was only sort of
15 relatively small amounts, so it wasn't possible to scale
16 up, but at that amount target yet. But, again, I'm not
17 even sure that numbers were talked about -- well,
18 I haven't seen that from the work I have done in putting
19 the statement together, but it's fair to say that the
20 ambition to push for lateral flow devices was incredibly
21 challenging because of the need to make sure the
22 manufacturers could deliver what they did.
23 Q. You set out that that continued to grow and one factor
24 in that was the approval by the World Health
25 Organisation of lateral flow devices --

1 A. Yes.
2 Q. -- as a test for Covid. And following that, a test came
3 directly from Number 10 to secure lateral flow devices.
4 A. Yes.
5 Q. And how many did you need to secure at that point?
6 A. So I believe there were various requests and the orders
7 are set out in the statement. So I wasn't involve in
8 the actual procurement but there were -- basically, it
9 was what capacity do they have, and then let's buy it.
10 And that was the sense.
11 And again, in terms of context, by the WHO declaring
12 it, it was also a matter of: let's get this before any
13 countries are. So there's a famous quotation of Dominic
14 Cummings saying, "Well, let's just buy, buy, buy and get
15 the stock in."
16 Q. And you set out in your statement as well that demand
17 for lateral flow devices continually ramped up over the
18 next couple of months. They were a key part of the
19 winter plan --
20 A. Right.
21 Q. -- the community testing programme, the route out of
22 lockdown that was announced in spring 2021.
23 We have also asked you in your statement, and you've
24 set out an answer that I'd like you to expand on, about
25 the impact that that increasing pressure to procure had

1 on your procurement process.
2 Had you not had that constant dialling up of
3 targets, how would your procurement process have been
4 different?
5 A. I think that needs breaking down a little bit because
6 it's also depending on what product we're talking about
7 here. So we -- at the time, there were sort of two
8 routes to market -- we call them routes to market -- and
9 basically access of procuring, and there was
10 the Microbiology Framework, where we could procure PCR
11 capacity. That original framework didn't have basically
12 the right lots so we didn't have access to buy huge
13 capacity of PCR capacity, lab capacity, nor did it have
14 the right value.
15 So if you breached the value of the framework, you
16 sort of make it redundant and you end up -- you can end
17 up sort of being challenged by other suppliers on that
18 framework. So we didn't have that and that's why the
19 effort was put in place to let that framework.
20 On the DPS side, the dynamic purchasing system, that
21 couldn't be put in place until we had products. So work
22 started in that autumn and the dynamic purchasing system
23 was established in March so that procurement could
24 happen.
25 So let alone the sort of -- the capacity, it was

1 important to have the right route to market, and that's
2 why, in the early days, the only solution was
3 Regulation 32. And then the other challenge was
4 capacity. So there was a global market, and needing to
5 procure this at pace and getting access to this product
6 rather than other -- them going to other places also put
7 a lot of pressure on the function. But it meant that
8 they had to sort of constantly let contracts and --
9 because the goalposts basically kept changing.
10 Q. And you've already mentioned that this was a brand new
11 product, most of them hadn't been approved at this
12 point, and the offers that you were receiving were for
13 tests that had not yet been evaluated and passed
14 testing.
15 So you also say that the majority of the offers that
16 you received for lateral flow devices were -- they were
17 all tested but the majority of them failed testing. How
18 did that affect your procurement?
19 A. Well, it just meant that there was smaller supply. So
20 the team at Porton Down who established the evaluation
21 function, I think they've now moved up to 200 lateral
22 flows, but they went through a lot of LFDs who were just
23 not of a quality or, sort of, sensitivity of picking up
24 Covid, and that's why it was quite a challenge of
25 then -- as soon as their test was approved, we could

1 then procure from them.
2 Q. I want to move ahead in the timeline just a bit. We
3 will come back and talk a bit more about the DPS and the
4 Microbiology Framework, but as another example of how
5 ministers interact with procurement of testing in this
6 period, I believe that there was a series of
7 conversations with the Treasury in autumn 2021 about
8 longer term procurement. What's the nature of those
9 discussion?
10 A. So in 2021?
11 Q. Mm.
12 A. So there was this sort of tension of demand, keep
13 changing, and there was new variants, and the landscape
14 was incredibly challenging to plan. So there was demand
15 forecasting, but often when a new announcement was made
16 or there was a new variant, it had to change.
17 But what we were very keen on in Test and Trace was
18 to get -- if you buy larger orders, you get better
19 discounts, and to actually start having planning also
20 for the winter, to make sure the pressure was eased off
21 the NHS. So there was a desire to buy sort of a larger
22 order of lateral flows. And there were negotiations
23 with the Treasury and basically an agreement was made to
24 sort of buy half of what was required. And then what
25 happened was that Omicron happened and suddenly there

1 was this sort of need for buying at really fast pace.
2 We ended up having to sort of do that at very short
3 timescales in December, and reverting back to direct
4 awards because we had sort of outdone the -- what was
5 available to buy through the DPS at that time.
6 Q. So, just to summarise that, it was NHS Test and Trace at
7 this point, in the early autumn, and then it became
8 UKHSA --
9 A. UKHSA, correct --
10 Q. -- in October, so we're at that --
11 A. Yes.
12 Q. -- transition period, but the testing programme, shall
13 I say --
14 A. Yes.
15 Q. -- was advocating for a contingency supply of lateral
16 flow devices get you through the winter. Treasury would
17 only approve half that supply. In the end, because of
18 Omicron, you ended up having to make a series of direct
19 awards, so not going through a more rigorous procurement
20 process, because of that last sort of -- sort of
21 last-minute urgent decision necessitated by Omicron?
22 A. So I would be cautious about using the word "rigorous",
23 because we still used the terms and conditions of the
24 DPS. It was more the fact that, with the dynamic
25 purchasing system, you run mini competitions, and they

1 can take, you know, two or three weeks, and at that time
2 we didn't have that. And we also needed the capacity
3 again from suppliers, and they hadn't been warned. So
4 suddenly it was back out to say, "Well, who can provide,
5 you know, these huge numbers of additional capacity at
6 short timescales, get them flown into the UK?"
7 And that's also why the number of Innova sort of
8 rose up, because again they had -- they just had more
9 capacity. So, yes.
10 Q. And at that time there was another factor, wasn't there,
11 that impinged on -- that was important for supply. The
12 Prime Minister announced on 8 December Plan B, and that
13 included a requirement for a Covid-19 pass, validated by
14 lateral flow test, and also the potential for an earlier
15 release from self-isolation if you'd previously tested
16 positive by testing with a lateral flow device.
17 When that was announced on 8 December, that
18 obviously had an impact on the amount of lateral flow
19 devices you needed to buy. Did you have any forewarning
20 of that announcement?
21 A. So I didn't personally, no, and I believe not many had,
22 in Test and Trace --
23 Q. Do you believe anyone from the commercial side of
24 testing knew that this was going to happen?
25 A. Not in the Commercial, no, because I would have known as

1 the director there, but I can't tell from other people
2 in the organisation or discussions with the Cabinet
3 Office.
4 Q. Thank you.
5 Just going to move to spending controls more
6 generally, and we'll touch on the DPS and the framework
7 that you've already explained.
8 But first of all, benchmarking. What were the
9 problems with benchmarking in this context, both with
10 PCRs and then later with lateral flow devices?
11 A. So, again, this comes back to the timing element of it.
12 So in the earlier days benchmarking was incredibly -- so
13 when I mean early days, I mean the establishment of the
14 testing programme in that spring of 2020. So it was
15 incredibly difficult to benchmark because the prices
16 that the team had to compare was on a standard framework
17 rate in a world where there was plenty of supply. When
18 demand increased, that was difficult to then work out,
19 well, what sort of pricing that they should be sort of
20 looking at. And that's where Bev will have some greater
21 detail in terms of what they did, but they got offers in
22 and sort of compared the prices to each other, the
23 different contracts.
24 What happened was obviously when we then put our
25 frameworks in place, that became easier, and with --

1 what you see with -- when you run competitions is, you
2 know, you can get a better price, and we saw a huge
3 improvement, I mean our DPS on the lateral flows, we
4 saved 70%, but -- on the pricing from the original
5 costings that had been in the early days, but I think
6 benchmarking, you have to be really cautious in the
7 sense that, what you are comparing, so in a world where
8 there is very little supply, then that does impact
9 pricing but the teams did, you know, all they could in
10 terms of trying to compare cost and look at whether the
11 offers were reasonable and then, ultimately, there was
12 a decision of whether, you know, through governance,
13 whether the investments should have been made and
14 I guess that's a really important point to make, that,
15 you know, decisions, procurement decisions, were made
16 through governance and scrutiny through our investment
17 board cycle.
18 **Q.** You've explained that in the spring of 2021, that was
19 when the new Microbiology Framework came into force, and
20 you also had a dynamic purchasing system for lateral
21 flow devices that went live around that time. Why were
22 the previous frameworks that PHE had in place not
23 suitable for that kind of procurement?
24 **A.** So the original Microbiology Framework didn't have the
25 procurement of lab capacity, so we added two new lots to

1 it in the revised version, so that we could go out and
2 buy from surge labs, additional labs. So that was
3 a really important factor. And the other thing was the
4 fact that, and I believe I mentioned it earlier on
5 around the cap of the spend. So if it's -- if one
6 procurement breaks the limitation of the spend, you make
7 the framework redundant and you actually sort of --
8 there's a higher risk, because other suppliers will say,
9 "Well, hang on, you've basically dismantled the
10 framework by one procurement."
11 And that's why Regulation 32, which is used
12 obviously for emergencies, but also, sometimes when
13 there's only one product as well, which we often see in
14 health, particularly in the vaccines sort of arena,
15 where there might only be one validated product, or
16 single source. So you can use it in that way.
17 **Q.** That perhaps takes us to lessons learned quite swiftly,
18 actually. One of the things that we've already
19 discussed is that PHE was not -- did not have capacity
20 to scale testing. And it was the organisation that had
21 the responsibility for protecting the public from
22 infectious disease. As you've explained, that
23 responsibility has transferred now to UKHSA.
24 So to what extent has the testing programme as we
25 knew it in 2020, 2021, been dismantled and what are the

1 plans to scale it up, should a pandemic of similar
2 proportions occur again?
3 **A.** Yes, so there's quite a lot in that question. So
4 firstly, you know, we don't know what the next pathogen
5 will be, or the type of pandemic. And a ministerial
6 decision was made to scale back, so we got rid of, like,
7 almost 2,000 contracts, we basically scaled back to sort
8 of a standard capability. And what we have now, within
9 UKHSA, is -- and that does lead me to some of the
10 lessons -- is that what's really important, because if
11 we don't know what the type of the disease it will be,
12 investing in, you know, some big lab that has a specific
13 testing capability may not be the right focus, so what's
14 important for us is to have access, which we didn't have
15 at the time, the right routes to market. So access to
16 labs, surge labs, that we can procure from at a rapid
17 scale.
18 Within UKHSA as well, what we're looking at, at the
19 moment, is there's a certain level of capacity that we
20 can do in-house. There's some further investments that
21 we're looking to make around -- if that can be
22 increased, but to give you an example, in terms of
23 capacity, it depends on what category of lab you need,
24 if it's CL3 or CL2, so the types of lab environment you
25 need.

