Introduction2
Opening Remarks2
SECTION ONE: OVERVIEW OF MY ROLE
Overview of my role as Parliamentary Under Secretary of State for Technology, Innovation and Life Sciences
Key bodies and decision makers7
SECTION TWO: THE DEVELOPMENT OF A TEST, TRACE AND ISOLATE SYSTEM 11
Overview of my role11
The development of a Test, Trace and Isolate system12
Engagement with industry and experts16
Other contributory sources20
SECTION THREE: TESTING
My role in identifying testing systems and technologies and expanding capacity24
Expert advice
Accessibility of testing34
Testing targets
Testing targets.    36      Barriers to an effective testing and tracing system    38      SECTION FOUR: ISOLATING AND ENFORCEMENT    40      The development of an isolation strategy and consideration of alternatives    40      Support for those isolating: my role    43      Rule, regulations, guidance and powers for enforcement: my role    44      Monitoring enforcement.    46      SECTION FIVE: PRIVATE SECTOR COLLABORATION    47
Testing targets.    36      Barriers to an effective testing and tracing system    38      SECTION FOUR: ISOLATING AND ENFORCEMENT    40      The development of an isolation strategy and consideration of alternatives    40      Support for those isolating: my role    43      Rule, regulations, guidance and powers for enforcement: my role    44      Monitoring enforcement.    46      SECTION FIVE: PRIVATE SECTOR COLLABORATION    47      'Priority Lane' for securing TTI contracts.    47
Testing targets.    36      Barriers to an effective testing and tracing system    38      SECTION FOUR: ISOLATING AND ENFORCEMENT    40      The development of an isolation strategy and consideration of alternatives    40      Support for those isolating: my role    43      Rule, regulations, guidance and powers for enforcement: my role    44      Monitoring enforcement.    46      SECTION FIVE: PRIVATE SECTOR COLLABORATION    47      'Priority Lane' for securing TTI contracts.    47      Gonflicts of interest    49
Testing targets    36      Barriers to an effective testing and tracing system    38      SECTION FOUR: ISOLATING AND ENFORCEMENT    40      The development of an isolation strategy and consideration of alternatives    40      Support for those isolating: my role    43      Rule, regulations, guidance and powers for enforcement: my role    44      Monitoring enforcement    46      SECTION FIVE: PRIVATE SECTOR COLLABORATION    47      'Priority Lane' for securing TTI contracts    47      Westbourne Communications and Deloitte    49
Testing targets    36      Barriers to an effective testing and tracing system    38      SECTION FOUR: ISOLATING AND ENFORCEMENT    40      The development of an isolation strategy and consideration of alternatives    40      Support for those isolating: my role    43      Rule, regulations, guidance and powers for enforcement: my role    44      Monitoring enforcement.    46      SECTION FIVE: PRIVATE SECTOR COLLABORATION    47      'Priority Lane' for securing TTI contracts.    47      Westbourne Communications and Deloitte    49      SECTION SIX: REFLECTIONS    50
Testing targets.    36      Barriers to an effective testing and tracing system    38      SECTION FOUR: ISOLATING AND ENFORCEMENT    40      The development of an isolation strategy and consideration of alternatives    40      Support for those isolating: my role    43      Rule, regulations, guidance and powers for enforcement: my role    44      Monitoring enforcement.    46      SECTION FIVE: PRIVATE SECTOR COLLABORATION    47      'Priority Lane' for securing TTI contracts.    47      Conflicts of interest    49      Westbourne Communications and Deloitte    49      SECTION SIX: REFLECTIONS    50      The scaling back and ending of TTI    50
Testing targets    36      Barriers to an effective testing and tracing system    38      SECTION FOUR: ISOLATING AND ENFORCEMENT    40      The development of an isolation strategy and consideration of alternatives    40      Support for those isolating: my role    43      Rule, regulations, guidance and powers for enforcement: my role    44      Monitoring enforcement.    46      SECTION FIVE: PRIVATE SECTOR COLLABORATION    47      'Priority Lane' for securing TTI contracts.    47      Conflicts of interest    49      Westbourne Communications and Deloitte    49      SECTION SIX: REFLECTIONS    50      The scaling back and ending of TTI    50      The legacy of TTI    54

Witness Name: Lord James Bethell Statement No.: 3 Exhibits: LB3/01-LB3/291 Dated: 16 April 2025

## **UK COVID-19 INQUIRY**

## THIRD WITNESS STATEMENT OF LORD JAMES BETHELL

I, LORD JAMES BETHELL, will say as follows: -

## Introduction

- I make this statement in response to a request from the UK COVID-19 Inquiry (the Inquiry) dated 31 October 2024 under Rule 9 of the Inquiry Rules 2006, asking for a draft witness statement for Module 7 of the Inquiry (ref: M7/BETHELL/01) (the Rule 9 Request).
- 2. I will necessarily focus on events that occurred during my time as Minister for Technology, Innovation and Life Sciences as these fall more squarely within the scope of this module. I have included events from 1 January 2020 to 28 June 2022 where relevant, but this statement will centre on the period of my appointment, being 9 March 2020 to 17 September 2021.
- 3. I confirm that this statement is from my own recollection of events, but I should note that I have had the benefit of reading the draft corporate statements (Statements A, B, C and D) for this module from the Department of Health and Social Care (DHSC). I have drawn from and expanded on their content, where relevant. I have also drawn from, and included, relevant content from my statements to the Inquiry for Module Four, submitted on 13 September 2024, and for Module Five, submitted on 20 December 2024.

