Witness Name: Baroness Dido Harding
Statement No: 1
Exhibits: DH/01 – DH/07
Dated: 30 January 2025

UK COVID-19 INQUIRY

WITNESS STATEMENT OF BARONESS DIDO HARDING

I, **BARONESS DIDO HARDING**, will say as follows:

SECTION 1. INTRODUCTION

1.1. I make this statement in response to the request sent to me by the UK COVID-19 Inquiry ("**the Inquiry**") dated 2 September 2024 ("**Rule 9 request**") for Module 5 which concerns the procurement of key medical devices and equipment between January 2020 and 28 June 2022 ("**the Relevant Period**"). The major focus of the questions in the Rule 9 request relate to my role as Executive Chair of NHS Test and Trace ("**NHSTT**") between May 2020 and May 2021, and my knowledge of the Relevant Period is limited to my time in post at NHSTT.

1.2. The Rule 9 request contains a significant number of questions, however, which I am not in a position to answer as they relate to matters of granular operating detail that would not be within my direct knowledge as Executive Chair. My role was to lead the creation of a very large and complex organisation from a standing start within a few weeks, in the context of a challenging and unpredictable global environment. Whilst the position of Executive Chair demanded knowledge of commercial and procurement requirements, my material focus was on the overarching objectives and leadership of NHSTT, not the detail of its commercial processes. As such, as Executive Chair I had limited personal involvement with day-to-day procurement structures, processes, procedures, and individual decisions on contracts, and about developments in science and technical requirements of COVID-19 polymerase chain reaction ("**PCR**") and lateral flow devices antigen tests ("**LFD**"), except where such matters required escalation to me (as one would expect of the role of Executive Chair). When NHSTT was initially established, David Williams acted as Accounting Officer and the commercial capability within NHSTT was provided by the Department

of Health and Social Care ("**DHSC**") with support from the Cabinet Office's Complex Transactions Team. Procurement decisions were taken by Ministers. As the organisation rapidly scaled, it became clear that NHSTT commercial requirements were becoming too great a draw on DHSC resources. We therefore needed an experienced individual to act as Chief Commercial Officer ("**CCO**") and build NHSTT's commercial function. After her appointment as CCO Jacqui Rock established the end-to-end commercial processes within the organisation so that these could be taken over from DHSC. Ms Rock remained part of the Government Commercial Organisation ("**GCO**"), which allowed for her to ensure consistency with ways of working across commercial teams in Government.

1.3. I have read the corporate witness statements provided on behalf of the United Kingdom Health Security Agency ("**UKHSA**") in Module 5 on commercial matters ("**UKHSA Commercial Statement**") and on science and technical matters ("**UKHSA Science and Technical Statement**"). Save where otherwise indicated below, I have nothing to add to those two statements. Further to that, I understand that the Inquiry will receive evidence from the former CCO of NHSTT and other experienced civil servants with commercial and public procurement expertise. Both are better sources to assist the Inquiry with the questions asked of me in the Rule 9 request relating to the specifics of procurement structures, processes, and procedures.

1.4. As this is my first statement to the Inquiry, I would like to take the opportunity to express my heartfelt condolences to all those who lost loved ones, were ill or experienced hardship during the COVID-19 pandemic. The devastation and suffering that it caused to so many – particularly the most vulnerable – was a global tragedy and can never be fully quantified. I welcome the opportunity to assist the Inquiry in its work, so that vital lessons can be learned for the future. I also wish to extend my gratitude to the tens of thousands of people who worked for and with NHSTT and to recognise the critical contribution they made to saving lives and supporting the country out of lockdown. The commitment of those individuals to public service – which involved considerable personal sacrifice – was admirable and should not be forgotten.

SECTION 2. QUALIFICATIONS AND BACKGROUND

2.1. When I took up the role of Executive Chair, I had over a decade of experience acting as a Chief Executive Officer ("**CEO**") or Chair, leading large and complex consumer-

facing organisations – physical and digital – through periods of change and growth. I also had 6 years' experience as a Board member, Chair and Deputy Chair of two of the largest public bodies in the country, the Bank of England and the NHS. The task of building NHSTT from scratch required a combination of different skills and it is important to note that it involved a monumental team effort. I do not pretend to have had all the skills necessary to build the organisation singlehanded. I was supported by an exceptional team of people from all parts of the public and private sectors. My experience was particularly relevant to NHSTT in four main areas:

2.1.1. People Leadership. Various of my roles have involved recruiting, developing and supporting leadership teams in both the public and private sectors, and leading and motivating large geographically dispersed workforces, which was one of my main tasks as Executive Chair of NHSTT.

2.1.2. Healthcare and public services. I understood the unique challenges involved in the leadership of essential public services in healthcare and beyond, having spent three years as Chair of NHS Improvement and six years on the Court of the Bank of England.

2.1.3. Retail and logistics. My experience of large-scale retail logistics, consumer marketing and operational management equipped me to oversee the construction of a vast multi-site service delivering nationwide COVID-19 testing and tracing.

2.1.4. Digital and tech. NHSTT needed to build an end-to-end digital system from test ordering, results delivery, contacts being contacted, and data written into patients GP records and aggregated to enable public health experts and ministers to make decisions. My experience of delivering digital transformation in telecoms, retailing and healthcare was directly relevant.

A. PEOPLE LEADERSHIP

2.2. By far the most important job of a CEO is to recruit, develop and support a great team. This is doubly true of an organisation growing at the speed required of NHSTT. My experience in the top teams at Tesco and Sainsburys and as the CEO of TalkTalk equipped me with the knowledge to attract and support the best talent possible and lead large groups of people through major change.

2.3. I was appointed Chair of NHS Improvement in October 2017 and held the role until October 2021. NHS Improvement oversaw the performance of all NHS Hospitals, Community and Ambulance Trusts in England. I was tasked by the Secretary of State for Health and Social Care ("**SSHSC**") with working with the Chair of NHS England to bring NHS Improvement and NHS England together. Both were large public sector organisations with several thousand employees. This was a substantial transformation program that involved, amongst other things, recruiting a new joint leadership team. As explained in Section 3 below, with the agreement of the SSHSC I took a leave of absence from NHS Improvement from October 2020 to May 2021 in order to fulfil my responsibilities as Executive Chair of NHSTT.