1 So we're looking at how that can be strengthened
2 internally to scale up, but at a, you know, slightly
3 higher amount. But then any further decisions on, let's
4 say, if we're going to do 100,000 tests a day, that is
5 part of the spending review planning because, again,
6 that's a decision for the government to say, well, what
7 do they want to fund? But I do believe that it's
8 important to have, and we've reflected a lot on this,
9 about making sure that we have the partnerships, the
10 understanding of the capabilities out in the
11 marketplace, as well as the routes to market.
12 And perhaps, if I may, to give you an example on the
13 lateral flow side. So we based on the lessons from the
14 evaluation and validation work we did, we've got
15 something called the diagnostics accelerator and it's
16 the team in Porton Down that basically works with the
17 industry to evaluate tests that are coming, so new
18 innovations, new products, and where we feel there's
19 a gap, so if there's a threat that we feel we need to
20 get access to a test, we collaborate and develop it
21 together, or we also provide the service to evaluate
22 manufacturers' tests so that they can commercialise and
23 scale up.
24 We don't have as an organisation, you know, funding
25 just to go out and, you know, build supply chains in

1 that regard, but what's really important is the
2 understanding of the products and the innovations that's
3 out there, and the other thing we've done is we are
4 looking at a -- we are doing the final touches on the
5 next version of a Microbiology Framework, where
6 innovation and products, innovative products, there's
7 going to be a real focus on having -- being able to
8 contract with manufacturers who have new inventions and
9 new products that we can then get access to.
10 So it's really important that there's kind of
11 a combination of areas, but particularly the
12 partnerships and understanding the market capabilities
13 is something that we're really focusing on, because
14 that's going to help us to then scale up, which will
15 then require additional funding if we need to reach the
16 testing amounts that we've seen previously.
17 **Q.** So you talked a bit about your partnerships with
18 industry in relation to innovation and, as my Lady's
19 Inquiry has heard, and indeed recommended in previous
20 modules, the importance of being pathogen agnostic --
21 **A.** Yes.
22 **Q.** -- in terms of preparedness. So we're perhaps better
23 prepared than we used to be, from what you've told us,
24 about -- for a pathogen-agnostic pandemic, in terms of
25 innovating, new tests, new treatments. But what about

1 in terms of scaling that up? Do the new frameworks and
2 the new routes to market you've described, give that
3 flexibility, not just for innovating a single product or
4 test, or treatment, but also for providing that on
5 a mass scale like we had to in the Covid pandemic?
6 **A.** So let me break this down. So just to say, it's not
7 just about being -- well, it is about being pathogen
8 agnostic but we've just recently procured -- so one of
9 the newest threats is H5N1, so avian influenza, and
10 we've procured some tests based on the evidence we've
11 seen, but clearly it is small scale, my Lady, and
12 I think the challenge here becomes then a funding
13 decision because we've got the routes to suppliers who
14 can scale up, but it costs money to keep them warm, and
15 it's incredibly expensive. And what we need to make
16 sure is that we're obviously keeping the right types of
17 technologies warm. So that's a huge, huge question here
18 when you're having to sort of trade off with other
19 challenges.
20 So from my perspective, this is where the Office for
21 Life Sciences comes in and the industrial strategy, in
22 terms of actually what is it that we want to do to
23 strengthen the diagnostic industry, because we can't
24 just keep it warm by, you know, UKHSA spending very
25 little -- a limited amount. This a much wider decision

1 around what we want to do to strengthen the industry,
2 but it's a really important one, because if we were
3 going to scale up, there's a whole set of kind of areas
4 that we need to consider in terms of making sure that if
5 we have, you know, the facilities here, the products and
6 the access to those raw materials, but it's a much
7 bigger, bigger decision than just for us.
8 **LADY HALLETT:** Is the answer to Ms Gardiner's question, "No,
9 we don't currently have the flexibility to scale up,
10 we'd have to do it as another pandemic hit, but that's
11 a political decision and not one that UKHSA can
12 control"?
13 **A.** Yes, I mean, we've got, you know, some -- in the
14 lower -- presumably three in ten -- or 12,000, that
15 could be scaled up to probably around 25, but beyond
16 that, absolutely, then that's a ministerial funding
17 decision.
18 **MS GARDINER:** What about UKHSA's commercial capacity? Does
19 that have the ability to scale, or will you again rely
20 on the Government Commercial Function, on external
21 consultants? What is the plan there?
22 **A.** So we, we're not starting from scratch again. So one of
23 the really important things of UKHSA is the
24 strengthening of particularly commercial capability but
25 also clearly our data analytics and other sort of key

1 specialist areas. So what we did subsequently was to
2 establish a function that we've just -- last year we
3 published our 5-year commercial strategy setting out all
4 of what our priorities are in terms of building
5 capability, not just within the function, but also
6 across the agency, because many of the -- you know, we
7 work so much with industry that it's important that we
8 have that commercial awareness.
9 So we've got a healthy function, and we've
10 upskilled, staff are accredited, and we've got the
11 ability to respond, and as an agency, respond to
12 multiple incidents at the, you know, on a sort of
13 regular basis. What we would need to, is, you know,
14 we've got the sort of core capability and much more than
15 previous organisations had, we -- there would become
16 potentially at a time where, if we were going to sort of
17 scale it up even further, we would need to top up, but
18 not in the same scale as what we saw in the early days
19 of test and trace where we basically had to build
20 a function and establish new systems, and -- as well.
21 **MS GARDINER:** My Lady, those are all my questions.
22 I believe there are some Rule 10s.
23 **LADY HALLETT:** Thank you very much.
24 Ms Mitchell, I believe you have a question. That
25 way.

1 **Questions from DR MITCHELL KC**
2 **DR MITCHELL:** I appear as instructed by Aamer Anwar &
3 Company on behalf of the Scottish Covid Bereaved.
4 You and Dame Jenny Harries introduce a 2024 to 2029
5 document called *A commercial strategy for UK health*
6 *security*, and in that document you indicate that you
7 will explore what you describe as the transformative
8 potential of artificial intelligence. Can you explain
9 what you see that transformative potential being, and
10 are there any current barriers to progressing with that,
11 such as cost, data protection, or simply not having
12 enough data?
13 What I'm looking for here is to find out what do we
14 need to change to ensure that that full potential is
15 reached.
16 **A.** I will try to be brief. This is a big question, because
17 artificial intelligence can be implemented in many ways.
18 Very locally, within the function, what we're looking at
19 is automation, better contract management, some of those
20 things that eases the pressure of staff to then focus on
21 some of the more strategic market engagement.
22 But it's also about how we handle data, as well. So
23 we have number of pilots going on in UKHSA looking at
24 how we can -- AI can help us to operate more
25 efficiently. So it's something that we're looking at.

1 We're not there yet, this is a 5-year strategy, but it's
2 something that we're really keen to work on. But also
3 with the wider commercial function, so this is something
4 that being part of the Government Commercial
5 Organisation and Commercial Function, we're looking at
6 to see how we can apply that making things easier and
7 simpler.
8 **DR MITCHELL:** My Lady, thank you.
9 **LADY HALLETT:** Thank you very much, Ms Mitchell.
10 Those are all the questions that we have for you,
11 Ms Collins. I'm not sure, will I be calling on you
12 again? I don't know. Has another module called on you?
13 Has Test and Trace?
14 **A.** I don't believe so, but UKHSA will be coming to,
15 I think, every single session, every single module.
16 **LADY HALLETT:** Well, I'm not sure if you personally have
17 escaped my further attention, but thank you very much
18 for the help you've given so far.
19 **THE WITNESS:** Thank you.
20 **LADY HALLETT:** Thank you.
21 Very well, I shall break now and return at 2.00.
22 **(12.57 pm)**
23 **(The Short Adjournment)**
24 **(2.03 pm)**
25 **LADY HALLETT:** Ms Gardiner.

