Witness Name: Haroona Irshad-Franklin
Statement No: 1
Exhibits: HF7/01 – HF7/08
Dated: 15 May 2025

UK COVID-19 INQUIRY

WITNESS STATEMENT OF HAROONA IRSHAD-FRANKLIN

I, **HAROONA IRSHAD-FRANKLIN**, 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 28 January 2025 ("**Rule 9 request**") for Module 7 and marked with the reference **M7/Franklin/01.**

1.2. I am currently the Head of Analytics and Engineering Transformation at NatWest Group and have been in this role since January 2023. I held several roles as part of the National Covid Response Team from July 2020 to September 2022. I was the Director of the Covid Status Certification where I led the design, delivery and live service of the Covid Pass. I was the Trace and Vaccines Divisional Director at NHS Test and Trace ('NHSTT') from June 2020 - November 2020.

1.3. I worked in the civil service as a Senior Civil Servant from 2004 to 2015 with roles spanning the Home Office and the Department of Health and Social Care ('DHSC'). This included operational roles in Counter-Terrorism and the UK Border Force, as well as leading on major transformation programmes such as Border Automation (e-passport gates) and the new Health and Social Care Network ('HSCN'). I also held data and security roles at HM Passport Office passport service. I left the civil service in 2015 to join Deloitte Consulting and was based primarily in Hong Kong working with a major railway engineering firm as my client. I was approached to return to the civil service in 2018 to lead the Future Borders programme at HM Revenue and Customs ('HMRC'). The basis of my experience, therefore, is in leading large scale

transformation programmes and front-line operational roles in Border Force and Counter-Terrorism.

1.4. I also undertook training as an Incident Gold Commander at Bramshill, and was a Gold Commander for Border Force during the 2012 London Olympics where I was one of three Gold Commanders responsible for overseeing entry and exit decisions at the Border in relation to the Olympic participants, supporting organisations and dignitaries. This included working with the Olympic associations, Special Branch and respective Ministers' offices.

1.5. In my role at NHSTT as Trace Divisional Director, I oversaw the contract management and operational oversight of the 119 Test helpline and the Trace contact call centres. This was one call centre, with two suppliers (Sitel and Serco) providing the different services for 119 test booking and trace calls. I worked with the Vaccines Team from December 2020 to February 2021, assisting with setting up the vaccines call centre to enable members of the public to make appointments and get information. I only had a few weeks to set this up and leveraged my work in NHSTT and associated contracts for the benefit of the Vaccines Team. Following this, I was then appointed as the Programme Director for the Covid Pass within the NHS App, delivering and then running the service from March 2021 to September 2022 (please note the NHS App is not the same as the NHS Test and Trace App).

1.6. The pandemic was an unprecedented crisis of our time, in which many lives were lost and families faced hardship and distress. The impact of the pandemic is still being felt today. I would like to acknowledge and express my personal sympathy for this global tragedy. I would also like to acknowledge the countless individuals, many of whom I had the honour of working alongside, who contributed to the Covid-19 Response, made important decisions and took action, often while dealing with a lot of criticism. I am deeply grateful to the Chair and the Inquiry team for their work and sincerely hope valuable lessons can be learnt. In the words of Martin Bromiley, *"So that others may learn and even more may live"*.

SECTION 2: RECRUITMENT TO ROLE

2.1. I had previously worked at DHSC from 2014 to 2015 as a Senior Responsible Owner ('SRO') for the HSCN network. This was a critical programme and contract which the Cabinet Office was seeking to terminate at the time I came on board. I was recruited

to develop the replacement strategy and programme and oversee the exit of the existing contract. At the beginning of the pandemic, I knew most of the senior management team in the Office of the Second Permanent Secretary as I had previously worked with them at DHSC. I was working at HMRC as the Director for Future Borders but was keen to support the civil service response to the pandemic and therefore spoke to the Second Permanent Secretary about roles in managing the Covid-19 portfolio and expressed my interest in developing a digital solution. When a director role within the Trace Team at NHSTT needed to be filled, I was recommended and subsequently had calls with the Chief Operating Officer ('COO') Tony Prestedge about my experience and availability, and then with Executive Chair Baroness Dido Harding about the requirements of the role before accepting the role.