## **Opening Remarks**

- 4. My reflections on this remarkable time are a mixture of sentiments. I have huge pride in what we were able to achieve from a low base, the technological and practical ground that we covered so quickly, and the impact we made on saving lives, protecting the economy and relieving pressure on our health and care services. The things that really stand out in my mind were the remarkable people I worked with, the culture of problem-solving and ambition, and the sheer scale and complexity of the project. But I also look back with a mixture of frustration and anger that we were put in a position where the public health doctrine, the public health infrastructure and the domestic diagnostic industry meant we started in such a weak position. And that our other policies, particularly the non-pharmaceutical interventions (NPIs) and the welfare support, did not work to support the credible objectives of the test-and-trace mission as effectively as they could have done.
- 5. The work of this module is of critical importance, possibly the most important module for our future response to the pandemic. Because in the last three years we have gone backwards, not forwards. The diagnostic infrastructure is dismantled. The data spine is closed down. The UK diagnostic industry has reverted to a small-scale, under-capitalised, science-led cottage industry. Our public health infrastructure, particularly the local representation, is weaker than ever. There is little surveillance of domestic or foreign pathogens and the social habits around home-testing and regular health screening have gone backwards. It is therefore imperative that this module lifts its head from any undiscerning interpretation of the headlines and simplistic anecdotage around testing and instead tackles the more serious issues. From my experience, I consider the following questions key to the task in hand:
  - What was the net impact of the COVID-19 test and trace system?
  - How was testing and tracing able to demonstrate its value and was it effective in meeting the following three key objectives;
    - (1) to diagnose illness and send people on the best treatment pathway;
    - (2) to provide surveillance of the spread of the disease so the nation can organise a data-led, intelligent response; and
    - (3) to contain the spread of the disease to reduce the prevalence of the pathogen, to reduce mutations, to minimise sickness and death, and to buy time for the development of vaccines and therapeutics.
  - Where were the acknowledged weakness, both in the system itself, and in the associated policy-making, such as:
    - (1) NPIs like lockdowns and closing the borders;

- (2) the design of welfare support to ensure people can stay at home; and
- (3) the use of the law and other forms of leadership to support adherence.
- Based on this, what are the determinants for a successful test and trace operation in the future?
- To what extent are those in place in the UK, and what could be done to support them?

## SECTION ONE: OVERVIEW OF MY ROLE

# Overview of my role as Parliamentary Under Secretary of State for Technology, Innovation and Life Sciences

- 6. I had entered Government as a whip in the House of Lords in mid-2019 and responsibilities included the Home Office (HO) and DHSC. It was working as a whip with responsibility for DHSC that gave me my first insight into what became the Pandemic. I can recall the Chief Medical Officer (CMO), Sir Chris Whitty, commenting that there is "this thing that we're all keeping a close eye on". By mid-January 2020 those of us in DHSC could see the growing threat and had started to react.
- 7. On 9 March 2020, I was appointed as Parliamentary Under Secretary of State for Technology, Innovation and Life Sciences (PS(I)). Further to my legislative business in the Upper House, my portfolio, which evolved to incorporate further COVID-19 related business (LB3/01 - INQ000486281 and LB3/02 - INQ000486339), included the following:
  - a) COVID-19
    - i. Supply (medicines and testing)
    - i. Treatments and vaccines
    - ii. Long term health impacts
    - iii. Test and trace: testing, trace, technology
  - b) Research and life sciences
    - i. Science and Research & Development
    - ii. Genomics, genetics, regenerative medicine
    - iii. Accelerated Access Collaborative
    - iv. NHS Test Beds
    - v. National Institute for Health and Care Research (NIHR) Overseas Development Assistance Budget

- c) Anti-Microbial Resistance (AMR)/Global health security
  - i. AMR
  - ii. Global Health Security
- d) International Diplomacy and Relations
  - i. Multilateral events (G7, G20 and WHO)
  - ii. Foreign and Commonwealth Office-led international funds
- e) Data and Technology
  - i. NHS IT
  - ii. Data to support innovation
- f) Medicines
  - i. Regulation
  - ii. Pharmaceutical Price Regulation Scheme
  - iii. Uptake of new drugs and med tech, including Adaptive Licensing and Early Access
  - iv. Cancer Drugs Fund
  - v. Complementary and Alternative Medicine
  - vi. Prescription charging
  - vii. Specialised commissioning policy
- g) Rare diseases
- h) NHS Security Management incl. cyber security
- i) Blood and transplants, organ donation
  - i. Health ethics
  - ii. Fertility and embryology
- 8. I was also given ministerial responsibility for cross-border travel measures including the red-listing of countries and the Manages Quarantine Service (MQS). As a DHSC minister, my responsibilities fell within the area of rules on quarantine and testing. I worked with colleagues from HO, Department for Transport (DfT) and the (then) Foreign and Commonwealth Office (FCO) under the central coordination of the Cabinet Office (CO).
- 9. In delivering effective relationships between DHSC and its Arm's Length Bodies (ALBs), I had sponsorship of a number of bodies, including: NHS Blood and Transplant (NHSBT), Human Tissue Authority (HTA), the Human Fertilisation and Embryology Authority (HFEA), the Medicines and Healthcare products Regulatory Agency (MHRA), National Institute for Health and Care Excellence (NICE), NHS Digital (NHSD), Health

Research Authority (HRA), the then joint organisation for digital, data and technology NHSX, and NHS Business Services Authority (BSA).