B. HEALTHCARE AND PUBLIC SERVICES

2.4. My tenure as Chair of NHS Improvement meant that I had detailed knowledge of the unique challenge of leading change in healthcare services.

2.5. In January 2019, I was commissioned by the then-Prime Minister, Theresa May, and SSHSC to lead the development of the first ever NHS People Plan. The Interim People Plan was published in July 2019. I therefore had first-hand experience of working closely with senior clinicians in the NHS and clinical and scientific leaders in the Medical Royal Colleges, relationships that were important in building a new national clinical service.

2.6. I was also Chair of Genomics England from 2019 to 2020 and had seen the challenges and opportunities inherent in scaling new healthcare services directly. I stepped down from the board of Genomics England in October 2020 to focus on the national pandemic response.

2.7. My experience at NHS Improvement and at the Bank of England (as Deputy Chair of the Court of the Bank of England and a member of Court for 6 years) meant that I had considerable experience in the governance of large, systemically important public sector bodies which were implementing technology transformation and large scale public procurement and of working with Ministers and senior government officials. This combined with my experience as Chair of the Bank of England's Remuneration Committee provided me with a detailed understanding of senior public sector recruitment.

C. RETAIL AND LOGISTICS

2.8. From 1988 to 2010 I had a career in retailing. I began in 1988 as a management consultant at McKinsey & Company primarily advising retailers and – apart from 2 years studying for a master's in business administration at Harvard Business School (1990-1992) – spent the following 22 years working for many of the UK's best-known retailers. I was Retail Marketing Director at Thomas Cook, responsible for a £20 million marketing and public relations budget. I then acted as Commercial Director of Woolworths PLC, responsible for buying, ranging and merchandising. In 2000, I moved to Tesco PLC. During my eight years at Tesco, I was responsible for buying £8 billion of Tesco's UK food range and led a global team of experts supporting Tesco's international businesses in Asia and Eastern Europe. In 2008, I became Operating Board Director and Convenience director at Sainsburys PLC. I led the scale up of the Convenience Division to cover 400 stores, 10,000 colleagues and over £1 billion annual turnover.

D. DIGITAL AND TECH

2.9. In 2010, I moved from retailing to Telecoms and was appointed CEO of TalkTalk Telecom Group. During my seven years as CEO, I led the demerger from Carphone Warehouse and post-merger integration of Tiscali and AOL which was a complex technology transformation program. I managed TalkTalk through the UK's first high-profile cyberattack and was tasked with securing the business and brand. I also spearheaded the campaign to 'Fix Britain's Internet' which led to the legal separation of Openreach from BT.

2.10. A member of the House of Lords since 2014, the primary focus of my parliamentary work has been digital regulation, including working on the creation of the Age-Appropriate Design Code in 2017. More recently, I worked on the Online Safety Act and Digital Markets, Competition and Consumers Act. I have also been a member of the Digital and Communications Select Committee since January 2022 and, before that, was a member of the Economic Affairs Select Committee from June 2017 to December 2021. In 2015, I was appointed to the Advisory Board of the UK Holocaust Memorial Foundation by the then-Prime Minister David Cameron with a specific brief to assist with digital activities.

SECTION 3. APPOINTMENTS

A. NHSTT

3.1. On 5 May 2020 the then-Prime Minister Boris Johnson called me and asked me to lead the then-called "Test & Trace Taskforce". From the conversation, I understood that the role was an operational (as opposed to a policy or political) one and involved the rapid expansion of the infrastructure to facilitate widespread testing for COVID-19 and contact tracing, which would be an essential end-to-end population service i.e. a service accessible to all the population ("**Citizen Service**"), and to recruit a permanent leadership team to lead the large organisation. I had understood that the role would be temporary. I accepted the position, and my appointment was announced publicly two days later, on 7 May 2020.

3.2. A formal letter of appointment was sent on 12 May 2020 **[DH1/01 INQ000528314]**. In it, the Cabinet Secretary explained that I would report to him and the Prime Minister and work closely alongside the Government Chief Scientific Advisor, Chief Medical Officer ("**CMO**") and Ministers from several other Government departments. It also made clear that Ministerial accountability for testing and Test and Trace would remain with the SSHSC. In practice I worked closely with the SSHSC and operated as part of his senior departmental team based in DHSC. In December 2020, my official reporting line changed so I reported directly to the SSHSC.

3.3. I was not paid any salary for my role as Chair of NHSTT. I continued in my role at Chair of NHS Improvement, in parallel with my role as Executive Chair of NHSTT until October 2020, when I took a leave of absence from NHS Improvement to focus on the COVID-19 response.

3.4. I initiated the search for NHSTT's permanent Chief Executive in May 2020, the month I was appointed. It was not clear at the outset how long my appointment as Executive Chair would last, as we did not know how long the programme would run, what it would require, or how long the search for a Chief Executive would take. I initially anticipated that I would act as Executive Chair for three months but ultimately remained in post for a year because of the process of recruiting a permanent Chief Executive.

B. NATIONAL INSTITUTE FOR HEALTH PROTECTION

3.5. In August 2020, the SSHSC announced that a new body would be established to bring together the health protection elements of Public Health England ("**PHE**") with NHSTT under a single leadership team. This was initially referred to as the National Institute for Health Protection ("**NIHP**"). Ministers subsequently changed the name to UKHSA.

3.6. The SSHSC asked me to act as Interim Executive Chair of NIHP. I took up this interim position on 18 August 2020 as an extension of my existing responsibilities at NHSTT. I did not accept a salary for this position. My function from this point was to continue to lead the scaling and operations of NHSTT, lead the work of developing NIHP and undertake a global search for the organisation's future leadership. As indicated above, the search for NHSTT's Chief Executive had already begun in May 2020. A job specification had been drafted, and executive search consultants instructed to identify potential candidates, whose background and experience were considered to assess their suitability for the role. The creation of NIHP meant that the job description was expanded and refined and the new permanent role of Chief Executive of NIHP was publicly advertised on 26 August 2020. A shortlist of candidates was identified shortly thereafter.