1 **MS GARDINER:** Thank you, my Lady. May I please call
2 Dr Beverley Jandziol.
3 **DR BEVERLEY JANDZIOL (affirmed)**
4 **Questions from COUNSEL TO THE INQUIRY**
5 **MS GARDINER:** Dr Jandziol, you've provided a witness
6 statement to the Inquiry. That is INQ000562340. It
7 runs to 76 pages, and it is signed and dated
8 31 January 2024, but I believe that that is a typo; is
9 that correct?
10 **A.** Yes, it should be 2025.
11 **Q.** Thank you. Is the witness statement otherwise true to
12 the best of your knowledge and belief?
13 **A.** Yes.
14 **Q.** Thank you.
15 Dr Jandziol, it would be useful to hear a little bit
16 about your experience before the relevant period. So
17 you're a procurement director with about 24 years of
18 experience. I believe before you were in government,
19 that was with a procurement consulting firm?
20 **A.** So 20 years' experience in procurement before Covid, the
21 pandemic. So kind of 24, 25 now. 15 years in
22 consulting and five years before that in corporate, sort
23 of, large corporate organisations.
24 **Q.** And when did you join government and in what capacity?
25 **A.** So I joined in September 2019 the Complex Transactions

1 Team, which I believe, my Lady, you've met some of my
2 colleagues who have also worked on the pandemic.
3 So I joined as a commercial specialist which is
4 a deputy director in the Complex Transactions Team and
5 the roll of the Complex Transactions Team was about 50,
6 it was around 50 people. It's a bit like an internal
7 consultancy of specialists, so we work on the most
8 challenging, risky commercial problems that are
9 occurring across government, so we'd work in different
10 government departments.
11 So I'd been in the organisation five months before
12 I was deployed in DHSC to support setting up Covid
13 testing.
14 **Q.** Thank you, and we'll get to that -- those events very
15 shortly.
16 I believe you're now commercial director in the
17 FCDO; is that right?
18 **A.** Yes.
19 **Q.** And what is your PhD in?
20 **A.** Cell biology. So I was sponsored by GSK and Medical
21 Research Council.
22 **Q.** So did that scientific background, was that useful when
23 you were doing your commercial work during the pandemic
24 as well?
25 **A.** It was very useful. I suppose it's quite an unusual

1 skill set, being sort of a cell biologist and
2 a commercial specialist, but it was very useful at the
3 time.
4 **Q.** And that wouldn't be standard, we understand, for the
5 sort of consultants within the CTT to have a scientific
6 background?
7 **A.** There's a few people with maybe science degrees but
8 probably not to the sort of post-doctorate kind of
9 level, but actually, it's got quite a real varied mix of
10 people with different backgrounds. Most of us have come
11 from the private sector.
12 **Q.** Moving now to the pandemic. You've explained the role
13 of the complex transactions unit, and it would be useful
14 to hear about when you initially got involved in the
15 coronavirus response. When was that?
16 **A.** So it was on 18 March 2020, and my line manager at the
17 time, Janette Gibbs, whose the -- she's the interim
18 director for complex transactions, she asked me to
19 attend a meeting at DHSC. I think the request had come
20 from Lord Bethell. I think it had gone to Minister Gove
21 at the time and then it had gone to Gareth Rhys Williams
22 but they said they needed some commercial support so
23 I was sent along to that meeting.
24 **Q.** And was it only you at that point?
25 **A.** It was only me.

1 **Q.** That meeting was on 18 March, as you've said. What was
2 the substance of that meeting?
3 **A.** So it was a mixture of -- so Lord Bethell was there, who
4 was the Minister of Innovation at the time, and a number
5 of colleagues from the Office for Life Sciences. There
6 was also Professor Sir John Bell and there was couple of
7 suppliers, as well, who operate in PCR, which is
8 polymerase chain reaction, we'll come on to that later.
9 So that was Randox and Thermo Fisher, but that was
10 generally the make-up of the individuals in that room.
11 And the crux of the conversation was that we were in
12 really dire straits. We had really limited capacity of
13 PCR testing which is the standard test, diagnostic test
14 for viruses. The capacity, I think across the whole of
15 the NHS and PHE, so Public Health England, was really
16 about 3,000 tests per day. And I remember
17 Professor Bell had said we need to get to the hundreds
18 of thousands, we need to get to 100,000, and we need to
19 do it really quickly. In days, he said, we need to get
20 capacity set up.
21 So that was kind of the main focus of the meeting of
22 that day.
23 **Q.** It might be helpful to look at INQ000535738.
24 This is an email dated 18 March. I believe this was
25 sent directly following the meeting that you're

1 referring to.
2 **A.** Yes. So this was almost a bit of a readout of that
3 meeting that we'd had.
4 There's another document which I think is in the
5 exhibits. There was a meeting the day before on the
6 17th, before I joined, I know Professor Bell was at that
7 and a few other of the colleagues who were at this
8 meeting.
9 **Q.** We will come to that document as well.
10 **A.** You will come to that, okay. Yes, this was the readout
11 and it basically explained the work strands who was
12 responsible for each area.
13 **Q.** That's great. And can we zoom out again on that email,
14 and we can just see down the middle column of that table
15 some of the attendees. Some of the people involved in
16 the implementation of what was agreed that day,
17 including, as you say, representations from industry and
18 also experts in that area.
19 **A.** Can I just say they weren't all in that meeting as well.
20 So some of them were -- so Qiagen, for example, weren't
21 in the meeting, Jeremy Farrar wasn't in the meeting. So
22 not everyone was in that specific meeting that I joined,
23 but there was sort of assigned actions after that.
24 **Q.** Mm-hm.
25 And if we go on to the next page of that e-mail.

1 Thank you.
2 I see you're down to lead on the commercial aspects.
3 **A.** Yeah.
4 **Q.** And as you've said, it was only you at that point.
5 **A.** Yes.
6 **Q.** At what point were you able to bring other people onto
7 the commercial aspect of the testing programme?
8 **A.** The next day. I brought some more people in from the
9 Complex Transactions Team.
10 **Q.** Was there any pre-existing commercial capacity that you
11 could draw on?
12 **A.** So DHSC did have a small commercial team, but DHSC is
13 more of a policy function, the commercial policy
14 function, so any procurements they did tended to be more
15 around the lines of specialist kind of technical
16 expertise or policy expertise. So they weren't used to
17 procuring. They didn't need to procure on a large
18 scale, so they didn't really have much of a team. So
19 that's why we had to bring people in from Complex
20 Transactions, and we broadened that out to other
21 government departments. But they were all people from
22 Government Commercial Function, but there were some
23 individuals in the commercial team who we worked with
24 quite closely, so started off with Ed James, but then he
25 moved into PPE, and then Lucy Mason, who was also

1 a deputy director under DHSC, she also formed part of
2 our team as well.
3 Q. What about PHE, they were the organisation within
4 government --
5 A. Yes.
6 Q. -- who was responsible for protecting the public from
7 infectious disease. What kind of commercial capability
8 did they have at that point?
9 A. So they did have a commercial team. I engaged --
10 I don't know if I'm allowed to name, but there was an
11 individual there who headed up a team. He joined as
12 part of our team. And he had a team of individuals
13 who'd set up the PHE Microbiology Framework, so he sort
14 of joined us -- when I, sort of, pulled the team
15 together, he sort of became part of it. And I supported
16 him in going out for a new framework as well, because we
17 knew the one that we had, it wasn't substantial enough
18 to be able to fulfil the procurements that we needed to
19 do.
20 Q. But that existing commercial capacity within PHE by
21 itself wouldn't have been sufficient to --
22 A. No, it was very small, and, you know, they had the
23 framework, but I don't think they -- you know, they had
24 quite a small capacity, so I don't think they could have
25 really done much more than they were already doing.

1 Q. Just to understand a bit more about the context in which
2 you were operating when you first got involved 18 March.
3 You've said in your witness statement that there were
4 certain aspects of the nature of the testing that made
5 it difficult to scale. So we're talking specifically
6 about PCR tests at this point. What were those
7 characteristics?
8 A. So, you know, I don't know if you've, sort of, ever been
9 a laboratory, but my PhD was a lab-based PhD, so I was
10 in a laboratory for three years. I also spent time in
11 GSK's laboratory during my PhD. You know, a lot of --
12 you know, we're talking specifically about PCR. It's
13 used in universities, NHS laboratories. It's a machine.
14 It has to -- you know, you need a qualified, skilled
15 professional to operate the machines.
16 One test could have a bill of materials of around
17 50 items, so if you don't have all 50 of those items you
18 can't run a test.
19 So when we talk about LFTs, so lateral flow tests,
20 and PCR tests, they're so different because, you know,
21 the process involved, it's someone in a laboratory
22 pipetting things into a dish and then putting it in
23 a machine and -- you know, we've moved on a bit from
24 them, as we scaled it up, but actually scaling up things
25 like that is really challenging, because you've got to

1 have the right personnel. All those -- every last item
2 you need to make that test happen, and then you've got
3 the, sort of, front end element, as well, of collecting
4 samples, getting it to the laboratory, and there's
5 a timeframe that you have to get it there otherwise it
6 degrades and it -- you won't be able to test the sample.
7 So it was a real sort of long, complex process, and
8 it was never designed to be scaled up to the hundreds of
9 thousands. And that's what made it really challenging,
10 as well. As well as the global demand and the global
11 shortage in requiring all those different products.
12 Q. And it's helpful to have that insight into some of the
13 logistical challenges in terms of transport of samples,
14 but as well with the supplies, the reagents, the
15 consumables that are required for each test, were some
16 of those -- were they generic or were they brand
17 specific? Were they required for other healthcare
18 consumables during the pandemic? How was that affected?
19 A. So it's a really good question. So a lot of the
20 systems, so the PCR platforms we were using were closed
21 platforms. And this is quite common in the health
22 sector. So I used to buy for BUPA as well as NHS
23 organisations, so I've bought quite a lot in that sector
24 as a procurement professional and we'd done the same in
25 PCR in that a lot of the solutions were closed platforms

1 and what that means is you've got a machine, you can
2 only use the branded consumables designed for that
3 machine. You can't just use an alternative generic
4 option.
5 And that made it very difficult for us, because we
6 were so reliant on such a small number of platforms and
7 these were all global, large global suppliers where
8 everyone in the world was wanting the same thing. And
9 even though we had arrangements with them, and we asked
10 for more volume, most of them said, "Well, we are
11 looking globally and we will give volume allocated by
12 population across a whole customer base."
13 So we had platforms in the NHS where we had the
14 platform but we could not get the reagents to operate
15 that equipment. So that was a real challenge and that's
16 one of the reasons we couldn't -- we were very limited
17 in the NHS network to be able to build the capacity
18 beyond a certain point.
19 Q. And is that something you were able to influence going
20 forward as testing technology developed in terms of
21 procurement?
22 A. So this is one of the reasons why we've tried to
23 diversify, as well, in some of the different
24 providers -- I'm talking very specifically about PCR at
25 the moment rather than alternative testing technologies,