- 10. My priorities developed as the pandemic progressed and were revised in July 2020 (LB3/03 INQ000486334 and LB3/04 INQ000327961), which I summarise as follows:
  - a) Offering mass testing for community and the workplace;
  - b) Accelerating development of effective vaccines and therapeutic;
  - c) Working with MHRA to navigate three big challenges: EU Exit; the Cumberlege Review (LB3/05 - INQ000486333); and COVID-19;
  - d) Working with NICE to deliver 'Nice Connect', their vision for delivering guidance in user friendly pathway;
  - e) Working with HFEA to ensure continued high quality and uniform care for those receiving fertility treatment;
  - f) Working with HRA to encourage research that helps us to manage the spread of the virus as well as being at the forefront of the next pandemic;
  - g) Working to increase public confidence in NHS and HMG Health policy at a local and national level measured via robust research, especially targeting hard to reach groups;
  - h) Working on appointments to positions filled during first round along with the list of interested and inspiring candidates for future positions;
  - i) International leadership role (working with like-minded countries to improve WHO response, sharing best practice via roundtables);
  - j) Initiating key changes to make recruiting volunteers for clinical trials simpler;
  - k) Creating a data hub using the data that was already being procured, through the daily morning dashboard of positive cases, for example, to create visibility across the system to understand what is needed and where when making a central purchase for distribution; and
  - I) Setting a sustainable and ambitious course for the life sciences industry pharma, biotech, MedTech, digital and diagnostics which, in the area of manufacture of key healthcare equipment and supplies, meant addressing known bottlenecks to the manufacturing process, in particular the UK's ability to scale up at pace, which was an early identified weakness.
- 11. As the Inquiry will be aware from paragraphs 21 to 31 of the Fifth Witness Statement of Sir Christopher Wormald, dated 25 August 2023 [INQ000253807], early discussions were taking place in the summer of 2020 on how to reform the public health system,

which led to the establishment of the UK Health Security Agency (UKHSA). Between October 2020 and May 2021, I was copied into a number of submissions and advice on the proposed public health reform, including the reallocation of Public Health England (PHE)'s responsibilities, but I provided very little substantive input into the plans which were largely led by officials.

12. On 28 May 2021 I sent a letter to the Chief Executive of newly established UKHSA, Dr Jenny Harries, setting out its remit, which was subsequently published on 13 July 2021. The letter was agreed by Jonathan Marron, Clara Swinson, Michael Brodie and Dr Jenny Harries herself and was the first opportunity for UKHSA to set out its role and strategic aims (LB3/06 - INQ000234910). It also incorporated some of my own key ambitions as shared during the formation of the test and trace business plan, including working with stakeholders to leverage our COVID-19 investments in consumer diagnostics, ambitious aims for pandemic preparedness and that UKHSA be integrated into the wider health family, working across the health and social care system and across government (LB3/07 - INQ000592835).

## Key bodies and decision makers

13. I provide a summary of my working relationships with the following key figures and decision makers involved in matters within the scope of this module:

## Ministers and junior ministers

- The Rt Hon Matt Hancock MP; Secretary of State for Health and Social Care (10 July 2018 26 June 2021). We had frequent interactions through my main three roles: (1) HOL handling, (2) departmental responsibilities and (3) political counsel.
- The Rt Hon Sajid Javid MP succeeded Matt Hancock on 26 June 2021.
- The Rt Hon Edward Argar MP; Minister of State for Health (10 September 2019 6 July 2022). Edward was an important ministerial colleague.
- Helen Whately MP; Minister of State for Social Care (14 February 2020 16 September 2021; 28 October 2022 - present). Helen was an important ministerial colleague.
- Jo Churchill MP; Parliamentary Under-Secretary of State for Public Health and Primary Care (26 July 2019 – 16 September 2021 – including Vaccines); Jo was an important ministerial colleague.

 Lord Agnew; Minister of State for Efficiency and Transformation (joint CO & HM Treasury) (from 14 Feb 2020 – 24 January 2022). Lord Agnew was an important ministerial colleague.

## Senior officials

- Sir Christopher Wormald; Permanent Secretary and Principal Accounting Officer (PAO). We worked closely as he oversaw the DHSC response.
- David Williams; Director General (DG), Finance and Group Operations and Second Permanent Secretary. David was delegated sole Accounting Officer (AO) for the PPE Programme; he was my direct senior connection.
- Shona Dunn; Second Permanent Secretary from 6 April 2021 to 3 June 2024.
  Shona was an additional AO on all departmental matters (including NHS T&T until the transition of the programme to UKHSA on 1 October 2021) and acted as deputy to the Permanent Secretary. She had direct responsibility for all matters relating to finance and group operations until she left the Department.
- Andy Brittain succeeded David Williams as DG for Finance in April 2021.
- Clara Swinson; DG for Global and Public Health (formally DG for Global Health and Health Protection). I had regular in contact and meetings with Clara, but not a direct report.
- Steve Oldfield; Chief Commercial Officer. Steve's responsibilities included medicines and medical technology policy, commercial strategy, development of commercial capability, and sharing of commercial best practice across the wider health family, as well as strategy for and engagement with the life sciences sector. In his role as DG for Commercial and Life Sciences, Steve was responsible for continuity of testing supply until 21 July 2020 when this moved to David Williams.
- Matthew Gould; CEO of NHSX from May 2019 to January 2022. NHSX was the joint DHSC/NHS England (NHSE) unit responsible for national policy on NHS technology, digital and data.
- Baroness Dido Harding; CEO of NHS T&T from May 2020 to May 2021.
- Professor Dame Jenny Harries; CEO of NHS T&T from May 2021 to 1 October 2021.
- Gila Sacks; Director of Testing Policy and Strategy, NHS T&T from May 2020 to October 2020.
- Ben Dyson; Policy Director for NHS T&T from May 2020 to June 2021.