3.7. The appointment of Professor Dame Jenny Harries as Chief Executive of UKHSA was made on 24 March 2021. Following a month-long handover period with Professor Harries, I left my role as Interim Executive Chair on 7 May 2021.

SECTION 4. ESTABLISHMENT AND RESOURCING OF NHSTT

A. Establishment of NHSTT

4.1. I was not involved in the decision to create NHSTT and I do not have any direct knowledge of the advice or assistance that led to the decision to establish NHSTT. I have read paragraphs 2.7 to 2.12 of the UKHSA Commercial Statement relating to the circumstances which led to the establishment of the NHSTT programme. This reflects my understanding, and I have nothing further to add.

4.2. NHSTT was an operational organisation implementing UK Government policy. The policy decisions were all taken by Ministers and as indicated above, Ministerial

accountability for the programme remained with the SSHSC. My job was to take Ministerial policy decisions and the scientific and medical guidance that the Scientific Advisory Group for Emergencies ("**SAGE**") and CMO set and provide advice to Ministers as to the best operating system and service to meet those requirements. Following Ministerial steers, I was then charged with implementing and running this operating system and service.

4.3. As detailed in the UKHSA Commercial Statement, NHSTT was tasked with delivering an essential service that was integral to the UK's approach to controlling the pandemic and whose goal was to "Test, Trace, Contain and Enable". This required us to rapidly scale up testing and implement an operational nationwide contact tracing system, build a national data platform and analysis function in the Joint Biosecurity Centre ("**JBC**") and design and implement the Contain framework and approach to local lockdowns. This included the construction of a national laboratory and testing site and a logistics network of over 2,000 testing sites that increased testing capacity and a large scale digital and human contact tracing service. NHSTT was a combined local to national end-to-end clinical service where the individual's journey (from deciding to order a test right through to their close contacts being asked to isolate and their test results being added to their GP record and aggregated into a national data set for analysis) needed to be designed, component parts developed and procured, people trained and the service launched and operated seven days a week. NHSTT did not have a role in respect of the procurement of personal protective equipment or ventilators.

B. My role in NHSTT

4.4. As I explained above, my role was to oversee the creation and scaling of this complex organisation. My initial brief was to launch this service within three weeks of my arrival and then to scale it to what the Prime Minister called "world class levels" within three months. To appreciate the principal issues which faced the creation of the complex organisation, it is important to understand some wider context.

4.5. To deliver the testing and contact tracing services required to respond to the COVID-19 pandemic, NHSTT needed to establish a distribution network the size of Tesco or Amazon. For context, Tesco was created in 1919, launched its online shopping platform in 2000, and – in its biggest sales week around Christmas 2019 – delivered

on 776,000 orders. NHSTT had to launch an integrated testing and tracing service within three weeks of my arrival. In five months, NHSTT expanded testing capacity from 921,958 PCR tests processed in the month of May 2020, to 7,415,253 processed in the month of December 2020. And at the same time, NHSTT developed new forms of testing and then scaled an end-to-end LFD distribution system, Citizen Service and data flow, all of which had to be responsive to the UK Government's strategic objectives, which could change weekly. Such was the pace at which NHSTT was required to, and did scale up, that by September 2020 NHSTT was the fourth largest government department in terms of budget spend and headcount (after NHS, DWP and HMRC) despite not having existed four months previously.

4.6. The principal issues that faced NHSTT, and by extension the procurement of key healthcare equipment and supplies, was the need to launch a service within weeks and then grow exponentially in less than a year to a size that retail companies and public services would normally only achieve in years, and to do so in an environment of considerable uncertainty. The service needed to be built as the scientific understanding of COVID-19 and the efficacy of testing and tracing was itself developing at great pace, and where the course of the disease changed suddenly and rapidly, making forecasting and planning extremely challenging.

4.7. My main tasks through each phase of the pandemic are set out below by reference to the wider objectives set for NHSTT (which go beyond the matters within the scope of Module 5 but are relevant to understanding the context that NHSTT was working in):

4.7.1. 7 May to August 2020 – Launch of NHSTT. My initial focus on appointment was to recruit an experienced leadership team, sprint to launch the service at the end of May 2020, and start to bring some support, structure and order to what was an exhausted group of people working flat out to extremely short term targets (including expanding testing to 200,000 PCR tests and launching contact tracing and JBC by the end of May 2020). The initial senior leadership team and I focussed on the imminent launch of NHSTT at the end of May 2020, setting out a medium term (i.e. the next 3 months) business plan (published 30 July 2020) **[DH1/02 INQ000512710]** – which set out our operational targets and work program until October 2020 – and scaling up the organisation as fast as possible. Many functions that you would expect to find in a large public service organisation were not yet in existence within

NHSTT and were either being provided by DHSC in addition to their own tasks or were not being done at all. For example, NHSTT's requirements for many of the corporate functions such as finance, legal, internal communications, data security, data governance, programme management, recruitment, were initially provided by DHSC but the demands on NHSTT meant that its use of DHSC's resources quickly outstripped what DHSC was equipped to support. NHSTT needed to build its own capability, a task that was made harder by the fact that this was several months into the pandemic and most government subject matter experts were already deployed onto other parts of the national pandemic response.

4.7.2. My role was to set the strategic direction, manage the current emergency leadership team, recruit a more permanent leadership team and explain to Ministers, including the Prime Minister, how fast we could build the service and how fast we couldn't. In doing so I was focused on developing operational services that (a) the public would use; (b) would be as flexible as possible to different needs as the pandemic developed; and (c) were underpinned by the latest data, science and technological evidence and insights. I spent much of my time problem solving across the whole of the NHSTT portfolio wherever required and leading the communication of our priorities and approach internally and externally to organisations NHSTT was collaborating with (which I expand on below), Ministers and parliamentarians, and occasionally to the public.