2.2. The NHSTT call centres for 119 Test and contact centres for Trace had been established before I started my role. Michael Brodie (the Chief Executive of the NHS Business Services Authority ('NHSBSA')), and subsequently the interim CEO of Public Health England ('PHE'), had been brought in previously with a small team to set up and oversee the NHSTT call centres. The additional responsibilities of the Service Operations Centre ('SOC') and SRO were added to my role after my appointment to NHSTT.

SECTION 3: ROLE AND RESPONSIBILITIES

3.1. Between June 2020 and November 2020, I led the central Trace Team at NHSTT, and my role included:

a. managing the call centres and operational tracing teams;
b. managing the contracts for the resourcing of the call centres. There were 3 contracts in total – the Tier 2 contract was with NHS Professionals and Tier 3 was with the companies Sitel and Serco. These contracts also covered the technology used in the call centres, with the technology 'Ring Central' provided by Sitel;
c. working with the media; and,
d. being the SRO for the replacement tracing IT platform (which I expand on further below).

3.2. My team dealt with the future strategy capabilities for Trace, and I also led the SOC overseeing any IT or operational incidents. I additionally oversaw:

a. the end-to-end tracing and isolation leadership (operations and transformational) across NHSTT, PHE and local authorities;
b. the development of contact tracing policy and strategy for England, working closely with colleagues in NHS Test and Trace, PHE, Ministry of Housing, Communities and Local Government ('MHCLG'), His Majesty's Treasury ('HMT') and other government departments;
c. the operational management of national contact tracing programs and inbound and outbound 119 citizen services, including outsourced contact centre providers;
d. the operational management of local contact tracing support, including (where needed) recruiting, training and developing local teams;
e. rapid performance improvement of the end-to-end contact tracing and isolation process using all levers including forward and backward contact tracing, face to face, phone-based and App-based tracing;
f. business ownership of the technology development roadmap to support contact tracing and isolation operations in the short, medium and long term; and,
g. people leadership and engagement across contact tracing colleagues in the NHS.

Trace: organisation and structure

3.3. The Trace service was one which we saw as coming together as a coherent health family, comprising people from NHSTT, PHE and local authorities. The model worked by drawing on the strengths that each organisation and each individual brought to Trace. For example, PHE's epidemiology expertise enabled contact tracing to build its operational capacity on a scientific basis. Collectively, the national model was scaled up in a very short period of time, and continued to develop during the pandemic, drawing heavily on the knowledge and experience of PHE colleagues [**HF7/01 INQ000607995].**

3.4. The primary objective of NHSTT, which was launched on 28 May 2020, was to control the rate of reproduction (R), reduce the spread of COVID-19 and save lives. The expanded web and phone-based contact tracing was intended to be

supported by a three-tier operating model in England which had been mobilised.

3.5. As the operational lead, I led on the strategy for Trace, this included implementing local Trace teams and overseeing the central team that provided support and escalation across the three tiers, which were as follows:

a. **Tier 1** (health protection teams ('HPTs') were public health specialists – they worked with local government to provide oversight of the programme and handled the most complex cases (including expanding the teams to work on these complex cases in partnership with local authority public health staff). PHE worked with local government colleagues including the Association of Directors of Public Health, Society of Local Authority Chief Executives and Senior Managers, Local Government Association and UK Chief Environmental Health Officers on this part of the programme. Both PHE and local authorities were expanding their teams to meet the challenge of ending lockdown. Tier 1 was managed by PHE, and they handled major events where there were outbreaks and were supported by Tier 2 and 3 as necessary. Examples of local outbreaks included care homes, schools, and social venues such as pubs. When a positive case provided details of where they had been, our data correlation could pinpoint a localised outbreak if others had also been tested or traced. This is why the data collected by NHSTT was so critical for PHE local authorities.