- Professor John Newton; National Coordinator of NHS T&T from May 2020 to July 2020.
- Tom Riordan; SRO for Contain, NHS T&T from May 2020 to September 2020. Tom was on secondment from Leeds City Council.
- Sarah-Jane Marsh; Director of Testing, NHS T&T from May 2020 to August 2020.
- Mike Coupe; Director of Testing, NHS T&T from September 2020 to December 2020.
- Mark Hewlett; Chief Operating Officer of Testing, NHS T&T from August 2020 to October 2021.
- Carolyn Wilkins; Director of Contain, NHS T&T from July 2020 to June 2021.
- James Sorene; Deputy Director, Test and Trace Communications from May 2020 to September 2020.
- Victoria O'Byrne; Director of Communications, NHS T&T from September 2020 to April 2021.
- Tony Prestedge; Chief Operating Officer, NHS T&T from May 2020 to August 2020.
- David Pitt; Chief Operating Officer, NHS T&T from 10 August 2020 to 9 February 2021.
- Mark Bailie; Director of Enable, NHS T&T from 26 May 2020 to 10 August 2020
- Simon Bolton; Chief Information Officer, NHS T&T from 12 August 2020 to 9 May 2021.
- Cathryn Richardson; Chief People Officer, NHS T&T from May 2020 to August 2020.
- Gareth Williams; Chief People Officer, NHS T&T from 12 August 2020 to 16 July 2021.
- Donald Shepherd; Chief Financial Officer, NHS T&T from September 2020.
- Elizabeth Fagan; Marketing Strategy Director, NHS T&T from June 2020.
- Ben Stimson; Chief Customer Officer, NHS T&T from 23 September 2020 to 15 June 2021.
- Steve McManus; Director of Tracing, NHS T&T from August 2020 to February 2021.
- Scott McPherson; Director General, Policy and Engagement, Community Testing Programme, NHS T&T until October 2021.
- Tony Keeling; Director for the Effective Contact Tracing Programme from 27 May 2021 to 31 October 2021.
- Beverley Jandziol; CO procurement lead for testing.

- Alex Sienkiewicz; Director of Public Health England. Alex was our main liaison point from Porton Down, the science and defence technology facility.
- Kathy Hall; Director of Digital Strategy and Transformation and Lead Director on COVID-19 Testing. Kathy led work on the disbandment of PHE and set up of OHID and UKHSA.
- Alex Cooper; COVID-19 National Testing Programme SRO (Pillars 2 & 3).
- Sue Bishop; Deputy Director, COVID-19 Testing Programme.
- Shirley Trundle; Programme Director, National Diagnostic Effort COVID-19.
- Tamsin Berry, Director, Office for Life Sciences

## Special Advisers:

- Jamie Njoku-Goodwin (10 July 2018 20 September 2020);
- Allan Nixon (8 October 2018 8 October 2021);
- Emma Dean (2 September 2019 2 January 2022);
- Ed Taylor (21 March 2020 26 July 2020);
- Damon Poole (1 September 2020 5 July 2022);
- Beatrice Timpson (9 November 2020 24 September 2021);
- Sam Coates (27 June 2021 5 July 2022).

## Key bodies with whom I engaged regularly:

- The UK Health Security Agency (UKHSA)
- Public Health England (PHE)
- NHS England (NHSE)
- NHSX
- NHS Digital
- MHRA
- Scientific Advisory Group for Emergencies (SAGE)
- The NHS Business Services Authority (NHSBSA)
- The Moral and Ethical Advisory Group (MEAG)
- The Office for Life Sciences (OLS)
- Department for Education (DfE)
- Home Office
- The Police and the Crown Prosecution Service
- His Majesty's Revenue and Customs (HMRC)
- His Majesty's Treasury (HMT)

- Ministry of Justice
- Department for Transport (DfT)
- Local Government

## SECTION TWO: THE DEVELOPMENT OF A TEST, TRACE AND ISOLATE SYSTEM

- 14. As the Inquiry will be aware, the Test, Trace and Isolate (TTI) system took on different names and iterations as it developed, such as: Test and trace; Test, Track and Trace; and. eventually, NHS Test and Trace (NHS T&T) as established in May 2020. Due to changes in corporate structures, I will refer to such iterations specifically where relevant. If I refer to the national programme of testing, tracing and isolating more generally, I will use the term Test, Trace and Isolate (TTI).
- 15. DHSC was responsible for setting overall test and trace strategy. As part of the DHSC, NHS T&T was subject to DHSC's financial, information and staffing controls, but its chair, Baroness Dido Harding, appointed on 7 May 2020, reported directly to the Prime Minister and Cabinet Secretary, rather than to DHSC ministers or the Permanent Secretary. From 3 December 2020, NHS T&T formally reported to DHSC, rather than the Prime Minister. Despite the changes to formal reporting lines, ministerial accountability for testing and NHS T&T remained with the Secretary of State for DHSC.