4.7.3. <u>September 2020 to April 2021 – Maturing of NHSTT and the expansion of testing methods</u>. By the end of August 2020 NHSTT was on track to scale PCR testing to 500,000 tests a day by the end of October. However, it was also becoming clear that that initial target – which had been set in June 2020 – would not be enough, as infection rates began to rise again with the start of the school year and further use cases started to emerge which required increased testing capacity. The JBC was fully functioning as were the Bronze, Silver and Gold 'Local Action Committees' (which had a role in responding to local outbreaks of COVID-19) and we had recruited a more permanent leadership team including a CCO. Much of my time was focussed on performance improvement (increasing PCR capacity, reducing the turnaround times for the processing of PCR tests, increasing the percentage of contacts traced within 72 hours and improving the support we gave local

authorities). At the same time, NHSTT were tasked with accelerating the development of new forms of testing to enable some form of mass testing. This added considerable complexity, for example as the scaling of LFD testing was the equivalent of launching a whole new business even faster than the scaling of PCR testing. I met weekly with the Prime Minister and at least twice weekly with SSHSC as we tried to develop and then source sufficient suitable tests for various 'use cases' (see the UKHSA Commercial Statement) including mass testing, testing in schools, workplaces and daily contact testing.

4.7.4. It was clear to me that NHSTT needed to work much more closely with PHE. The operational capability that we were building in NHSTT could only be effective if combined with the scientific and clinical expertise of PHE. Initially we made a series of joint senior appointments to bring the two organisations closer together but then Ministers decided to create what was initially called NIHP, and became UKHSA, to combine the health protection elements of PHE with NHSTT. Therefore, my role became broader. I spent more time on internal communication, on designing the future combined organisation and on recruiting a permanent Chief Executive and Chair of NIHP. To give clarity we produced a further business plan, published on 10 December 2020 which set out the next phase of operational work we were focussed on **[DH1/03 INQ000528315]**. It is worth noting however that despite our attempts to set out a plan and deliver to it, the course of the disease and the resulting ministerial decisions meant that much of my time was focussed on working across government to solve unexpected and often urgent problems, for example supporting the implementation of the tiering system, addressing the testing of hauliers at Dover over Christmas 2020 after the emergence of the Alpha Variant and standing up testing in secondary schools for the beginning of January.

4.7.5. <u>April 2021 onwards – Path out of lockdown</u>. Once the Prime Minister decided to appoint Professor Harries as Chief Executive and Ian Peters as Chair of UKHSA, my role was to ensure both that the organisation maintained momentum during this leadership transition and that I had handed over everything effectively to them both. At this stage, as the vaccine rollout gathered pace, NHSTT was starting to plan for declining PCR testing capacity. Genomic testing was scaling rapidly as the understanding and

approach to handling COVID-19 variants developed, the design of UKHSA was gaining traction and we launched the Universal Testing Offer enabling everyone in the UK to access free LFD tests for regular asymptomatic testing. The combined organisation was operating in shadow form in a more mature way than previously with programme boards, investment boards and change programmes in place as one would expect to find in a complex organisation of this scale.

4.8. As Executive Chair of NHSTT, I did not have any direct role in the award of contracts. I was not the Accounting Officer for the organisation. The Accounting Officer remained the Second Permanent Secretary of DHSC. I was not the signatory to any contracts. At the direction of the Prime Minister, HM Treasury gave NHSTT increased spending controls delegation to expedite its work to £150 million (see the UKHSA Commercial Statement at paragraph 4.48). Delegated authority to approve spend and to sign contracts (which were separate delegations) could be exercised in defined circumstances. My role was to provide operational advice to Ministers to enable them to make decisions on spend. I did not sign off on purchase orders and could not sign and/or execute contracts on behalf of the SSHSC. I did not have formal oversight of spending controls. Whilst I would have escalated any potential issues that came to my attention in respect of NHSTT's spending, I was not responsible for ensuring that the organisation stayed within its funding envelope; that was the role of the Accounting Officer. I had no role in the ongoing management of contracts. I was not a direct or indirect beneficiary of any contracts awarded by NHSTT for delivery of PCR or LFD tests.

4.9. I was not directly engaged with the specific and specialist procurement and supply chain management processes, which fell within the responsibility of the officials who worked in the commercial and operational teams in DHSC ("**Testing Commercial Team**"), the NHSTT commercial team ("**NHSTT Commercial**"), including the CCO, who worked with the Testing Operations teams. Accordingly, I did not introduce, adapt or oversee any processes or procedures to deal with potential conflicts of interests or political donations, nor would it have been appropriate for me to do so given my role in NHSTT. As far as I am aware, donors to, or those with connections to political parties, did not receive preferential treatment in the commercial work relating to PCR and LFD testing equipment because all offered products had to undergo a technical evaluation as to whether the offered testing technology functioned as a validated COVID-19 test. In any event, the effectiveness of those

processes and procedures, and any adaptations made to them during the pandemic are better commented on by others who worked to such processes and procedures.

4.10. I have been asked about my knowledge and connection with Oluwole Kolade. I first met Mr Kolade when he applied to join the Board of NHS Improvement as a Non-Executive Director when I was Chair. I had been a part of the appointments panel who received his application (which is a matter of public record). The panel put forward potential candidates to the Minister for the role of Non-Executive Director, which included Mr Kolade, and the decision on who to appoint was made by the Minister. I did not know him socially or politically. I knew of the connection between Mr Kolade and Livingbridge EP LLP, as he was Livingbridge's CEO, but I did not know that he had any connection to Efficio Global Ltd until I read the Rule 9 Request. I have since seen a media report insinuating that Efficio Global Ltd was awarded contracts because of Mr Kolade's donations to the Conservative Party, but I had not seen nor was I made aware of any such allegations at the time. I was not aware of the nature or extent of any donations made by Mr Kolade to the Rt Hon Matt Hancock MP (then SSHSC) or to the Conservative Party. I was not aware of, nor did I provide any assistance to Mr Kolade or Efficio Global Ltd in relation to the applications, selections and award of contracts to Efficio Global Ltd for PCR and/or LFD testing services. Other than contact I had with Mr Kolade as part of NHS Improvement, I have had contact with him on three occasions in relation to a charity of which I am a trustee; twice in 2023 and once in 2024. As indicated above, I did not have any role in the award of contracts.

4.11. The structure of NHSTT is set out in organograms exhibited to the UKHSA Commercial Statement. Those accurately reflect the structures that were in place over the period that I was Executive Chair, as far as I can recollect.