1 but, for example, later on we brought on Perkin Elmer
2 which had been a very low volume PCR provider, and not
3 one we were really using. So -- because we were
4 careful, as well, we didn't want to sort of take volume
5 where it was maybe needed elsewhere, because when we had
6 the NHS labs and the Lighthouse labs we didn't want to
7 cannibalise the supply so that's when we were trying to
8 diversify the different PCR platforms that we were
9 using.
10 **Q.** Thank you. I want to get on to the use of Lighthouse
11 labs now, actually, and you've mentioned the meeting
12 that took place before the meeting you attended on the
13 18th, on the 17th. I just want get up the document that
14 was produced at that meeting.
15 It's INQ000055915 and page 1.
16 This says that it's the output from the Downing
17 Street testing workshop. You weren't at this meeting;
18 is that right?
19 **A.** Yes, I wasn't there.
20 **Q.** Do you know who was? Who produced this document?
21 **A.** I think Lord Bethell was there. I think
22 Professor John Bell was there. I think Kristen McLeod
23 was there as well. I'm not sure who else. Maybe
24 Kathy Hall, but I'm not certain, because obviously
25 I wasn't -- I wasn't there. But I did receive this

1 readout when I joined on the 18th.
2 **Q.** And we can see the initial target there has been set as
3 increasing the NHS lab-based testing capacity, that's
4 existing capacity --
5 **A.** Yes.
6 **Q.** -- within the NHS from 5,000 a day to 25,000 per day.
7 And on the next page we see the other prongs of the
8 four-pronged approach:
9 "Urgent and specific antigen testing for protecting
10 frontline staff and maximising our workforce.
11 "...
12 "Mass-market testing for ordinary people using
13 pregnancy-test-style pinprick blood tests."
14 And:
15 "Extend our national mass population surveillance."
16 I'm not going to address surveillance testing with
17 you today. You've set out in your witness statement
18 that that's not something you were particularly involved
19 in. But I do want to specifically address the scaling
20 up of mass testing, because that was the key aspect of
21 what was happening in the period of time when you were
22 involved.
23 You describe in your witness statement that there
24 were five pillars that grew out of those workstreams
25 that we've just looked at. And I want to get another

1 document up which is INQ000535762, page 1, and just
2 paragraph 1 there sets out a very quick summary of those
3 five pillars.
4 **A.** Yes.
5 **Q.** You've already explained Pillar 1 to us in terms of the
6 existing capacity, and what you say in your witness
7 statement about that pillar is that it was clear within
8 days that Pillar 2, ie, the creation of new testing
9 facilities, was how the demand for capacity was going to
10 be fulfilled. Why do you say that?
11 **A.** So I didn't actually fully answer your first point, but
12 it comes back to the NHS, so even though the theoretical
13 capacity was around 5,000, they were actually doing more
14 like 2,000, 3,000 tests a day, and that included PHE, as
15 well. You've got, I think it's about 185 laboratories,
16 so distributed across the UK. You have the, I think
17 the -- so if I think of the sort of NHS England, so
18 you've got 185, and they're broken down into 29 regions
19 but they're quite disparate and operating in isolation.
20 And as you mentioned earlier, were they testing for
21 other things? They were using PCR to test other
22 diseases. So that capacity, whatever they had in the
23 laboratories wasn't just -- they couldn't just
24 ring-fence that only for Covid. We did, we did actually
25 switch some testing to Covid to increase capacity which

1 I can come on to later, but we knew that with a network
2 of that many laboratories, to really scale up without
3 putting pressure on the NHS, it was just not going to be
4 feasible and also because of their platforms that they
5 had, were quite restrictive, for all the reasons I've
6 just mentioned, we needed new capacity. We needed
7 additional machines. We needed additional personnel and
8 additional supplies, and we could only do that in new
9 laboratories because they've got a footprint in the NHS
10 labs that you couldn't just extend, because they're in
11 hospitals, the pathology labs based in hospitals.
12 **Q.** So I want to go to INQ000561740.
13 This is a slide deck from -- which is entitled
14 "Workstream 2", which is the precursor to Pillar 2.
15 **A.** Yeah.
16 **Q.** "Commercial Overview". And this from the middle of
17 April, so this is a month later, but it gives us an
18 insight into what was required for this scaling up of
19 testing through the private sector.
20 We can see, on the right-hand side there, the kind
21 of things you were procuring, and it's not just
22 consumables, it's not just testing, and it's also not
23 just labs, because you are procuring physical testing
24 sites, which many of us have been to ourselves in the
25 course of the pandemic, and you're also procuring a huge

1 logistics operation. You've explained some of the
2 complexity of that.
3 We can see some of the organisations involved named
4 on this, and were these organisations -- how were they
5 brought into the system?
6 A. So in the, you know, very early days we were talking to
7 as many organisations as possible who had capability.
8 And I think it's probably different to maybe some of the
9 other areas, like PPE, where actually most of the
10 organisations we dealt with were well established
11 organisations, because when you're delivering solutions
12 like PCR and the reagents there's a lot of controls and
13 quality controls and a lot of investment in producing
14 these kind of consumables and reagents.
15 We -- you know, Randox, Thermo Fisher, a lot of
16 these organisations were already either on for -- their
17 frameworks -- not necessarily that we could always use
18 them, which I'm sure you'll come on to later, but we had
19 sort of the PHE Microbiology Framework, we had the
20 suppliers who we knew were already working in the NHS.
21 So Thermo Fisher was well established. Amazon is
22 obviously a huge logistics provider. There was a number
23 of organisations who had just said, "What can we do to
24 help?"
25 Randox had a lab that was already up and running.

1 It was quite small scale but actually they had an
2 accredited process for running Covid testing, so, you
3 know -- and the first Lighthouse lab, UK Biocentre,
4 happened to be a lab, a working lab that was basically
5 about to close because it couldn't sustain funding --
6 Q. Could you just explain what you mean by Lighthouse lab?
7 A. Sorry. So I'm not really sure why we call them
8 Lighthouse labs, to be honest, I can't remember, but it
9 was deemed as a sort of a lab that would be high
10 throughput, outside of the NHS system, run by the
11 commercial sector, to deliver a sort of -- to increase
12 the capacity.
13 So the first one was in Milton Keynes, and it was
14 the UK Biocentre, and it was John Bell who knew that
15 that lab was operating, but about to not operate any
16 more, and -- (overspeaking) --
17 Q. And is that shown on the slide, Milton Keynes --
18 A. Um, yes. So it was the very first one in, sort of,
19 Manchester, and Scotland came soon after.
20 So, yes, they were basically set up so that was
21 already operating. So it was quite serendipitous that
22 it was about to close but it had staff, and they had PCR
23 machines, and that's why that was the first lab.
24 And, you know, I was involved in negotiation,
25 Tim Byford who was one of my colleagues, I got him to

1 lead on this workstream.
2 So my job was more overarching, looking across all
3 of the workstreams, so oversight of all of the
4 commercial procurements we did, and then I put
5 colleagues in each of the workstreams.
6 But yes, that's how we sort of engaged with
7 Thermo Fisher. Amazon I think had volunteered to offer
8 some logistic support. They said they didn't want to do
9 it long term but they had an infrastructure already in
10 place, but a lot of these names changed quite soon
11 after, as we sort of put new contracts in place.
12 Q. Yes, thank you.
13 So we can take that one down now but could we have
14 back our summary of the five pillars at INQ000535762.
15 And paragraph 1. Thank you.
16 We've looked at paragraph 1 -- at Pillar 1. We've
17 looked at Pillar 2. Pillar 3 I just want to touch on
18 briefly:
19 "Development of antibody tests that can be proven to
20 work."
21 Are we led to believe, by this, that at this point
22 there were not antibody tests that could be proven to
23 work?
24 A. So in parallel, we had been buying antibody tests,
25 which -- very early on in the pandemic there was a view

1 that if people had antibodies, it might mean they'd been
2 exposed to it and it gives them some immunity. We --
3 the scientific view quite not long after was that it
4 actually probably wasn't going to help us that much, but
5 at the time it was seen as a way of testing people,
6 seeing if they had immunity, and that might mean people
7 can go to work.
8 We had bought a significant number of antibody
9 tests, most of them, once -- when we tried to validate
10 them, they weren't suitable. So that's --
11 Q. So you had bought them prior to them being validated?
12 A. Yes, we had to take -- we took that sort of high-risk
13 decision, and this was very early. This was probably
14 the first few days I was there, and it was the Secretary
15 of State. I was in a meeting with him and others. We'd
16 have these sort of daily updates, we were still in the
17 office at that time so not working from home. And other
18 nations were buying up all these tests, most of them
19 came from China. They wouldn't actually send us samples
20 so we couldn't pre-validate because they were just
21 saying, "We're so busy we're not sending you samples".
22 So we were authorised to spend up to £100 million on
23 these tests.
24 Pam Doyle, who's another colleague of mine, led this
25 workstream. We bought a lot of the tests, we tested

1 them, they weren't validated, and we recouped most of
2 the costs. We kept a small amount for the surveillance
3 studies but most of them we just -- we cancelled the
4 contracts and we didn't take up the orders for those.
5 And that's why, at this point, it was we need one
6 that's proven to work, so you'll see my evidence, that's
7 when we went into the development of a test of our own
8 with a consortia called Abingdon Health.
9 Q. Thank you. I've already mentioned that we're not going
10 to cover surveillance testing in detail, but we will
11 look at Pillar 5, which is set out here as "Building
12 a British diagnostics industry at scale."
13 This document is from April, and it is explaining
14 the launch of Pillar 5, this national diagnostics
15 effort. Why was that seen as necessary at that point?
16 A. Because we had so many limitations on suppliers. As
17 I've pointed out, a lot of the closed platforms we had,
18 we just couldn't get any more supplies, so that
19 effectively makes them redundant.
20 We had looked into seeing if we could open up the
21 platforms and get -- obtain approval from organisations
22 to try more generic reagents to see if they'd work with
23 them, but that didn't really go anywhere. So what we
24 used this for was to one, understand if there was other
25 suppliers out there, who could supply different PCR

1 platforms or the reagents and consumables that go with
2 them. So coming to my point earlier, it wasn't just
3 sort of what you needed in the laboratories, we were
4 really short on swabs, so you probably remember the
5 swabs you used to put up your nose or in your throat at
6 the time. You had viral transfer media, you had the
7 test tubes that you put the viral transfer media in, and
8 then the swab. So there was a lot of things where we
9 had shortages of, and if there's a break in that chain,
10 if any of those things are missing, you cannot run
11 a test. You could have a full lab working but if you
12 don't have the swabs to collect the samples then you
13 can't run tests. So we used it to sort of open up to
14 the life sciences industry.
15 So I think that first call we had, which I joined
16 Lord Bethell and the Secretary of State, and I sort of
17 listed the key areas where we had real shortages, and it
18 was to basically ask the life science industry: does
19 anyone have capability and capacity to provide these
20 products, these items?
21 I would add, as well, that there was a lot of
22 goodwill, as well. We had GSK and AstraZeneca opened up
23 their supply chains, so they put us in touch with their
24 own supply chains, and, you know, so gave us -- we
25 gained a lot of contacts through that route, as well.