## Overview of my role

- 16. A feature of the COVID-19 response was that ministerial responsibilities and priorities were updated on a regular basis. As far as I am aware there was no formal 'Minister for Test and Trace' in the published ministerial list but this was a phrase used colloquially in some official documents and the press which reflected that I had junior ministerial responsibility for the establishment of TTI, and as part of my revised junior ministerial priorities in July 2020, I was asked to lead on a new 'strategic test and trace policy' (LB3/03 INQ000486334). This was in collaboration with the Minister of State for Care, Helen Whately MP, on Joint Biosecurity Centre analysis and the Minister of State for Patient Safety, Suicide Prevention and Mental Health, Nadine Dorries on local infection control.
- 17. In the beginning, when TTI strategy was being formulated, we had no mass testing capacity. This was an issue that I was tasked with addressing early on as this sat within my wider responsibilities as Minister for Technology, Innovation and Life Sciences. As

part of the build-up to the 'Operation Moonshot' mass testing programme, and NHS T&T, into which it was later subsumed, I was involved in helping to set Government strategy in the scaling-up of UK testing capabilities.

- 18. On 17 March 2020, I attended a roundtable meeting at No 10 on the topic of mass testing at which I was tasked with developing a plan for the fastest way to scale up antigen testing using entirely non-NHS/PHE facilities (LB3/08 INQ000592582). The plan needed to be based on sourcing external facilities as neither PHE nor NHS had the kind of rapid, high-volume throughput capacity that we so desperately needed. To plan a response around the existing infrastructure or attempt to scale it up somehow would have been extremely disruptive to the NHS's COVID-19 response and would likely have been more difficult than starting a mass testing project from scratch. Using my own handwritten notes from the roundtable meeting, I produced a testing action plan which was shared with the Prime Minister the next day (LB3/09 INQ000592583 and LB3/10 INQ00055915) The plan formed the basis of our early testing strategy with its 'four-pronged approach' which was later developed into the 5 Pillar testing strategy and published by the Government in April and is set out in more detail below at paragraph 57.
- 19. The first prong focused on increasing the NHS lab-based testing capacity from 5,000 to 25,000 per day. To support such ambitious testing numbers, I knew we had to scale up the near non-existent clinical infrastructure and data framework at an unprecedented rate. I use the words 'near non-existent' in relation to mass throughput testing capability for which the system was simply not designed. I remember exploring all corners of the industry for solutions, including laboratories that dealt with animals or agriculture that did have high-volume throughput, but standards were just too different. Further, we were dealing with an extremely dangerous pathogen, for which the facilities were not designed to accommodate safely at such scale. I spent a lot of my time urging people to do things 10 times as fast and think a million times bigger. For example, on 29 March 2020, I produced a memo for the PM on how to industrialise UK testing where I set out the urgent steps to address the issues of limited availability and increase our testing capacity. This was considered at a meeting at No 10 to discuss the actions required for the scaling-up of testing (LB3/11 INQ000497129; LB3/12 INQ000566069; ; LB3/13 INQ000566071).

## The development of a Test, Trace and Isolate system

- 20. I refer the Inquiry to the DHSC corporate statements for this module for a more detailed timeline of how the structure of TTI developed, including how DHSC's role expanded to take combined policy and operational responsibility for testing, tracing, and isolating, resulting in the eventual creation of NHS T&T in May 2020. I have been asked a number of questions about the use of data and how DHSC worked with Devolved Administrations to inform the development of TTI, with reference to rules for travel, the structure of the TTI system and how this changed. These were not areas with which I had any direct involvement or detailed knowledge and therefore direct the Inquiry to the corporate statements from DHSC which should be addressing these topics.
- 21. Prior to the pandemic, responsibility for contact tracing sat with PHE and was conducted by health protection teams (HPTs) in collaboration with local authorities. I think it important to note, and as the Inquiry has heard in previous modules, PHE was not fully prepared to deal with the scale and magnitude of the pandemic. There were no pre-existing plans for testing, tracing or isolating. For further background on structures that existed within PHE and Public Health in Local Authorities including PHE's earlier exercises in preparedness, and where devolved administrations chose to follow a common approach, I refer the Inquiry to the DHSC corporate Statement C for this module. Given contact tracing is a devolved matter, I direct the Inquiry to the relevant devolved administrations to understand where policies deviated. Some smaller scale exercises in contact tracing had taken place in response to the MERS-CoV outbreak in South Korea in 2015, and Mpox in 2019, but early policy emphasised that its role was limited to the early stages of the pandemic, before any wider community transmission was sustained. During those early stages, PHE were using their established procedures for tracing and isolating the first cases of COVID-19 and local authorities had limited involvement. As I set out further in my reflections below, it would have been preferable to rely more heavily on localised contact tracing resources. We liaised with Directors of Public Health wherever possible who were, in my experience, extremely knowledgeable and helpful, but unfortunately did not have the requisite power or resources. This is especially true when compared with countries that had successful local contact tracing strategies, such as South Korea, who had a strong history of local health infrastructure.
- 22. In relation to contact tracing specifically, any rudimentary system that existed within PHE proved, despite some optimistic efforts, simply not fit to be scaled up to the extent that it was needed. It may be said that we were starting with a blank sheet, but it was even worse than a blank sheet; we were under the mistaken belief that some kind of

basic system was in place. This distraction created a false sense of security and was in itself a hurdle to moving with the kind of urgency and scale that was so needed at the beginning.