4.12. As of September 2020, once NHSTT had been fully launched, I had 12 individuals reporting directly to me: the PHE Chief Executive, the Chief Medical Advisor, the Testing Divisional Director, the Tracing Divisional Director, the JBC Director General, the Contain Divisional Director, the Chief Finance Officer, the Chief Customer Officer, the Policy Lead, the Chief Operations Officer, the Chief Commercial Officer, and my Chief of Staff. Each of those individuals ran substantial teams of their own. The number of teams reporting to me, as well as the frequency and purpose of that reporting changed frequently during my time as Executive Chair as one would expect with an organisation that was doubling in size every one to two months.

4.13. The Executive Committee which I presided over at that time comprised 14 people. Where – in the context of a FTSE 10 company or large Government department (operating in non-emergency times) – executive teams might meet for an hour each week and for a half-day monthly, the NHSTT executive team met daily and for a half-day weekly. Where those companies or departments would hold a Top 100 meeting (i.e. a meeting with the most senior managers/employees) every month, we were holding them every week, sometimes more, as emergency meetings were called whenever needed (for example when there had been a significant policy announcement) to ensure leaders had the context they needed to deliver their plans. I would have one-to-one meetings with each person directly reporting to me at least once a week and would frequently talk to them late at night and over the weekend.

4.14. In terms of contact with the wider workforce, any CEO works hard to communicate with staff across their organisation, to explain the direction they are setting, to listen to feedback at all levels of the organisation and act on that feedback to improve staff engagement and morale. In an ordinary context, in an organisation of this scale, one might expect all-staff meetings to be held every six months, senior management meetings to occur monthly and occasional front-line visits. In this case, calls were held with all directly employed staff every two weeks and with contact tracers which involved thousands of people every couple of months. Immediately on appointment, I started a weekly blog (which later developed into a video blog) that was sent to all those who were directly employed, as well as those engaged in contact tracing and working on testing sites, to give them a wider sense of what NHSTT was doing. I also held remote lunches with staff from across the organisation to gather their feedback and visited testing sites and laboratories regularly to get frontline staff feedback.

C. Recruitment

4.15. I recruited the majority of the first executive committee of NHSTT over the first weekend after I was appointed. Whilst the leadership team I inherited at the beginning of May 2020 had done an extraordinary job scaling PCR testing to 100,000 a day they were utterly shattered and did not have the operational experience that was needed to build NHSTT to the scale required. I set out to bring into NHSTT experienced, seasoned leaders from the NHS, Local Government and the private sector. I sourced candidates via head-hunters, the Chair of the Local Government Association, the Cabinet Secretary and the Deputy Chair and COO of NHS England

and, where it was possible to identify multiple candidates, interviewed them over the weekend and first week wherever possible with the second permanent secretary at DHSC or Chief People Officer once they were appointed. The individuals we appointed were either seconded from their permanent organisations or on gardening leave from commercial jobs, and therefore immediately available. I asked them to serve for 3 months initially. This process is obviously not standard for public or private sector recruitment but was essential given the urgency of the problem at hand.

4.16. The initial focus was on launching NHSTT at the end of May, but the next urgent problem for all my leadership team was recruitment. The exponential growth of the service, doubling in size every one to two months, meant that we were recruiting large numbers of people over the summer of 2020.

4.17. Paragraphs 4.20 to 4.28 of the UKHSA Commercial Statement set out the issues NHSTT faced in recruiting staff with the requisite skill sets in the required numbers for the commercial work that NHSTT was tasked with and the resulting need to bring in private sector contractors and consultants. Save in respect of the recruitment for senior leadership roles, I was not personally involved in individual recruitment decisions of those joining NHSTT from the private sector, but the UKHSA Commercial Statement reflects my understanding. As far as I am aware, external consultants and/or contractors were not able to make final procurement decisions and/or sign contracts. These resourcing challenges affected almost all areas of NHSTT's work, including procurement work, which is the focus of Module 5. To stand up a service at speed, we needed to call on talent across the whole of society, both public and private sector. The skills required were wide ranging, including but not limited to:

4.17.1. Service design and development.
4.17.2. Scientific and clinical expertise.
4.17.3. Technology design and development.
4.17.4. Programme management.
4.17.5. People recruitment and management.
4.17.6. Operational delivery.
4.17.7. Central functions such as finance, legal and communication.

4.18. Some of these skillsets – such as technology design and development and programme management – were extremely hard to find at scale within the military or civil service. These skills gaps were exacerbated by the fact that NHSTT was

launched several months into the pandemic and both the civil service and military were already at full stretch as we scaled NHSTT. The only practical routes to the initial scaling of NHSTT were to temporarily fill roles with external consultants or outsource elements of the service to private organisations.

4.19. One factor which made efforts to scale up NHSTT's workforce particularly challenging was the speed at which the COVID-19 pandemic developed, and the resulting speed and frequency at which Government policy decisions were made.

4.20. The mixed team of personnel which was needed and made up NHSTT brought together a wide range of skills and capabilities. This created an innovative culture which enabled NHSTT to be built from scratch. This diversity in skill set and background was one of NHSTT's strengths in operation and this is an important lesson for future pandemics.

4.21. At its peak in December 2020, NHSTT employed close to 55,000 people either directly or through commercial partners. The split between civil servants and private sector contractors/consultants changed almost daily. It is an impossible task to confirm the exact percentage of staff at NHSTT who were contracted from the private sector during the Relevant Period.

4.22. Once NHSTT had been launched and it was clear that the service would be required for more than a few months, the then-Chief People Officer launched several concerted efforts to recruit civil service staff to replace consultants, especially in management roles, on the basis this would be both less expensive and provide greater long-term continuity and therefore be better value for money. This proved extremely difficult to achieve, partly because some of the skill sets were in very short supply across the civil service (e.g. programme management, digital development) and partly because working in NHSTT was inherently a short-term assignment under enormous scrutiny, which certainly deterred some candidates. Given the frequently changing course of the pandemic, it was difficult to provide certainty to colleagues for more than a few months and as the pandemic progressed this became less and less appealing to those in permanent civil service roles who were looking beyond the pandemic.