1 But yeah, we also knew we needed more, and also we
2 were interested in potential alternative testing
3 solutions.
4 Q. So you've mentioned some aspects of this already, but in
5 terms of your engagement with experts and industry in
6 the life sciences sector, how did you go about doing
7 that in mid-April 2020?
8 A. So we had -- so we did the callout, so I think that
9 first session where there was 500, it was prior --
10 Q. It was at the industry webinar on 8 April?
11 A. Yes, so prior to that what we used was -- what was
12 actually very helpful. So we had a few frameworks.
13 There was some of the NHS frameworks and the PHE
14 Microbiology Framework and what they were really useful
15 for is actually telling us which suppliers were
16 operating in this market. So I don't know if you'll
17 come on to frameworks, there was a challenge using that
18 framework unfortunately because of the regulation we
19 were operating under. But what it was helpful is, you
20 know, a lot of the suppliers were on that framework, and
21 even though we couldn't necessarily use the framework
22 always to award contracts, we knew who the main, main
23 suppliers were in this sector.
24 Q. So that's a proactive approach by you?
25 A. Yeah, that's what we did, so we contact, you know, we

1 contacted them, and understood what -- what capacity
2 they had. Some of them had other solutions they were
3 developing, as well, so that really opened up our
4 conversations.
5 So myself and my team, we were really proactive in
6 talking to those suppliers, and that's why actually some
7 of the solutions were introduced because of those quite
8 proactive conversations of having that sort of really
9 positive starting point of these frameworks that we
10 could refer to.
11 Q. And then did suppliers also approach you?
12 A. So there was -- so I think there were some legacy
13 inboxes where there was kind of offers coming through to
14 I think to DHSC. Also BEIS, they were sometimes
15 referring. You know, people did start contacting me,
16 although we had a sort of mailbox, people did contact me
17 directly after we did that webinar as well.
18 So yes, people did contact me and my colleagues
19 directly.
20 Q. Can we have up INQ000551339 at page 7. Thank you.
21 This is a WhatsApp chain which I know you've seen,
22 but you weren't on at the time, and that's been provided
23 to the Inquiry.
24 It's a WhatsApp group entitled "HSE support group",
25 and this is a message from James Bethell sent on

1 17 April, and the WhatsApp chain involves a variety of
2 people including other senior politicians, MPs, and some
3 civil servants.
4 He references here the kind of call to arms that
5 you've described, where this call to British industry
6 has been put out. He says:
7 "We have received 5,000 enquiries in the last two
8 weeks from companies. We have a huge team ... We have
9 engaged ... many ...
10 "But many companies are offering tests which are not
11 relevant for our battle plan."
12 And he links the battle plan there. That might be
13 a typo but these says many of them:
14 "... do not meet our standards. I appreciate many
15 are frustrated, but we do have high standards and it is
16 reasonable to apply these to protect the ... people."
17 He gives some more details of that and then says at
18 the bottom:
19 "This is a difficult message to deliver. We are not
20 closed to new ideas but we are drowning in helpful
21 suggestions while at the same time being very focused
22 about delivering some very tough deliverables. If there
23 are any standout companies that you really think we're
24 missing, do please email me ... and I have a fast track
25 process. But also please be aware there might be strong

1 clinical or practical reasons why we cannot take up
2 every offer for help."
3 First of all, we've heard in this Inquiry already
4 about other calls to arms in relation to PPE and
5 ventilators, and the impact that that has had on
6 procurement teams, in terms of having a huge number of
7 offers to deal with.
8 He says here that "We are drowning in helpful
9 suggestions". Was that your experience at the time?
10 A. Yes, yes, I would say so. So what I would say is, so
11 BSA, the Business Services Authority for the NHS, so
12 they were handling a lot of the sort of inbounds, and
13 there was a webform that people could fill in, which
14 I think we publicized on that, that call to arms event
15 we had. But it was a really challenging period and
16 I would like to give a bit of context here, as well. So
17 you've heard how in the PPE Cell there was 500 buyers,
18 between March and August there was 25 to 30 of us at any
19 one time doing all the commercial work, and, you know,
20 it was unsustainable and really difficult long hours.
21 I was in there for nine months working those kind of
22 hours, and it was great that people were coming forward,
23 but I think the challenge we had is it is so technical
24 and there's a, you know, it's not like it's a product
25 that if it's got a stamp you can use it. It has to be

1 technically compatible with the platforms we have.
2 You have to have every single item for it to
3 function, you know, you need the RNA extraction
4 reagents, you need the PCR agents, you need the pipette
5 tips. So we were getting inundated with a lot of things
6 that we just didn't need or they weren't suitable.
7 I think we had a really good process, we had a lot of
8 technical people, so we had the Technical Advisory Group
9 and the Viral Test Advisory Group, and I sat on that as
10 well. But I think we were, sort of, very robust but
11 when we were having this kind of volume coming true, it
12 was difficult.
13 Sometimes it was coming to our inboxes as well.
14 I think I was averaging 200 emails a day. I didn't have
15 any support with my inbox until the autumn of 2020. So
16 yeah, there was a huge volume. So we became a lot more
17 targeted. So we would say we are only interested in RNA
18 extraction, or we're only interested in antibody LFTs,
19 and then we started to -- that's how we would then
20 prioritise what we were looking for, where the shortages
21 were, and we'd -- we wouldn't necessarily always discard
22 something forever, but there was no point looking at
23 swabs, for example, if we'd secured enough swabs.
24 So that's kind of what we needed to do, but it was
25 hard.

1 Q. And did that adapted approach of putting out perhaps
2 more specific calls to arms about, say, we only want RNA
3 extraction at the moment, did that produce more useful
4 results and fewer of these overwhelming amounts of
5 offers?
6 A. I think it did help but even on that first call to arms
7 on the 8th, I think it might be in my exhibits, even on
8 that one I did actually specifically say where we wanted
9 support. So I think there was maybe four key areas
10 that I said, you know, "These are the items we need,
11 this is what we're looking for."
12 Q. Ultimately do you think that call to arms was a good
13 idea?
14 A. I do, actually, because I don't think we were engaged
15 enough with the life science industry, and where we were
16 already engaging with suppliers who we'd sort of
17 proactively contacted through the frameworks, you know,
18 where -- you know, those we knew were operating in this
19 sector, I think it was really important because some --
20 some suppliers might not have had something we needed
21 right then, but a lot of -- we'll probably come on to
22 it, with the sort of different technologies that were
23 being developed, it actually gave us an opportunity to
24 talk to suppliers who were working on things that were
25 quite innovative and different.

1 Q. So perhaps if you'd already had those industry contacts
2 and been in a better position in terms of your contact
3 with industry more widely, you wouldn't have needed to
4 do that call to arms and would have been able to make
5 more -- (overspeaking) --
6 A. Potentially and I know that Professor John Bell said in
7 his statement -- so obviously he's a scientist and he's
8 engaged a lot with industry, you know, he said that
9 there's just not enough of that openness and, you know,
10 we need to be connected to particularly our domestic
11 life science industry. We'd, sort of -- a lot of the
12 supplies we were using -- were mainly based in the USA,
13 and that was problematic as well because of the US
14 Defense Act. That did impact us. We were over-reliant
15 on, you know, consumables and products from China first
16 of all.
17 So actually, part of the life sciences strategy he
18 was working on was really looking at our domestic sector
19 and I don't think we were close enough to it and we
20 didn't have enough insight into what was available.
21 Q. Thank you.
22 One more point on this message from Lord Bethell.
23 He mentions that:
24 "If there are any stand-out companies that you
25 really think we're missing, do please email me [gives

1 out his email address] and I have a fast-track process."
2 Do you recognise the "fast-track process" he
3 describes there.
4 A. We didn't have a fast track process. What we had was
5 we've have, like, a consolidated database which we would
6 triage from, and we would fast track something if it was
7 one of our priorities. We wouldn't fast track it
8 because it came from a certain individual; we'd fast
9 track it if it was something that we needed. And if it
10 wasn't, then we wouldn't.
11 So it was -- anything that was prioritised was
12 purely based on technical need or, you know, if we had
13 a shortage of something and it offered an alternative.
14 Q. If something had come into the process through a contact
15 who was a senior member of government or another
16 politician, would it have been marked in any way
17 "fast track", "priority"?
18 A. It wasn't marked "fast track" or "priority". We did
19 mark them because, similar to the PPE Cell, it was
20 a distraction. We had loads of referrals from all
21 across government. And not just the current government
22 but other MPs -- (overspeaking) --
23 Q. Sorry, how would you mark them?
24 A. We'd mark it as to who it came from, so that we could
25 feed back. And we only did that -- we did it for

1 a short period, but, again, there was a time where we
2 were getting chased to feed back and it was just
3 distracting and we were so busy, we were working like
4 18 hours a day and trying to secure supplies to get to
5 100,000 in six weeks, and it was just distracting.
6 What I would say is that most of the chasing wasn't
7 actually coming from the referrer in our case; it was
8 coming from the supplier. And it was almost like
9 sometimes the supplier who had been referred felt that
10 they should be prioritised because they felt that they
11 had a connection, and -- whereas actually, I think,
12 a lot of the time it was just -- it was referred and the
13 referrer wasn't chasing us as much as the supplier was.
14 But either way it was just distracting.
15 So we would mark it and then if they didn't pass
16 validation we could then just inform them and say, "This
17 hasn't gone anywhere", and we tried to sort of
18 proactively manage it in that way.
19 Q. And would you proactively inform a supplier that they
20 hadn't passed validation if they can't come in via a --
21 A. Yeah, we would just do it anyway. So we had -- I think
22 there's quite a few exhibits where we've got
23 a spreadsheet. We had those where we would progress,
24 some we would hold and some we would reject, and of --
25 and we'd have a reason for why they were rejected.