- 23. PHE was also, in my experience, culturally hostile to any form of engagement with the private sector at a time when massive expansion of testing capacity was necessary, where existing tracing capacity was very clearly not scalable and when the capacity to design new diagnostics for this novel virus were not held within the organisation. At the time, I felt like I was pushing back on this approach and took the view that we needed to procure as much as we could, committing to purchase orders where necessary to ensure the industry had the necessary funds to expand their capacity.
- 24. For context, the limited contact tracing conducted by PHE during the 'contain' phase of the response to COVID-19 prioritised testing based on clinical need and, separately, prioritised contact tracing in high-risk settings. It was apparent even at this early stage that we had a massive problem. Once we moved to the 'delay' phase of the response the first national lockdown on 23 March 2020 when households were isolated and contact tracing was stopped (other than for specific outbreaks and other 'high-risk' situations), there was an opportunity to put distraction to one side and to re-strategise. We planned to rapidly expand our testing capability and to bring testing, contact tracing and self-isolation together as a more effective tool for supporting the country out of lockdown. It was at this time that I became more focussed on identifying individuals, tools and technologies that could help us increase testing capacity and deliver such an integrated TTI system at incredible pace.
- 25. The development of an integrated TTI strategy was intrinsically linked to the availability and speed of testing. Any system needed to be designed around the ever-changing technology and speed at which positive cases could be identified, as well as our growing testing capacity and subsequent expansion of eligibility. I set out my role in relation to the identification of testing technologies and the expansion of testing capacity below at paragraphs 54 to 68 below.
- 26. I set out examples in the following paragraphs of meetings and discussions that show my knowledge and involvement of early TTI strategy development more generally.
- 27. On 13 April 2020, I received a note from Lord O'Shaughnessy on setting up a 'tech and tools' challenge, in a similar way to the earlier 'ventilator challenge', which

suggested our priorities were to clarify our needs, communicate those to the tech sector, and start identifying those companies who are most likely to be useful (LB3/14 - INQ000592608).

- 28. On 16 April 2020, I held a call with a number of colleagues from DHSC as well as PHE, NHSX, and Behavioural Insights TeamBIT on TTI strategy, suggesting this be the first in a series of weekly one-hour governance meetings for the programme of work on TTI, including the development of the NHSX App. As part of the medium-term strategy, I was to lead on the technology, data and design elements of TTI (LB3/15 INQ000592625). In response to the action points, an email discussion took place between David Halpern (BIT), Matthew Gould (NHSX) and Anthony Finkelstein (UCL) on potential issues around data personalisation and the need for recruiting contact tracers and driving app uptake (LB3/16 INQ000592630).
- 29. On 17 April 2020, I conducted a meeting on modelling and forecasting for TTI that sought to identify the volume/type of contact tracing capacity needed and that which was available (LB3/17 INQ000592624). We also discussed how far incidence needed to reduce to make it possible to move to a new package of measures to control transmission which would include TTI.
- 30. On 18 April 2020, I was made aware of a commission from CO seeking papers on both the PHE UK-wide human contact tracing plan, and DHSC UK-wide programme timeline and plan on the whole TTI programme, including app development and ramp up of human contact tracing resource and analysis of testing capacity required to meet the maximum demand (LB3/18 - INQ000592629). The resulting presentation, which was shared with me on 21 April 2020, sets out the plans as commissioned (LB3/19 -INQ000592635 and LB3/20 - INQ000592636).
- 31. On 21 April 2020, I received slides setting out a broad strategy for large-scale, integrated contact tracing and testing programme (LB3/21 - INQ000592634). The strategy fell under 6 pillars as follows:
  - a) Pillar 1 NHSX App;
  - b) Pillar 2 web/phone-based contact tracing;
  - c) Pillar 3 wider tech;
  - d) Pillar 4 swab testing;
  - e) Pillar 5 antibody testing;

f) Pillar 6 – immunity risk certification.

The slides set out a plan of action points under each pillar on a weekly basis to the end of June 2020, as well as overall actions and priorities for the programme.

- 32. On 23 April 2020, PHE published a paper entitled 'Key issues for contact tracing for consideration by NERVTAG' which set out how the proposed NHSX app would operate and explored key related questions for consideration by NERVTAG, such as whether contact tracing of 'self-diagnosed' cases in the absence of laboratory confirmation is a proportional public health approach (LB3/22 INQ000120159). At the time, PHE recommended that such individuals be alerted to any recent potential contact with a possible case, be advised to re-double their efforts regarding hygiene and social distancing where possible, and to isolate themselves and obtain a test if they developed symptoms. The paper sets out that the NHSX app proposed to go further than PHE advice by informing contacts of symptomatic individuals to place themselves in quarantine for 14 days. For a number of reasons, including maintaining public confidence in the app, NERVTAG recommended that it be consistent with PHE advice and go no further.
- 33. On 24 April 2020, I held a further weekly TTI governance meeting, as planned, with the then Minister for Patient Safety, Suicide Prevention and Mental Health, Nadine Dorries MP and other DHSC officials (LB3/23 INQ000592640 and LB3/24 INQ000592641). Discussions centred around designing a system that incentivises individuals to understand and manage risk from the virus to themselves and to others, for which a paper had been prepared (LB3/25 INQ000592639). We also discussed resourcing, communications and the potential Isle of Wight pilot.

## Engagement with industry and experts

34. I think it important to note that early strategic meetings and conversations with experts and stakeholders centred around the idea that we could be living with this virus for a long time, or it could get worse, as with the 1918 flu pandemic. The long-term strategy for TTI was that of a fallback plan in case the vaccine did not work. We were, however, often working from the basis that we should not rely solely on the promise of a vaccine, and in a stage of the pandemic when many things that could go wrong did go wrong, I personally took these warnings very much to heart. There were some clinicians who were more hopeful, like the Deputy Chief Medical Officer (DCMO), Professor Sir Jonathan Van-Tam, who always thought the chances were better this time, but we could not be sure.