4.23. I think it is important to acknowledge the significant contribution the consultants who worked within NHSTT made to saving lives during the pandemic and supporting the

country back to normality. However the country responds to a future pandemic, it is highly likely we will need to bring in consultants at short notice to fill gaps in expertise and enable rapid response, just as we did in 2020.

4.24. There were occasions on which NHSTT was instructed by HM Treasury and/or the Cabinet Office to reduce operational capacity in testing and contact tracing only for infection rates to rise rapidly and resourcing needed to quickly scale up existing services to meet demand. Further to that, NHSTT was frequently tasked with building new services within short time frames, which required consultants to be brought on and retained. As such, NHSTT continued to use substantial numbers of temporary labour and resourcing throughout the pandemic.

SECTION 5. NHSTT OBJECTIVES AND STRATEGY

5.1. The aims and objectives of NHSTT are set out in paragraphs 2.7 to 2.12 of the UKHSA Commercial Statement. I agree with what is summarised there and do not repeat them here.

A. Operational Tool

5.2. NHSTT was never set up to be a single solution for COVID-19. It was one tool – not the only tool – that the UK Government set out as their response to COVID-19. The Non-Pharmaceutical Interventions ("**NPI**") that we all lived through – such as social distancing and face coverings – were the first element of the response. The second was NHSTT. The third was the vaccine programme and the fourth was therapeutic treatments aimed at helping people cope better with COVID-19.

5.3. Evidence demonstrates that, whilst NHSTT did not enable the UK to avoid lockdowns, it prevented between 1.2 and 2 million infections, potentially saving thousands of lives. NHSTT's work played an essential role in keeping schools, hospitals and care homes operational during the pandemic. The data used is addressed in **[DH1/04 INQ000262568]**. I understand the use of data will be explored further in Module 7. The data used by the NHSTT Testing Operations teams for forecasting, inventory management and supply changed daily and is addressed in the UKHSA Commercial Statement.

5.4. There were significant operational challenges to running NHSTT. The rate at which it scaled – doubling in size roughly every one to two months – was extraordinary. Growing a business or government department of NHSTT's size and remit would, more typically, take many years. Delivering value for money in any public service involves the balance of three competing factors: financial cost, quality, and time. In normal, non-emergency times, the focus is frequently on saving cost whilst ensuring quality, and the trade-off is often time. During the pandemic, the opposite was true. The Prime Minister and Chancellor made it very clear to me in my first meeting with them on 7 May 2020 that the human cost to the country from the loss of life and damage to the economy was so great that the cost of the service was secondary to the speed of scaling the service. The quality levels were set clinically, as one would expect, and Ministers instructed us to build NHSTT as fast as we possibly could. Clinical quality is non-negotiable. Therefore, financial cost became the more elastic factor.

5.5. As a result, at the express instruction of Ministers, NHSTT had a high commercial risk appetite and frequently was required to take decisions that in more normal times would not be considered value for money, but in the pandemic made sense because they maximised the speed at which the service could be built. For example, NHSTT took greater than normal procurement risk in acquiring multiple types of tests in advance of their efficacy and use cases (which has been explained in the UKHSA Commercial Statement) being fully established, so that if those tests were proven to be effective then the UK had secured stock in advance of other countries, before we had to compete with them for limited supply. Contact tracers were recruited in very large numbers and trained in advance of the system being trialled and fully tested in order to be able to launch the service nationally within weeks of being commissioned.

B. Collaboration

5.6. Collaboration between NHSTT and other Government agencies, the Devolved Administrations ("**DAs**") and local authorities was crucial to the success of NHSTT. The extent of collaboration required in respect of matters relevant to Module 5 are, in my mind, indivisible from the collaborative working that was established to carry out NHSTT's work beyond the procurement of COVID-19 tests because, as I explain above, NHSTT was delivering an end-to-end service. In many ways NHSTT was seen as an 'arm's length body' of DHSC (akin to PHE) and was included in the majority of operational, scientific and some policy conversations across government regarding

the pandemic. I worked with Ministers and senior officials, as did my team, as part of the collective government effort in responding to the pandemic.

5.7. Collaboration with local authorities was one of NHSTT's top priorities, as we adopted a local and national – rather than centralised – approach. One of my first appointments in May 2020 was Tom Riordan, then CEO of Leeds City Council, as the first "Contain" Director. Tom led NHSTT's relationships with local authorities and he and I worked closely together to prepare the Contain Framework (the purpose of which was to support decision makers in the developing and execution of Local Outbreak Control Plans by clarifying decision making responsibilities and the scope within which they could be exercised), secure funding for local authorities to build their local action plans and improve access to NHSTT data for local authority teams. NHSTT via the Contain team and JBC made working ever closer with local authorities a clear priority to build a 'Team of Teams' as we scaled the service as set out in the NHSTT business plans.

5.8. I worked closely throughout the relevant period with officials in HM Treasury and the Cabinet Office particularly after NHSTT was granted enhanced delegated spending limits. My team and I met weekly with Cabinet Office and HM Treasury officials to review progress of NHSTT to ensure they were sighted on our work and agreed with our operational plans and priorities as they evolved.

5.9. NHSTT was part of DHSC so worked extremely closely with colleagues in DHSC. I personally became a de facto member of the senior staff of DHSC. Many support services were initially provided by DHSC until NHSTT outgrew them.

5.10. Relationships with NHS England were more complex. Pillar 1 (described in the UKHSA Commercial Statement) was testing in NHS laboratories. NHSTT colleagues worked closely with NHS England to support them to scale Pillar 1 testing. NHSTT sourced testing supplies and provided funding for scaling up NHS labs and once developed sourced rapid testing including LAMP and LFDs for the NHS. NHS England attended Local Action Committees and the JBC worked with NHS England to collate analysis including hospital capacity to assist decision making in the autumn of 2020 and beyond.