1 Q. Thank you. We can have that off the screen now.
2 I'd like to consider more generally the effect of
3 the policy announcements and public announcements in
4 particular on NHS Test and Trace procurement decisions
5 and the involvement of ministers in those procurement
6 decisions.
7 You've already told us that when you were brought
8 on, on 18 March, the NHS's existing capacity was maybe
9 said to be about 5,000, but in reality was about 2,000,
10 3,000.
11 In the email we looked at earlier, it said that the
12 initial target was about 100,000 tests per day by the
13 end of April. Do you know how that target came about?
14 A. So I think on that document you showed earlier, from the
15 meeting on the 17th, it actually says 100,000. So it
16 was already decided early on.
17 I think, from what I recall, I don't know if it was
18 say -- I think it might have come from SAGE, which is
19 sort of the Scientific Advisory Group for Emergencies,
20 I think they had done some sort of calculation as to if
21 you were making sure that you had enough capacity to
22 test people with symptoms, frontline staff in hospitals,
23 and other key workers, you would need 100,000 tests per
24 day. I think that's sort of where that target came
25 from.

1 Q. So that's based on a calculation of how many people
2 might potentially get Covid and therefore need tests --
3 A. And infection rate -- yeah. I think -- at that early
4 stage, obviously.
5 Q. Yes. And you've also said that at that point you'd only
6 just been brought in, so does it follow that there was
7 no commercial involvement in the setting of that target?
8 A. Yes, there was no commercial involvement.
9 Q. So are you aware that in the setting of that target
10 anyone did any kind of checks into how feasible it would
11 be to procure the tests necessary, or the testing
12 capacity necessary to carry out that number of tests?
13 A. I doubt there would have been any feasibility done.
14 Q. And when you were brought on and told, "This is the
15 target and this is the deadline", did you feel it was
16 a feasible target that you were going to be able
17 to meet?
18 A. I mean, I'm an optimistic person but I'll be honest,
19 kind of knowing how PCR works, I was a bit ... I wasn't
20 sure we would be able to do it, in all honesty. It felt
21 like a huge task, and it was, because it was taking it
22 to a whole different scale than we were used to, but
23 also, if you think about how it normally happens, people
24 are in hospital, they're in the hospital, they take
25 their sample, it gets sent to the lab in -- it was

1 changing that whole dynamic. It was collecting samples
2 from people all over the UK from hundreds of test
3 centres, then the logistics of sending that to labs and
4 directing it to where there was capacity.
5 And I think this is why -- I think I mentioned in my
6 statement, I think by the end of April there was 20,000
7 people working in test and trace. Now, obviously, most
8 of them were -- they were in the laboratories and
9 logistics and the test centres and, you know, where we
10 all went to, and got our swabs. But to stand that up in
11 six weeks was quite incredible, really. But in -- early
12 on, I wasn't sure how we were going to do it because we
13 just couldn't even get some of the most basic things.
14 Q. You say in your witness statement that from about July
15 of 2020 your experience was that Number 10 in particular
16 got more and more involved in decisions about testing,
17 and that sometimes this would lead to contradictory
18 decision making as between NHS Test and Trace and
19 Number 10. Can you give us an example of what you mean
20 by that?
21 A. So just to give some context, as well. So from the very
22 beginning, I had contact with Number 10. I worked quite
23 closely with Will Warr and James Phillips, who are both
24 special advisers, and Will Warr had convened those daily
25 calls from the 18th. So there had always been

1 engagement. I think the reason they sort of intervened
2 more from July onwards was because it was relating to
3 sort of the mass testing.
4 I think where it got a bit challenging at times was
5 obviously Baroness Harding came in late May to set up
6 and establish NHS Test and Trace. You know, at that
7 point we weren't, you know, I'd just started the pilots
8 for asymptomatic testing, so mass testing wasn't really
9 even on the radar at that point. But I think what
10 became challenging was there was a strong view on the
11 back of the asymptomatic testing pilots that I'd sort of
12 led on with LAMP, and we started getting more insight of
13 what other countries were doing. I think that's where
14 Number 10 at that point wanted to go for a real sort of
15 nationwide mass testing approach, which was kind of at
16 odds with the approach that we were, you know, the
17 direction we were moving in, in test and trace, if you
18 like. We'd sort of been focusing at that point on
19 winter capacity and building up capacity for another
20 wave.
21 So I think that's where they intervened.
22 You'll see from the sort of, the large purchase of
23 lateral flow tests that we did later on, which I think
24 is in one of the exhibits --
25 Q. Yes, perhaps it's helpful to have a look at that,

1 actually.
2 Can we have up INQ000561757. Thank you. If we can
3 just have the next page, and actually the last page of
4 this document.
5 So we have here an email, this is from
6 2 October 2020, this is from James Phillips who we can
7 see has a Number 10 email address, and I think you say
8 in your witness statement that he was an adviser,
9 a special adviser in Number 10.
10 He says that he is:
11 "... very concerned to hear that we have been
12 leaving lateral flow tests unbought whilst we wait to
13 identify the right amounts for each test."
14 He says that the stakes are very high.
15 "For tests that look half decent at Porton Down ..."
16 Which is where you carry out validation of tests, as
17 I understand it.
18 A. Yes.
19 Q. "... we should buy maximum as soon as possible -- any
20 unnecessary delays longer than 3 hours phone me ... any
21 hour of the day and I will give it my full attention ...
22 "Maybe we have misunderstood but it's just worth
23 restating the risk appetite."
24 He also goes on to say that:
25 "America set the precedent by buying literally all

1 the Abbott tests so people can't complain."
2 And he also references further down that:
3 "... the tests referred to are the very ones that
4 the global ACT alliance just bought en masse ..."
5 So is it right to say that at that point there was
6 a huge amount of concern from Number 10 that if we
7 didn't buy tests --
8 A. Yes.
9 Q. -- they would be bought and there wouldn't be any left
10 for the UK.
11 If we can just go up one page, and here we have
12 a reply to that email from Dominic Cummings. I think
13 we're all aware of what his role was in Number 10. And
14 he says:
15 "Agree -- buy buy buy.
16 "I cannot begin to describe the PM's reaction if we
17 miss the chance to buy 200 [million] of these things
18 [because] we're thinking about what to do with them,
19 waiting for CST to sign a letter, et cetera.
20 "I'd like the deal done by [close of play] today and
21 planes in the air ASAP to collect ..."
22 In that second sentence, where he says, "We're
23 waiting -- thinking about what to do with them, waiting
24 for CST to sign a letter", do you think that's a fair
25 description of what the commercial team were doing at

1 the time, or the reasons for the hesitancy?
2 A. So, and I do need to give a little bit of context here.
3 So this comes across as very dramatic, in some ways, and
4 it was. And it was a Friday and I remember it very
5 well. But the first thinking around sort of mass
6 testing actually, it was the end of April when we first
7 got a sort of proposal in, and then -- so there'd been
8 work looking at sort of asymptomatic testing and mass
9 testing in the sort of months beyond that.
10 I worked closely with Will Warr and James Phillips
11 who are both special advisers, worked closely with
12 Dominic Cummings. We were already looking at making
13 a significant purchase of these lateral flow tests. We
14 had already bought 40 million, we were doing further
15 validation at Porton Down and we were probably a week
16 away from buying a more significant volume.
17 Q. I think you say in your statement 180 million?
18 A. Yes, and so -- and actually, this was on the back of --
19 there was a weekly meeting, I didn't attend this
20 meeting -- there was a weekly meeting to talk about this
21 and after the meeting had finished James Phillips had
22 called me to say, "I'm going to send you an email, we
23 need to buy sooner."
24 And that's --
25 Q. Was that the email that we just --

1 A. Yes, so that's what started. I do want to bring out
2 something that is quite important, and I bring this out
3 quite a lot in the statement, you know, we were
4 already -- I had two individuals negotiating with the
5 suppliers. So we'd paid for 40 million and we wanted to
6 buy more and we were trying to reduce the costs. So
7 I do think this was the right decision to buy these
8 tests and we needed to buy them quickly, especially
9 as -- I think the WHO were about to announce that it was
10 a valid form of testing, so that would have immediately
11 sent a global market sort of frenzy for them.
12 But I think what was really challenging was that we
13 can't just spend over a billion pounds in a day. You
14 know, you can't just write a cheque and get aeroplanes
15 in the sky at the end of the day. I'm the only civil
16 servant on this email thread apart from Simon Case, who
17 never got involved in the conversation. And, you know,
18 actually we did push back and say you're right, we do
19 need to buy these, but I needed to do a business case,
20 I needed to do a ministerial submission, and I did it
21 all in one day with the support of my team, and we
22 concluded negotiations on this over the weekend, which
23 saved £700 million. There's not been a lot of
24 discussion around, actually, our interventions and
25 actually where we did deliver value, often pushing back

1 at Number 10 and other senior individuals, but this was
2 a real challenge for our commercial team, including
3 myself, around the pressure we were under, but we still
4 would push back and do the right thing.
5 So I think this was the right decision to make, but
6 often you would be on these threads and we'd get these
7 direct instructions, and it just, you know, it just
8 became, you know, cramming everything that you would
9 normally do in months and years into literally one
10 weekend.
11 Q. Thank you. I want to look at another example that you
12 reference in your statement.
13 This is INQ000561737, and page 6.
14 So, at the bottom, we have an email dated
15 9 April 2020 from Lord Feldman. He says:
16 "... slightly irate Gordon on the phone. He had
17 a meeting with Bev."
18 We assume that's you.
19 A. That's me.
20 Q. "Essentially, he says he has now sourced both test kits
21 and extraction kits ..."
22 If you can just go down. Thank you.
23 "I believe his tests work across a range of open PCR
24 machines ...
25 "He can deliver ..."