- 35. It was clear that all countries around the world were seeking to stand up test and trace systems of some kind. Some started from a strong base countries like South Korea had a strong tradition of local public health infrastructure, or Taiwan and New Zealand who took a tough approach to border control informed by their experiences of the SARS pandemic. All were moving very quickly to put such programmes into place.
- 36. It was clear that early and purposeful engagement with the scientific community was needed to encourage and facilitate innovation. I set out my engagement with the industry in relation to the identification of testing technologies and expansion of testing capacity in more detail below at paragraphs 54 to 68. We were also in regular consultation with experts in relation to tracing.
- 37. Tracing is a central component of any response to a pandemic, and we had sought to build a thoughtful strategy from the outset; a strategy to contain the disease until the arrival of a vaccine. My strategic role in relation to tracing systems and technologies therefore largely centred around the time of the first national lockdown when we recognised the dire state of readiness, and we formally moved from the PHE managed 'contain' phase of contact tracing towards the development of the NHS T&T as set out above at paragraph 24. The development of a strategy for NHS T&T very much relied on the availability of tracing technology so much of our early discussions involved an exploration and understanding of the technologies available. For a detailed summary of the way in which DHSC, NHS Digital and NHSX engaged with experts in the development of tracing technologies and the eventual development of the NHS T&T app, I refer the Inquiry to the DHSC corporate Statement C for this module. I set out examples of my involvement in the identification of some of these technologies and how we engaged with experts with the associated issues, such as privacy, in the following paragraphs.
- 38. On 6 April 2020, I was approached by a representative from SQREEM Technologies who had used their AI platform to develop a product which could prove useful for contact tracing. I put them in touch with Matthew Gould and Nadine Dorries MP, who were looking into this at the time (LB3/26 INQ000592600). I went on to have a meeting with SQREEM on 13 April 2020 (LB3/27 INQ000592607). At the meeting they explained that they were working with several governments, including South

Africa. The platform, which messaged people in real time, meant that contact tracing could be done in real time. Given the UK's use of its own app for proximity events, it was identified that the geo-location technology that SQREEM used could be particularly helpful in identifying high risk locations for decontamination (LB3/28 -INQ000593219). On 19 April 2020, I received a follow up email from SQREEM setting out the ways in which they could get started on collaboration with us (LB3/29 -INQ000593224). On 4 May 2020 I received a note on an initial review of SQREEM by the National Cyber Security Centre (NCSC) which identified a number of limitations and risks, noting that it was unlikely to be a replacement for the NHSX app but could provide useful data that was separate to the app and should be considered further in that context (LB3/30 - INQ000593233). I responded with my view that, while I agreed we did not envisage this as a replacement for the app, it may be a useful complement for certain demographic groups who did not participate in the app, for example, which I asked to be explored further (LB3/31 - INQ000593234). It was decided that SQREEM, as an ad tech service, was unlikely to be able to produce a product that could reliably identify individuals, such as superspreaders, with any accuracy. It also raised serious privacy concerns that were, ultimately, insurmountable (LB3/32 -INQ000593235).

39. I requested a meeting with NHSX about combining PHE contact tracing and the NHSX tracing app. I agreed with the Secretary of State for DHSC that the two parts needed to be brought into one project, but this involved more detailed exploration of the technology and subsequent data considerations, upon which I asked to be briefed (LB3/33 - INQ000592609). On 15 April 2020, I discussed the issue with officials from NHSX, who took me through slides on integrating data, knowledge and services through contact tracing (LB3/34 - INQ000592610 and LB3/35 - INQ000592611). Follow-up actions from the call included a presentation on the full range of options on data and privacy for ministers to consider. I was clear that the direction of travel was away from having a standard immunisation certificate while the science remained inconclusive on immunity. We needed to see how data from the app could help inform decision making (LB3/36 - INQ000593220). I also received a further note setting out what the tech-enabled version of 'top-down' contact tracing would look like (LB3/37 -INQ000593221 and LB3/38 - INQ000593222). I responded on 16 April 2020 to thank the team for the note and welcome an exploration of all types of models to understand: (1) how we could forecast the track-and-trace industry; (2) the drivers of need and numbers for track-and-trace-activities; and (3) levels of community prevalence required for a reasonable track-and-trace strategy to operate (LB3/39 - INQ000593223).

- 40. A central issue to discussions with experts on the development of TTI was on the gathering and management data. The availability of data was essential to our understanding of the transmission of the virus and would inform decision-making on the use of interventions and the management of outbreaks. This was a key area in which the advice of experts was sought in relation to TTI and the proposed NHSX app.
- 41. On 19 April 2020, I received an advanced copy of a rapid evidence review due to be published by the Ada Lovelace Institute on the technical considerations and societal implications of using technology to transition from the COVID-19 crisis (LB3/40 INQ000592631 and LB3/41 INQ000592632). The review was undertaken with a view to supporting the Government and its proposed technical solutions to reduce transmission, making recommendations to support well-informed policymaking in response to the crisis. It was the product of input from more than twenty experts drawn from areas including technology, policy, human rights and data protection, public health and behavioural sciences. I shared the review with colleagues in DHSC, NHSX and BIT, inviting them to join me in speaking with representatives from Ada Lovelace, as well as those from the Royal Society and the Alan Turing Institute who had undertaken similar initiatives (LB3/42 INQ000592622 and LB3/43 INQ000592599). I noted the importance of drawing on their expertise as much as possible, in a structured way.
- 42. On 27 April 2020, at a 'Track Trace and Certification' meeting, we discussed recommendations from SPI-M/NERVTAG that the app should inform contacts to isolate before the index case was confirmed as positive via a test and that those contacts would not be tested until they became symptomatic (LB3/44 INQ000592648). An updating note on the programme for No 10 was also discussed (LB3/45 INQ000592647). Following the meeting, in an email chain between attendees, we raised our concerns about the recommendations (LB3/46 INQ000592651). In the chain, I agreed with a concern raised by Lord O'Shaughnessy that it did not make sense to only test symptomatic contacts, if our aim was to chase the chain of infection as far as possible. I further referred to the Taiwanese method of targeted, localised isolation to enable schools to stay open. I sought clarification from Ben Dyson on the advice against asymptomatic testing. I noted the huge bearing that this would have on our testing numbers and asked for further explanation of the logic