5.11. NHSTT sourced, procured and delivered testing for all use cases, as they developed, in the UK. As testing capacity expanded and asymptomatic use cases were

developed in the autumn of 2020, NHSTT worked increasingly closely with other government departments including the Department of Education (university student testing and schools testing), the Department for Business, Energy and Industrial Strategy (workplace testing), the Home Office (prisons testing, borders policy), the Department for Transport (haulier testing), and the Foreign, Commonwealth and Development Office (overseas matters). Most of this work was managed by my team, though as required I engaged in direct discussions with senior officials and ministers.

5.12. NHSTT worked closely with the DAs, particularly in relation to Testing Operations teams and the JBC (as detailed in Section 5 of the UKHSA Commercial Statement) where representatives of the DAs were embedded in the NHSTT teams. I chaired the UK Government and Devolved Administrations Board ("**UKG-DA Board**"), which was set up to oversee the UK-wide aspects of the programme and ensure collaboration and shared learning between the UK Government and DAs. The UKG-DA Board was also the decision maker on Four Nation issues escalated from the thematic boards of which the DAs had membership – namely the Investment Board, Operations Committee, and Change and Strategy Prioritisation Board.

5.13. NHSTT worked closely with PHE and relied heavily on PHE colleagues' scientific and public health expertise. PHE did not have the depth of operational or commercial expertise to scale, nor relationships with the private sector diagnostics industry, as required for NHSTT. I did not engage with PHE's commercial team and instead NHSTT relied heavily on colleagues seconded from the GCO and Cabinet Office Complex Transactions Team.

5.14. NHSTT worked closely with the UK regulators who oversee the development of clinical diagnostic and digital services, this included Medicines and Healthcare products Regulatory Agency, the Information Commissioner's Office and the NHS National Data Guardian. The majority of this work was conducted by the clinical, digital, and public health experts within NHSTT, though as with most areas in NHSTT I did attend some meetings when required. NHSTT Commercial's engagement with industry is detailed in the UKHSA Commercial Statement.

C. Impact of Policy and Science on NHSTT

5.15. During the first few months of the COVID-19 pandemic, the World Health Organisation ("**WHO**") were encouraging all countries around the world to scale up

testing, advising that testing, isolation and contact tracing should be the "backbone" of the global COVID-19 response. Ministers were therefore keen to investigate all forms of testing which might enable lockdown restrictions to be relaxed or removed entirely.

5.16. The scale up of the testing service was an iterative one. The science of COVID-19 was not settled in 2020, nor the development of and access to tests. There was also limited understanding of people's behaviour (including the take-up of and compliance with testing, tracing and isolation). Ministers decided which hypotheses to investigate and NHSTT would be tasked with exploring them as fast as possible, often in parallel.

5.17. Inevitably, as our knowledge developed during the pandemic, some working hypotheses were abandoned whilst others were taken forward and became crucial tools in the UK's COVID-19 response. This iterative process of service development – which enabled the UK to deploy effective LFD antigen tests at scale before most other countries – is not unusual; it is how almost all new major consumer services are developed. What was unusual was the pace at which these new services were trialled and developed and the scale and speed at which they were launched.

5.18. UK Government decision making was affected by wider, and not unsurprising, disagreements on the appropriate policy approach which created challenges for NHSTT to deliver operationally. For example, NHSTT faced various difficulties in obtaining HM Treasury approval for Lighthouse Laboratories in the summer of 2020. Had NHSTT had greater delegated procurement authority during this time, this would likely have reduced the capacity issues we experienced in the autumn **[DH1/05 INQ000528312]**. It was these frustrations which led to the substantial delegated authority that was agreed with the Prime Minister and HMT from 22 September 2020.

5.19. These challenges were further exacerbated by the inherently unpredictable nature of the pandemic. In December 2020, NHSTT was encouraged to move towards a more "business-as-usual" environment and increase focus on value for money across the organisation (including in relation to procurement). Shortly afterwards, a new variant of the virus emerged which led to the standing up of new use cases such as the testing of hauliers at the border and of secondary school staff and pupils at very short notice and the need for a third lockdown. This meant that simultaneously NHSTT was being challenged by the Prime Minister to scale faster, and the Cabinet Office to slow down **[DH1/06 INQ000528313, DH1/07 INQ000528316]**.

5.20. One hypothesis being debated amongst scientists during the summer of 2020 was that if an entire population was tested twice over a two-week period and all those who tested positive for COVID-19 isolated, it would dramatically reduce the incidence of the disease and enable a release from lockdown before any vaccine had been developed. This was modelled on a testing regime adopted in Slovakia and was particularly popular with Special Advisors at No 10. The Prime Minister referred to this as "Operation Moonshot". Initially, a budget of £500 million was agreed and then the funding available was extended to £2.9 billion. This funding was approved by HM Treasury.

5.21. This was one of the hypotheses which led the Prime Minister to task NHSTT with rapidly scaling up testing capacity. Ministers also asked NHSTT to work on several other hypotheses, namely: testing all school children weekly to keep schools open; testing university students at the beginning and end of term; testing all care home residents and staff; testing weekly in workplaces; daily testing of close contacts of infected individuals; and giving local authorities testing capacity to reach vulnerable communities as they saw fit. NHSTT was tasked with trialling these various testing services over the course of autumn 2020 and scaling procurement so that there was sufficient testing capacity should they all prove effective. These services were all trialled in parallel, at a time when NHSTT was also continuing to scale PCR testing. Between August and December 2020, NHSTT reported to the Prime Minister during a weekly 'Testing Meeting', providing progress updates on the scaling of testing capacity and efficacy of various services being trialled.

5.22. The difficulties with Operation Moonshot as originally conceived – namely simultaneously testing the whole population twice as a one-off intervention to avoid the need for lockdown – were the sheer scale of testing service that it required and the fact that near 100% compliance with testing and isolation was necessary for it to be effective. I was among those who expressed concerns about adopting a whole population testing model and argued that some of the testing budget should be diverted to support the vulnerable to isolate. I understood at the time that the CMO and many local authorities also had concerns with this model. The Prime Minister and his advisors were keen to pursue Operation Moonshot. However, during the iterative process referred to above, the approach to mass testing evolved.