1 Lord Feldman won't comment on price.
2 "I think important not to leave Gordon hanging after
3 the work he has done. The gift of 100k units arrives
4 tomorrow."
5 And he ends:
6 "We should try to get this done if we can."
7 Just so we can understand this email, who is Gordon
8 and what deal does this relate to?
9 **A.** So Gordon is the CEO of Oxford Nanopore, and they had
10 proposed to supply BGI-branded -- so BGI is
11 a manufacturer in China -- of PCR test kits. So these
12 are for processing in the laboratory. And they had
13 proposed to sell us 3 million, at a price, with 100,000
14 on top gifted. Which, you know, I -- you know, I had
15 concerns about this deal for a number of reasons, but
16 part of their offer was "You buy 3 million, we give you
17 100,000 units."
18 **Q.** You buy some and you get some free?
19 **A.** Yeah, which is ... yeah, kind of --
20 **Q.** It's not a usual thing you encounter in public
21 procurement?
22 **A.** Yeah, so it was known as a gift. We're not comfortable
23 with gifts, but that was what the offer was. I had
24 a number of problems with this --
25 **Q.** Can we just look at the rest of the email and we'll get

1 to those.
2 **A.** Yes, certainly.
3 **Q.** Can we go up one page -- sorry, another page. Thank
4 you.
5 We can't see who this email is from but it's from
6 someone within NHS. They confirm some details about the
7 tests, but they also say that they don't think that
8 there has been an unacceptable delay.
9 Then they say:
10 "Based on discussions with Bev and the NHS labs, we
11 propose on asking for [so many] tests a month ... and
12 not haggling on price."
13 And you mention the use of that word "haggling" in
14 your witness statement. Can you explain some of your
15 response to that word?
16 **A.** I think it's a really dismissive term to use when we
17 were just trying to responsibly spend public money. But
18 I was coming under a lot of pressure not to challenge
19 the price, and I thought the price was inappropriate,
20 even in the current market of significant supply and
21 demand issues.
22 And I think you earlier spoke to Sarah Collins
23 around benchmarking. Well, it was challenging to
24 benchmark, my Lady, because we had the framework which
25 had pricing in. Obviously that pricing was based on

1 a business-as-usual environment where we don't have the
2 supply and demand, but actually, you can still
3 extrapolate from that as to what is a reasonable uplift
4 in cost, when you've got a difficulty around supply and
5 demand. And we'd also secured PCR tests from others.
6 There was also someone on my team who'd done even
7 further research, BGI were actually on the framework,
8 the PHE framework. So we knew if we went to them
9 directly how much we could secure that for. I can't
10 go -- for reasons I can't go into today, there was
11 reasons why we couldn't buy direct from BGI. But the
12 offer that they gave was, I felt it was unacceptable,
13 and unjustifiable, and that's why I challenged it. But
14 I kept coming under pressure as to not to haggle.
15 **Q.** And I believe that ultimately you recommended that you
16 were -- that you reduce the volume purchased?
17 **A.** And the price.
18 **Q.** And the price. And was that recommendation accepted?
19 **A.** Yes, so Lord Bethell -- it was escalated to
20 Lord Bethell, and I shared with him the brilliant sort
21 of detailed work that my colleague Anna had pulled
22 together, and when he reflected on that, he said we
23 wouldn't accept it at the price they were offering, so
24 they reduced the price significantly.
25 The reason I wasn't happy to buy 3 million of these

1 tests was because the product -- we only had a certain
2 number of machines that were compatible with this test,
3 and I was worried that if we bought 3 million, we
4 wouldn't get through them all because they were
5 untested. The view was that they would work on more
6 machines, but they hadn't been validated on more
7 machines. So we reduced the volume to *(redacted)*
8 instead of 3 million, which was just as well, because
9 I think we still -- we still lost -- I don't think we
10 used them all.
11 I think there was around 100,000 that expired, so
12 had to be disposed of.
13 **Q.** And were there other examples where you ended up
14 procuring or committing to volumes of tests that
15 ultimately weren't needed?
16 **A.** Yes, definitely. So, I mean, this was an example where,
17 you know, I was able to push back and we reduced the
18 volume. But there were other situations where, you
19 know, I would challenge, but it's not really my decision
20 to make at the end, and sometimes my advice was listened
21 to, and sometimes it wasn't. It was more challenging in
22 the autumn of 2020, because this was when there was
23 a bit, coming back to your earlier point of friction,
24 there was, you know, Number 10 were keen on doing sort
25 of nationwide mass testing, but this was changing quite

1 a lot. Test and trace were -- had some concerns around
2 that --
3 **Q.** I'm so sorry, I'm going to have to stop you.
4 My Lady, something has been said which we consider
5 may breach a restriction order.
6 Could I invite you, please, to pause the live feed
7 while we address you more fully on the issue of concerns
8 so you can decide what steps to take if any?
9 **LADY HALLETT:** Pause the live feed, please.
10 **(Pause)**
11 **MS GARDINER:** I think we just need one minute.
12 My Lady, thank you. We are going to ask for your
13 permission to make a restriction order over the comment
14 that Dr Jandziol made over the quantity of tests
15 procured, which was *(redacted)* as -- for reasons of
16 commercial sensitivity.
17 **LADY HALLETT:** Certainly. Easy mistake to make, don't blame
18 yourself.
19 **THE WITNESS:** Thank you.
20 **LADY HALLETT:** Feed up.
21 On again, please.
22 **MS GARDINER:** Thank you, I might move further to one further
23 instance of interaction between the centre of government
24 and procurement of the testing equipment. We've talked
25 at length about some of that friction that was there,

1 and you and your colleagues' desire to stick by the
2 principles of good procurement and preserve public
3 money, but there were also examples where there was
4 concern from Number -- from senior figures in government
5 that they were not being given enough time to make
6 decisions about large -- spending large quantities of
7 money.
8 And I want to look at INQ000471020. And if you'd
9 start at page 3.
10 Thank you. So we can see here an email from someone
11 on behalf of Lord Agnew. And if we can look at that
12 email, it notes that:
13 "The [Prime Minister] has publicly committed to
14 ramping up testing capacity ... In reality, the maximum
15 testing capacity that the market can currently provide
16 is around [half of the figure that's given] ... However,
17 Dido Harding is not willing to engage with any challenge
18 from [Cabinet Office] -- not sure what experience you're
19 having on the HMT side. From what I can see, it seems
20 as though Gareth is asking ... sensible questions."
21 And if we can zoom out, we can see that below that
22 he has -- whoever this email is from has pasted some
23 comments from Lord Agnew and then, below that, some
24 comments from the Government Chief Commercial Officer,
25 Gareth Rhys Williams, who you've said, as you set out in

1 your witness statement, also relayed his concerns to
2 you.
3 And you're not in this email chain, but you have
4 provided us, in your witness statement, with other
5 emails which indicate you were aware of these concerns,
6 and you've also seen this e-mail.
7 So I just want to look at those comments from
8 Lord Agnew. In particular, he says:
9 "As I'm sure you will agree it is ridiculous to ask
10 me to approve a £1 ¼ billion programme in one day."
11 And he asks various questions including:
12 "Has CST been involved?
13 "When did you get it? What challenge have you
14 deployed?"
15 And then at the same time, if we can look one page
16 down at the comments from the Government Chief
17 Commercial Officer, Gareth Rhys Williams, he also makes
18 number of comments, and we're not going to look at all
19 of them, but his initial comments are:
20 "While I get that the political imperative is to set
21 this up, and fast, there are aspects I'm really not
22 happy about!!!"
23 And in particular he says:
24 "Rule 32 -- Unforeseen??? Really??
25 For 6 months!!!!"

1 With a great deal of exclamation points.
2 And:
3 "DA ..."
4 We take that to mean "direct award".
5 "... why -- what's wrong with a competition? Why
6 didn't we start this earlier?"
7 So similar question to Lord Agnew.
8 And if we can also look at a document which you've
9 provided to the Inquiry.
10 So this is INQ000535833. We can start at page 3.
11 Thank you.
12 This is a response that you drafted to particularly
13 Gareth Rhys Williams's questions.
14 We see at question number 8 you're responding to
15 Gareth Rhys Williams's question about why not a direct
16 award. And if you go down, you can see your response.
17 You state that:
18 "None of the current PCR providers on the
19 existing ... framework are able or willing to provide
20 the ... volume ..."
21 And you provide some more context for that, you say:
22 "There is no suitable framework ..."
23 And that:
24 "The quickest route to a competition is via
25 a suitable Framework agreement ..."

1 Which would take six to ten weeks.
2 Not going into any further into the detail of what
3 that framework would look like, can you expand on the
4 questions that were asked about why these senior
5 government figures were being asked to approve such
6 a large spend in such a short period of time?
7 A. So it was unreasonable to ask them to approve it in
8 24 hours, and, you know -- so I completely understand
9 their frustration. And I know that in my statement
10 I refer to another email where the chief of staff of
11 Baroness Harding had spoken to, I think it was,
12 Kate Josephs, the director general in the Cabinet
13 Office, to say that there had been problems on our side
14 in getting this submission together, and because there
15 was delays on our side, it had led to delays to get them
16 to Cabinet Office.
17 So I think it was unreasonable to ask for that
18 turnaround time.
19 I drafted this, I drafted the submission that went
20 to the ministers as well as worked with my colleagues
21 who supported me, but drafted the sort of business case.
22 It was really challenging, because we were trying to
23 maximise the capacity in the current lab footprint we
24 had in the NHS, as well as in the current Lighthouse
25 labs before we created new Lighthouse labs. And that

1 was really onerous and difficult. It's hard to sort of
2 track time there because one day felt like a week. It
3 felt like it took a long time. I'm sure it was a couple
4 of weeks, but in the meantime the Prime Minister had
5 announced "We will get to 500,000 tests per day" by that
6 date -- I think it was October. We had to do it, and we
7 were already behind.
8 So I think by the time we got this to Cabinet
9 Office, we were under immense pressure, because this was
10 expanding current capacity across the NHS, the current
11 Lighthouse labs, and adding some additional ones. And
12 that takes time.
13 I actually think all the questions were valid, and
14 it's quite hard when you were in there and you've got
15 real knowledge of the detail, to sort of reflect and
16 grasp the fact that actually, this looks probably quite
17 odd to those who aren't as close to it. And, you know,
18 in hindsight, a lot of these questions I should have
19 pre-empted and just put them in the original case, so
20 they didn't actually have to ask them, but I was so into
21 the detail of it, and frankly under a lot of pressure,
22 because this was just one thing of many things that I
23 was looking at, at the time, but my view is they were
24 valid questions. Unfortunately, this is just a draft.
25 I couldn't find in my archive the final version. That's