b. **Tier 2** (clinical contact tracers) were health professionals from NHS Professionals who interviewed positive cases by phone to understand where they had been and who they had met. This sometimes would include people aged under 18, who could not be contacted through text or email or who did not have access to a computer. They also dealt with the more complex tracing of contacts and escalated issues to the PHE team if needed.

c. **Tier 3** were call handlers. They reached out to the contacts of people with COVID-19 who could not be reached by text or email to encourage them to use the web-based system. They also helped people who were having problems with the online system or who did not have access to a computer. They escalated complex cases to Tier 2. Contact tracers

worked on shifts from 8am - 8pm 7 days per week so contact tracing would continue over the weekend. Web-based contact tracing services could be accessed 24 hours a day by people who used it to either inform about their contacts or for those contacts to access and receive advice **[HF7/02 INQ000607996].**

3.6. To provide further detail regarding the three tiers, PHE experts were working with local government to provide oversight of the programme and work with local authority public health staff to handle the most complex tracing cases and expand the teams if necessary. Local insight continued to be provided by local government and local HPTs including on the recruitment of new specialist staff into local teams **[HF7/02 INQ000607996, page 18].**

3.7. It was my role to ensure that people were being contacted and to work with local councils, including on isolation payments. For Tier 2, it was more effective for this to be carried out by local councils, as they had the training and resources to assist with this work. I also advised on the strategy concerning the reset of the number of call handlers required for Tier 3.

3.8. When I took on the role at NHSTT there were 18,000 call handlers that were not being fully utilised, and I was able to reduce this number to 12,000 with no operational impact. There were also regular review calls with the Cabinet Office ('CO'), Crown Commercial Service and lead Minister Lord Agnew, who wanted to see value for money and increased utilisation. I assisted the Executive Board of NHSTT and the CO by advising on costs and contracts related to tracing operations but was not the sole decision-maker on these matters. I also advised on the need to balance having scientific expertise alongside operational expertise and this was an ongoing discussion point during my tenure. I was of the view that bringing together scientific expertise and operational expertise would enhance the effectiveness of identifying and managing the spread of the virus and the service provided by NHSTT. The ability of the scientific community to provide insight on transmission and epidemiological factors, married with the expertise of operational experts, would ensure plans are efficient and implemented through co-ordinating resources and management of any issues. This would result in quicker responses, the ability to pivot and effective resource management and faster containment of the virus.

3.9. I worked closed with the NHSTT executive team and the Trace policy team. I included the policy leads in my daily standups so operational, clinical, strategy and policy were joined-up. I also ran the Agile Lighthouse team within NHSTT, which was a discrete team set up to look at ideas to improve or enhance contract tracing. This team piloted different ways in which to manage test and trace strategy, and this is described in more detail below at paragraph 3.12.

3.10. Primarily, my stakeholders were local government leads including the Manchester Mayor and chief executives of local and city councils. A lot of the direction was provided by Baroness Harding in her position as Executive Chair of NHSTT, and it was clear that a key area for development was the need for more operational expertise when making decisions. This was highlighted by an incident in late September/early October 2020 when 18,000 records were delayed in their release due to a technology issue and their late release created an adverse impact on the service. This is addressed in further detail below. The decision to release the records late was taken by a clinical team but the impact was operationally and reputationally damaging at the time and we needed to carefully consider the communications to the public surrounding this. Therefore, any strategy needed to balance clinical and operational expertise, so wider considerations could be brought into play, and decision-making was grounded in the data and reports produced the Joint Biosecurity Centre ('JBC').

3.11. In respect of public communications for Trace service, I did not lead on the communication strategy, but I did support it. During my tenure, I was asked to meet with journalists from ethnic publications, and also recorded a public message on the need to isolate during Ramadan. Overall, communications were not as highly effective as needed at times and were prone to individual interpretation in terms of the self-isolation rules. In the future, a more local and personalised approach region by region may be more effective, as a community in Surrey will be having a different experience to an inner-city community such as Tower Hamlets in London.