5.23. In early November 2020, the focus shifted from a whole population Slovakia-style testing model to a regional approach; namely testing the entire population of specific regions based on tier status. On 21 November 2020, a proposal was made to COVID-O to offer a community testing programme to everyone over 11 years old in the high prevalence areas of North East, North West and Yorkshire and the Humber (which all contained local authority areas which had been in Tier 3 (or similar) restrictions for the longest). Again, I was among those who expressed concerns about the proposal, alongside – as far as I can remember – the CMO, not least because there was a lack of support for blanket community testing amongst local authority leaders, who favoured a targeted approach to mass testing, but also because I thought the proposal was impractical because of the sheer scale of testing required and the low likelihood of the required level of compliance. Ultimately, Cabinet Ministers approved a version of the community testing programme which was locally led by Directors of Public Health and much more operationally deliverable.

5.24. My team and I were relieved that a more targeted testing proposal was adopted which had the support of local authorities (which as indicated above was crucial to the success of the NHSTT programme). The adopted proposal became the Community Testing Programme ("**CTP**") and the procurement which had taken place in anticipation of whole population Slovakia-style testing model was reallocated to the CTP and other use cases such as schools testing. The scale up of testing services continued to evolve and the Universal Testing Offer ("**UTO**") was rolled out in April 2021. The UTO was based on proposals which NHSTT had made in the autumn 2020 as an alternative to whole population Slovakia-style testing. This will be dealt with in more detail in my Module 7 statement.

SECTION 6. LESSONS LEARNED

6.1. Whilst as Executive Chair I did not have any day-to-day role in procurement, having gone through the process of launching and scaling NHSTT, recruiting and leading the Executive team of NHSTT and drawing from my prior experience in the public and private sector, I would like to share my reflections on lessons to be learned for procurement for future pandemics and other national crises that necessitate large scale procurement. I have restricted myself to lessons learnt for procurement in this statement as I am assuming that broader learnings regarding testing and contact tracing will be explored in Module 7.

6.2. Prior to the COVID-19 pandemic, the UK did not have any plan for mass scaling of testing or tracing services and our public health teams, operating at their normal, non-emergency capacity, were unable to cope with the first wave of COVID-19. I think the same would be true were another pandemic to hit today. The previous government decided to decommission the Rosalind Franklin laboratory which had been expressly designed and built to provide surge diagnostics capacity for the future. That was a mistake. Building surge capability for future pandemics and national emergencies is essential.

6.3. No matter how much preplanning is done and/or stockpiles of equipment laid down, a novel pathogen will almost certainly require different testing regimes. This means that a new service will need to be designed, developed, procured and operated.

6.4. The procurement legislation, frameworks, and tools were not fit for purpose in 2020. Whilst the Procurement Act 2023 makes many positive changes, including enabling future commercial teams to move with agility within standard frameworks, it does not, and cannot, ensure that government has the appropriate skills, systems, and processes to use these new tools.

6.5. To harness the appropriate skills to scale quickly, the UK should build and maintain a public health reservist resource – with core public health skills like contact tracing and more corporate skills such as programme management and consumer digital design and development – who are trained and ready to respond when needed. Such resource would be comparable to the GCO, who provided outstanding commercial support to NHSTT, or to the military, who provided logistics support. Unless this resource is developed during non-emergency times, the UK will again find itself in the position of having to rapidly recruit a vast workforce from a standing start, which takes too long to scale and is more costly. Developing a trained, accredited group of experts in these areas who can be deployed across Government in an emergency would enable a faster and more efficient response.

6.6. The UK should also recognise that a combination of public and private expertise, properly procured and recruited, deliver better outcomes in response to national challenges. The size of the team needed for NHSTT's work would not be proportionate to fund during non-emergency times. There is a risk that the vilification of consultants who worked on the UK's COVID-19 response will make it harder to build such a diverse and talented team in response to future emergencies. The UK

therefore needs to maintain up to date commercial frameworks which enable consultants from the private sector to be rapidly onboarded in a crisis and ensure that this is done in a way that gives the public confidence in their involvement.

6.7. When I first started in May 2020 it seemed to me that some colleagues in PHE were nervous of the private sector, including being cautious about building strategic partnerships with the commercial diagnostics sector. Relationships with academia in, for instance, modelling, statistics, behavioural science, and data science generally, did not appear to me to be as broad outside public health as were needed. I know that UKHSA is working hard to build skills and strategies to prevent this happening in future but without conscious government encouragement and funding I fear that inevitably UKHSA will become isolated again. The UK Government should ensure maintaining collaborative relationships with the commercial diagnostics sector and broad academic institutions beyond public health (in statistics, data analytics, behavioural science etc) is a stated priority for UKHSA going forward and appropriately funded.

6.8. More broadly, the UK was substantially disadvantaged in the early months of the pandemic when starting to scale testing because we lacked a domestic diagnostics industry. In the autumn of 2020, the lack of a domestic LFD manufacturing capability meant that we were totally reliant on Chinese LFD manufacturing. The UK Government should designate diagnostics as critical national infrastructure (in keeping with a pandemic being the number one risk on the national risk register) and ensure the UK maintains capability in the sector to develop, manufacture, and process clinical diagnostics.

6.9. Finally, procurement of testing in 2020 was made harder by conflicting ministerial instructions. I appreciate that the Inquiry has already considered government decision making in Module 2, but it would be remiss not to consider how the lack of clear centralised decision making by ministers made the operational challenge of procuring tests harder. As set out above in paragraphs 5.18 (in relation to the expansion of the Lighthouse Laboratories' estate) and 5.19 (in relation to NHSTT being encouraged to move towards a "business-as-usual" environment in December 2020), NHSTT received directly contradictory instructions from the Prime Minister and Cabinet Office ministers and officials on several occasions, that led directly to scaling of testing being slower than required and/or more emergency procurement than might have been needed. Whilst we cannot say now what, if any, material impact greater alignment on

decision making in these areas would have had during the COVID-19 pandemic (in respect of volumes of testing equipment procured, prices paid and the speed of distribution), we must in future aim for that alignment. I appreciate the huge complexities inherent in navigating a crisis of the proportions of a pandemic, but my experience is that the larger and more complex the problem, the more important it is that there are clear lines of accountability and clear and swift decision-making processes.

STATEMENT OF TRUTH

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

Signed:

Personal Data

Dated: 30th January 2025