1 why there's some gaps --
2 Q. Some version of this went to the -- (overspeaking) --
3 A. Yes, a version did go back to them, answering all their
4 questions, and we did obtain sort of approval on the
5 back of that.
6 Q. Thank you.
7 I've one further question for you, it's something
8 that you've touched on but not directly addressed. We
9 know from your statement that because of the limitations
10 on commercial capacity, that was pre-existing, a large
11 number of private consultants were brought on to assist
12 you in the commercial operation. You have given us
13 a great amount of detail, which I'm not asking you to
14 repeat, in your witness statement about the implications
15 of that, but one comment that you made is that:
16 "There was a lack of understanding of our role with
17 many seeing Commercial as rubber stampers."
18 And you also say:
19 "There was at times a cavalier attitude to the value
20 for money."
21 Can you just briefly explain what you mean by that?
22 A. I think it's worth referring to Baroness Harding's
23 statement, because I think she set it out very clearly.
24 The direction she'd been given from the Prime Minister
25 was scale up test and trace, and scaling up at speed has

1 to be the priority. The quality element is
2 non-negotiable and because, you know, I've reiterated
3 a lot in this session technical compatibility, all those
4 things, that sort of makes that aspect of it quite
5 simple, because it's either compliant and able to be
6 used or not.
7 Then the third point is value for money, and it was
8 very clear that that is secondary to the other two, and
9 particularly speed and scale.
10 While I agree with that principle, it didn't -- you
11 know, from the perspective of me and my team, we were
12 still very much focused on value for money, and we were
13 challenged, but it was really hard because we were
14 constantly sort of coming up against this view of: what
15 are you doing? Why are you doing this? You just need
16 to write a contract. You just need to sign a contract.
17 And I think, for us to just do our job, it felt like we
18 had to have really thick skins and that just doesn't
19 feel right, that for such an extended period we were
20 constantly battling to do the right thing.
21 So yes, speed was definitely a number one priority,
22 but you can still do that in a responsible way, but
23 there was this view of just -- well, we just have to
24 spend. It doesn't matter, whatever it costs, this is
25 what we have to do.

1 And, you know, I've detailed it in my statement but
2 the team of 25 to 30 people, you know, we either avoided
3 cost or actually actioned(?) cacheable savings of
4 £1.5 billion of public money, but that was quite hard to
5 do because that meant pushing back and pushing back, but
6 I can genuinely say we didn't want to delay something
7 critical happening but trying to drive that value for
8 money, and you have to do it when there's no
9 competition, and there was no competition because we had
10 to buy everything that we could use from everyone and
11 then you have to use a different form of leverage.
12 **Q.** Thank you.
13 **A.** But that did make it very difficult.
14 **MS GARDINER:** Thank you.
15 My Lady, those are all my questions, I believe there
16 are some questions from core participants.
17 **LADY HALLETT:** Thank you. Just a few more questions for
18 you.
19 Mr Dayle, who is over there.
20 **Questions from MR DAYLE**
21 **MR DAYLE:** Thank you, my Lady.
22 Dr Jandziol, I ask questions on behalf of FEMHO, the
23 Federation of Ethnic Minority Healthcare Organisations.
24 You had significant involvement in the procurement
25 processes during the pandemic, particularly for NHS Test

1 and Trace services.
2 And so I will ask for your reflection on a few
3 topics of interest for FEMHO. Firstly, to what extent
4 was the procurement of NHS Test and Trace services
5 tailored to meet the needs of those serving minority
6 ethnic communities?
7 **A.** Thank you for the question. So I think our approach was
8 always to increase access as much as we possibly could,
9 so that meant reaching rural areas, making sure we had
10 enough coverage in, you know, more densely populated
11 areas as well. So I can't answer specifically about did
12 we have an approach geared towards ethnic minorities in
13 isolation, but what we did take into account was we
14 needed to be able to have home kits so people could
15 actually send samples and test at home and post it, and
16 also enough centres across the UK that were accessible
17 for everybody to get to.
18 Has that sort of answered your question? Or do you
19 want me to add more to that?
20 **Q.** Well, that spoke more to geography, I was thinking more
21 in terms of minority ethnic communities, or race or
22 ethnicity. But if that's as far as you can go, that's
23 fine.
24 **A.** I think it was just as much access as we could to
25 everybody. I mean, one of the areas that I'd sort of

1 worked quite closely on was the sort of portable
2 testing, as well. It moved into sort of more community
3 testing from mass testing. But again, getting more
4 devices out into different communities so that they were
5 more accessible, but it was more just having as much
6 access as possible across the nation but not
7 specifically directed at ethnic minorities.
8 **Q.** Very well. And next question. Were independent or
9 ethnic minority-led healthcare providers consulted in
10 the development and implementation of NHS Test and Trace
11 contracts?
12 **A.** So we talked to a lot of organisations, and there was
13 nothing recorded as to whether they were minority
14 ethnic-led organisations. We were very proactive in
15 talking to lots of organisations, and the type of
16 organisations that had struggled, frankly, in the past,
17 to work with the NHS and PHE, often small organisations
18 who struggled, there was too many barriers to sort of
19 get on frameworks. But no, we didn't deliberately
20 target those that were led by ethnic minority or, you
21 know, leading that -- those organisations. But we tried
22 to speak to as many organisations as we could, and often
23 those that would normally maybe not have access to
24 government contracts.
25 I would like to also refer to the database that was

1 shared with me from the Rockefeller Foundation, which
2 had 1500 suppliers on there. That was geared more
3 towards mass testing but that was the starting point for
4 our triage process when we were looking at solutions.
5 So it was really about casting the net wide and looking
6 at different types of organisations, and particularly in
7 the domestic market, as well, we were keen to look at.
8 **Q.** All right. And I suppose, in light of what you said
9 about the absence of a record around ethnicity, I'm
10 wondering whether you can say anything about how their
11 input might have influenced the final service provision.
12 Are you in a position to say? I suppose it would be
13 fine in the absence of the record that we were talking
14 about, or you were talking about?
15 **A.** I can't say we did that. What I would say though, is
16 I think actually more engagement with the public in
17 general around, particularly when we look at mass
18 testing. Mass testing is only beneficial if people then
19 act on the results of that test, and I know that when we
20 did the pilot, first asymptomatic pilot in the
21 Southampton area, we had -- we had sort of selected
22 people at random, and we'd got some really interesting
23 feedback on behaviours and some people's views about
24 testing, which I think would have been really good to
25 explore more detail, because it explored the behaviours

1 and maybe some concerns or misconceptions that people
2 had.
3 So I think if we'd expanded on that, it would have
4 been quite useful and probably looked into sort of
5 making sure we had enough coverage across different
6 demographics, including minority ethnic groups.
7 **Q.** Thank you.
8 How did the procurement process ensure that NHS Test
9 and Trace services were integrated with secondary and
10 social care providers, particularly those catering to
11 ethnic minority patients?
12 **A.** So we engaged a lot, and I also regularly engaged with
13 the devolved authorities but also local governments, and
14 they were heavily involved in sort of the community
15 testing once that, sort of, had moved from being mass
16 testing to community testing.
17 I can honestly say I'm not -- it wasn't sort of in
18 my remit to, sort of, understand how we were targeting
19 certain groups. But we did care a lot about the care
20 sector, and particularly in care homes. So one of the
21 first pilots we did was the, sort of, lab in a van which
22 went around care homes. Again, it was about increasing
23 accessibility to vulnerable people to have access to
24 sort of rapid testing.
25 But I can't say if there was any sort of emphasis on

1 going to those home providers which were -- you know,
2 had a larger demographic of those who were minority
3 ethnic groups.
4 **Q.** And my final question. How did government ensure
5 compliance with Public Sector Equality Duty in
6 procurement decisions related to test and trace? Can
7 you say?
8 **A.** It's hard to say. I mean, we have really firm
9 specifications for pretty much everything that we
10 procured. So the sort of qualitative specification was
11 the blueprint for what we had to buy. So I've got no
12 visibility of how that was established to take into
13 account equalities.
14 **MR DAYLE:** Thank you.
15 **LADY HALLETT:** Thank you, Mr Dayle.
16 That completes our questioning for you, thank you
17 very much indeed. After working 18-hour days for so
18 many months, I hope you got back to an ordinary sleep
19 pattern, did you? It sounds like an awful burden on
20 you.
21 **THE WITNESS:** Yeah, it was quite a challenging period, but,
22 I mean, I would like to say that it was also quite
23 incredible. There was a lot of positives about working
24 in there. There was a lot of camaraderie, and people
25 did amazing things.

1 But I do want to say, you know, it was -- I got
2 quite emotionally attached to the programme. My husband
3 is a consultant anaesthetist, so he was really working
4 really hard, and actually when I could see the impact of
5 what I was doing, the impact it has on him in his job,
6 it was a really strong motivator. But it was difficult.
7 But what I would say is -- you know, I've included
8 lessons learnt, but I think on reflection and seeing
9 other evidence, I think there's a lot more -- I'd
10 happily share other thoughts, but I think there's things
11 we could do to allow for preparedness that are
12 pragmatic, because it's -- we haven't got a lot of
13 money. You know? So you can't just -- you know,
14 I think we need to come up with recommendations that we
15 can actually do, but would have an impact, and I do have
16 some thoughts on that.
17 **LADY HALLETT:** If you'd like to send them in to the team,
18 I'll be really grateful to receive them. And as you
19 say, I've got to be really careful that when I make
20 a recommendation it's something that I can persuade the
21 government that it is worth their while to spend
22 precious resources on. So any thoughts along those
23 lines will be gratefully received.
24 **THE WITNESS:** Thank you very much.
25 **LADY HALLETT:** Thank you very much for your help so far.

1 **THE WITNESS:** Thank you.
2 **LADY HALLETT:** Thank you.
3 That completes it for today, I think Ms Gardiner.
4 **MS GARDINER:** Yes.
5 **LADY HALLETT:** And I shall return on Monday, 17 March, at
6 10.30. Thank you.
7 **(3.33 pm)**
8 **(The hearing adjourned until 10.30 am**
9 **on Monday, 17 March 2025)**
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