Trace Operations

3.12. As noted above, the Trace operations team included an 'Agile Lighthouse', which was a piloting site that looked at how we could improve ways of working. Small groups of Tier 2 and Tier 3 contact tracers, co-located in Newcastle,

focused on exploring operational improvements in a real-world environment. At any one time, the lighthouse worked on 3 - 6 pilots **[HF7/03 INQ000607998].** I was onboarded as the Delivery and Operations Director following the set-up of the Agile Lighthouse - see slide 8 **[HF7/04 INQ000607997].** The first wave of lighthouse pilots generated high-quality, actionable data that helped support improvements in the service. By way of example, the team found that the use of texts to inform individuals of information was more productive and effective than just phone calls. Letting people know they would be contacted increased the likelihood of people picking up when called and also the ability to disseminate information to affected people became easier.

3.13. I set out some of the completed Lighthouse pilots in this presentation dated 30 September 2020 **[HF7/01 INQ000607995],** specifically at slide 10. For example, one of these pilots related to a follow-up survey for people who responded that they had a negative experience of a prior contact tracing call. The top three negative experiences which were identified from this particular pilot were:

a. Tracing Timescale: there were issues surrounding the timeliness of individuals being contacted by the tracing team/SMS service.
b. Systems: some system issues were noted, for example timeouts were noted when completing online forms and password management.
c. The Tracing process - multiple contacts (Index and Contact), a dislike of the digital approach and an inability to reveal Index case were some of the issues noted.

SECTION 4: TRACING (POLICY/STRATEGY/OPERATIONS)

Operational Strategy

4.1. In August 2020, I produced an update which provided the latest data on operational performance for Trace and outlined areas of improvement in addition to projects which were underway at the time, see **[HF7/03 INQ000607998].** In respect of local contact tracing models, the following key points were noted on Slide 3 of my PowerPoint:

a. I planned to move to a 'Local by Default Model'. This was jointly led by the Trace and Contain team. The key change was a move from 48 hours to a 24-hour handover for local contact tracing with a target date of 15 August 2020 for implementation.
b. Moving to a standard, dedicated regional/local model for Tier 2 was proposed as a rollout. We planned to keep the local operating models in place.
c. Key dependencies included CTAS developments to define data by local postcodes and to revise the Tier 2 management structure of the NHSP, so teams were regionally/locally allocated.

4.2. We then planned to move Tier 3 to a Regional Model. The purpose of this was to align the service with the plans for 119 and to the regional ambition for tracing contacts. The key in achieving all of these aims was in the data. The SOC reporting was important so that we could continue to see the early indicators as they emerged and could then continue to develop the differences in local models and outcomes.

4.3. In respect of enhanced contact tracing, our aim was to expand the scope of this and to incorporate what was often referred to as backward Contact Tracing. As slide 4 of my presentation **[HF7/03 INQ000607998]** set out, from 10 August 2020 Tier 2 call handlers would complete an extended contact tracing questionnaire to capture information about where individuals may have caught their infection (i.e. by asking where they stayed, where they worked or studied, and what activities they did). The purpose of this was to enable us to identify settings or events associated with multiple cases and alert Tier 1 local HPTs to clusters of infection. Our plan was for cluster reporting to be piloted the week following questionnaire deployment. To achieve this, we planned for communications beforehand in order for local teams to understand what information would be made available to them.

4.4. Following this, we planned to work with HPTs and regional directors to develop the cluster reports and further to improve the system's ability to link cases and detect clusters of infection.

4.5. We had identified ongoing areas of improvement, for example, building awareness of the Test and Trace service, tracing contacts as fast as possible, maximising

cooperation with self-isolation and maximising the number of contact completions, see slide 6: **[HF7/03 INQ000607998].** In order to assist with these improvements, a series of pilots were set up with the purpose of running trials, for example:

a. Isolation trial: this was set up to assess how we could improve isolation compliance by communicating with people throughout isolation and to identify which was the best medium to do this.
b. Notification pre-call trial: this was set up to consider whether notifying individuals that a member of tracing team would call them would improve our ability to reach contacts.

4.6. My presentation also highlighted the need to streamline and integrate the servicing and supplier models (see slide 11 **[HF7/03 INQ000607998]**). By way of example, the 119 service did not support contact tracing queries, and where an individual had a query of this nature and called to provide contact details, they had to wait for a member of the contact tracing team to call them. Contact tracing (via Tiers 2 and 3) operated as an inbound service only and did not support queries about tests at the time. If someone asked about a test, they were advised to call 119. In my view, this was a disjointed service with room for improvement.

4.7. For the future, my view was that a multi-skilled frontline team was required whereby:

a. inbound and outbound teams were blended;
b. the service would provide support on testing and contact tracing;
c. the team would make outbound calls to contacts when not handling inbound queries;
d. a frontline team would cover the scope of the 119 team at the time and Tier 3 agents; and
e. new index cases would be escalated to the Tier 2 team.

4.8. In terms of the use of technology, for the duration of my tenure, existing platforms and systems were used. There was also a reliance on using the suppliers' call centre technology (Ring Central). The existing PHE infrastructure (CTAS) was aging technology that needed to be updated and therefore inadequate to support the scale of the pandemic, which is why a new platform was required. The programme to replace CTAS was called the Strategic Trace Solution with IBM as the vendors at the time. I was the SRO but did not run the team on a day-to-day basis.

4.9. Different technological trials were conducted while I oversaw the Agile Lighthouse project. As stated above, it comprised a team of 30+ experienced contact tracers from locations around the UK to undertake trials and test innovative ways of working, including new communication styles and capabilities to improve the effectiveness of tracing potential Covid sufferers. The Strategic Trace platform was being developed to replace the existing PHE system CTAS at the time, and examples of trials and tests we undertook included.

a. texting before calling to improve pick-up rates;
b. extending calling times to later in the evening to improve pick-up rates;
c. testing of contacts without symptoms;
d. asking index cases to reach out to uncontactable contacts to prepare them for a call; and
e. booking tests for contacts through the new software.

4.10. In addition, there was also a lack of data analysis to support Trace and the SOC, therefore a mini project was created to improve this sitting alongside the day-to-day operations. Deloitte were the consultants brought in to deliver this. They created and managed the operational management information reporting to support the optimisation and continuous improvement of the test and tracing contact centres including case creation, isolation advice and follow-ups in line with policy.

4.11. In terms of delivering contact tracing, this required the use of the private sector and consultants. As noted above, the Tier 2 and Tier 3 contact tracers were from private suppliers. Tier 2 required the use of people with a clinical background given the nature of the tracing and questions and were sourced from NHS Professionals. The Tier 3 suppliers (Serco and Sitel) were also private suppliers who ran contact centres nationally.

4.12. The key decisions I was involved in, in respect of tracing within my time in this role were, in summary form:

a. local tracing decisions, including the move to a 'Local by Default' model as outlined above at paragraph 4.1;
b. the decision to make payments to eligible individuals to support their ability to stay at home (which required me to work with local councils);

c. bringing in data capability to support the SOC by developing MI reporting to support case creation, isolation advice using data to analyse and optimise results and continuously improve. This was also to help with the correlation of data and records across testing and trace results; and
d. the reduction and/or increase in operational capacity and any supporting commercial decisions.

4.13. The advice on tracing was done in conjunction with clinical colleagues from PHE – we had a dedicated tracing senior lead who was my counterpart. We also relied on the modelling from JBC and the information from testing. We engaged globally to look at other tracing operations and worked closely with local councils to understand the impact in different regions based on the population profile.

4.14. Additionally, modelling and data fed into the tracing decisions outlined above. For example, I considered call usage reports (including peak times and duration of calls) from the suppliers. This allowed us to make decisions on opening and closing times for the call centres. Data and modelling reports were part of the executive briefings primarily and/or generated as per above.

Challenges

4.15. The biggest challenge which I had to lead personally during my time in the role was the delay in contacting and reporting circa 18,000 data records in October 2020. In October 2020, a technical issue was identified in the data load process that transferred COVID-19 positive lab test results into reporting dashboards. After rapid investigation, the team identified that 15,841 cases between 24 September 2020 - 2 October 2020 were not included in reported daily case numbers **[HF7/05 INQ000607993].** Of these 15,841 cases, over 75% (11,968) related to cases between 30 September 2020 and 2 October 2020. The following exhibit details the background of this matter and the communications around this at the time in detail - **[HF7/06 INQ000607994]**.

4.16. Of these cases, the vast majority (75% / 11,968) related to cases that should have been reported between 30 September 2020 and 2 October 2020 and so this delay in contact tracing would have had a reduced impact on their likelihood of transmitting the disease, based on typical incubation periods. This

issue did not affect people receiving their COVID-19 test results and all people who tested positive received their COVID-19 test result in the normal way.

4.17. The reason for the spike was due to a backlog of cases not coming into the system and the monitoring system not picking these cases up. When my team and I were alerted, the cases were pushed through to ensure we were able to start the contact tracing and importantly continue to monitor the results. Over the weekend of 3 – 4 October, I made the decision to bring on an additional 6,500 hours of support (the equivalent to around 812 staff) to process the backlog that had been created and to trace contacts efficiently.

4.18. The delay of the records being released meant major delays in handing over the details of almost 18,000 positive cases to contact tracers. This meant that close contacts who had been in contact with someone who had tested positive had a delay in being contacted and therefore a delay in starting isolation. This also impacted the daily case figures for call handlers and the reporting on positive cases. It took circa 48 hours to remedy circa 80% of the cases (the remaining 10% to 20% had moved out of the time range to be contacted).

4.19. This incident saw the UK's positive case figures soar after the backlog was finally added to the official tally, with 12,872 cases recorded on Saturday and a further 22,961 on Sunday. The decision to release the delayed records was taken without wider consultation with myself or my team so no advance impact assessment or contingency could be implemented, and I am unsure of the reason for this. My Trace team led this, and I was supported by my head of operations, head of the NHSTT SOC who also reported to me and the call centre leads in managing staff and keeping an account of number of people contacted. I was asked to lead the incident after receiving a call from Baroness Harding.

4.20. To deal with the immediate pressures and capacity issues created by this incident and growing positive case numbers, I wrote a submission to the Secretary of State for Health and Social Care on 9 October 2020 **[HF7/07 INQXXXXXXXXX].** The submission sought to temporarily increase the numbers of Tier 2 and Tier 3 staff, train and re-deploy readily available Tier 3 staff to undertake Tier 2 tracing, and to encourage the greater public to use self-service digital channels. I estimated that we could clear the backlog by 17 October with these resources, and that the daily caseload would be managed thereafter. This was subsequently approved.

4.21. I also assisted in ensuring that the public communications around this at the time reflected the details of the issue accurately.

Evaluation of Policies and Strategies relating to Trace

4.22. Guidance in respect of tracing adapted over the course of the pandemic as more information became available. A key change in guidance was the change in isolating times and the ability to test and release, whereby people could pay for a test after 5 days and leave isolation if they tested negative. Mitigation was through linking testing more closely with tracing. However, this change was implemented after I left my role and there is little I can offer by way of comment.

4.23. In evaluating Trace policies there is one example which I wish to refer to. During my tenure at NHSTT, my team were sent a set of 4 potential options from the CO to consider in being able to support people staying at home. We looked at these from a cost, ability to implement and effectiveness perspective and were able to advise they would not work. Each region and each city had to be considered from a unique position and perspective. Consideration needed to be given to densely populated areas, multiple family abodes, access to gardens or outdoor spaces and there was no 'one size fits all' solution.

4.24. This email sets out a summary of the 4 options being considered at the time in respect of the Test and Trace Support Payment Scheme ('TTSP') and the pros and cons of these **[HF7/08 INQ000607992].** The scheme we were committed to rolling out involved local authorities (unitary authorities and district councils) making payments to people on low incomes who could not work as a result of having to self-isolate. There was urgency to this at the time, as the plan was for local councils to have this in place for 12 October 2020. The email sets out that HMT's policy was for such a scheme to be delivered by local councils (to avoid creating a new form of income support or income replacement). The four options we were presented with were as follows:

a. Option 1: centralised scheme (using the HMRC systems that support SSP administration), with central verification processes and payments administered by employers.

b. Option 2: hybrid option, with central system for applications and some (or all) elements of verification, but with payments made by local authorities.
c. Option 3: national website for applications, with applications passed to local authorities for them to carry out verification checks and make payments.
d. Option 4: local authorities set up their own application systems.

4.25. Of the four options identified, the default option was to proceed with option 4, where NHSTT would support local authorities to set up their own online application systems (and alternatives for people without digital access) and to run their own checks with Department for Work and Pension ('DWP') systems (the Searchlight system) and with NHSTT to check for eligibility. They would also be expected to run at least a sample of post-payment verification checks with employers.

4.26. The self-isolation rule was introduced on the 28 September 2020 which implemented the introduction of fines up to £10,000. £500 was paid to individuals on low or no income and who could not work from home, and the budget for this came from the central government. This policy was crucial to ensuring that those on low incomes were able to self-isolate without fearing financial loss from not being able to work. To support the overall policy, the Trace call handlers were calling individuals on a regular basis and if someone did not answer or the call handler suspected they were violating their self-isolation, teams from the local council or local police could be dispatched to the address.

4.27. Alongside overseeing the changes in the script and rotas for the additional calls, my team also had to devise how the money could be sent to the local authorities as they needed to make the payments. I brought together a combination of policy, digital and operational leads and local council leaders to jointly test and devise a solution – including how to line the different technologies to create an end-to-end process. This was completed in record time and enabled payments to be made from early October onwards, with some payments being backdated to 28 September 2020 if required.

SECTION 5: LESSONS LEARNED

5.1. The first key lesson of the pandemic for me was that the siloed pandemic response effort between clinicians, civil servants and the private sector was not optimal. In the event of a major national incident there needs to be a clear chain of command. This

was done well by certain pandemic response agencies such as the military and police, but they have the training and planning for major events and this is not provided to other government departments.

5.2. Another key lesson is whether there is the opportunity or appetite at a national and local level to have a Mass Incident or Response Team in the event of another national pandemic. The lesson learnt was that a holistic approach was required – an example would be the decision to pay eligible individuals a payment (of £500) in the event they were required to isolate and unable to work. In order for this to occur, we needed to consider how the payment could be made both technically and legally as well managing the records. This was a collective national and local council effort and done quickly once the hurdles that needed to be overcome were understood. Any future team or organisation needs to look at data-driven decisions that consider economical, clinical, social and legal points as a minimum – solely focussing on just one will not give the full picture of the effort required.

5.3. In relation to inequalities, the main inequality in the tracing area I observed was from a socio-economic perspective. If the data as I recall was correct then this also created a disparity in certain ethic groups. Those on lower incomes and or zero-hour contracts found it more difficult to isolate and were more likely to not be contactable. Future pandemics need to consider a more holistic approach when undertaking scenario planning – clinical, locality, socio-economic, community profiling including religious backgrounds and regions, will bring up different challenges which need to be addressed – a more regional approach rather than a national one had greater impact during the Covid-19 pandemic.

5.4. The final lesson is the role of the private sector. There is a role for the private sector in a future pandemic as there was during Covid-19, but it should be based on relevant experience. A number of senior individuals rotated through NHSTT in senior roles but lacked the understanding of how government operates, which levers can be pulled and how decisions should be audited as they had only ever worked in the private sector. This comes back to having a clear chain of command. The public health system in the UK is complex and whilst all experience is valuable during a pandemic and some skills can be transferred, this takes time and requires support to understand blockers, regulations and ways of working. The complexity of the health landscape should not be underestimated and the need to balance clinical expertise with other skills such as commercial and operational (including from the private sector) is critical.

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: 15 May 2025