behind the advice as it would seem unlikely to survive interrogation. On 28 April 2020, in response to my query to Ben Dyson, I received further clarification on the recommendations, setting out the SPI-M/NERVTAG advice in more detail, along with their reasoning; that if the primary contact is isolated sufficiently quickly, they are very unlikely to have been infectious before the point of entering isolation. The further clarification and summary of the advice is set out in the following email chain (LB3/47 - INQ000592652). It was also confirmed that they would keep the issue of asymptomatic testing under review.

- 43. As set out above, experts from BIT were often engaged to advise on the public's interaction with NHS T&T, including on issues of privacy and messaging. For example, on 11 May 2020, I received a summary of the results from a BIT experiment on public willingness to download the app and comply with contact tracing app instructions (LB3/48 INQ000592662).
- 44. Consideration was given to privacy concerns at every stage of development of the COVID-19 App. For example, an Ethics Advisory Board was established to provide independent challenge to the development of the app and papers from the Information Commissioner's Office (ICO) were also commissioned on data protection expectations of contact tracing (LB3/49 INQ000571265).

### Other contributory sources

- 45. Throughout the pandemic DHSC interacted with other countries and international partners to identify best practice with regard to testing and contact tracing. I was particularly interested in coordinating with our counterparts in Taiwan whom I considered to be taking the right approach which seemed potentially applicable to the UK, not least given our geographical similarities. A key element of Taiwan's successful strategy was the early closing of their borders which meant that even in the early days, by the time we were live to the potency of their contact tracing, it may have already been too late to replicate it it is almost impossible to have an effective track-and-trace system with open borders. In any case, I set out our interaction with international comparisons below which I address again in my reflections section, as I believe it to be useful to future preparedness.
- 46. On 10 March 2020, I followed up on a meeting with the CMO where we had discussed getting a briefing from the Taiwanese health team in Taipei to understand their different

approach to COVID-19 management. A call was arranged between the DCMO and a representative from Taiwan's Centre for Disease Control on 20 March 2020 to understand Taiwan's approach to managing the spread of the virus, including the use of digital technology and the development of faster testing (LB3/50 - INQ000592587). I understand that the call was rescheduled but I do not know when the meeting eventually took place, if at all, as I do not have access to the scheduling, as I was no longer a party.

- 47. Following the proposed meeting between DCMO and his Taiwanese counterpart, I sought a briefing from the Taiwanese ambassador to understand how Taiwan organised its track and trace. I was then advised by the FCO that NHSX would be put in contact with Taiwan's Department of Cyber Security instead (LB3/51 INQ000592618).
- 48. On 19 March 2020, I was sent a slide deck on international best practice in using technology to respond to COVID-19 that had been put together by NHSX, the Department for Culture, Media and Sport (DCMS) and FCO and Science and Innovation (SIN) networks with the assistance of digital technology consultants, Kainos (LB3/52 INQ000592588 and LB3/53 INQ000564689 As set out in the slides, after putting out a call for input, the FCO had received responses from over 20 countries which included over 50 individual ideas on best practice examples and offers to collaborate with NHSX, the content of which are summarised within. It was also suggested that further input and details, as awaited from countries such as Canada, Australia and New Zealand, would be added to the document as they continued to be sent in. I do not recall receiving the original responses from each country nor whether the slides were updated with further content. I believe this information would have been held by FCO.
- 49. On 22 April 2020 I received a readout of another meeting that was held between DCMO and Taiwanese counterparts the previous week to discuss what could be learned from Taiwan's approach to TTI in general, as well as seeking their collaboration on our digital approaches to TTI (LB3/54 INQ000592637). The readout sets out that Taiwan had linked its databases and collaborated with telephone companies to track people in quarantine. It also sets out that the DCMO had discussed UK plans to produce an app that tracked proximity of phones via Bluetooth with his counterpart who said that the Taiwanese Department for Cyber Security were looking into a similar app. It was agreed that 'an exchange of thinking and ideas' be set up.

- 50. Between 16 April 2020 and 4 June 2021 there were weekly calls between G7 health ministers who provided updates on how each country was managing the spread of the virus. These meetings proved a useful forum for exchanging ideas which often touched on testing, tracing, isolating and systems for TTI, providing useful comparators. I attended a number of the weekly calls on behalf of the UK. A total of 10 meetings were placed in my diary between 16 April 2020 and 3 June 2021. It is not clear from my diary whether all of these meetings did in fact take place, and I cannot otherwise recall with certainty, but I provide all the readouts that I was able to locate from the following meetings that I attended:
  - a) 24 April 2020, at which testing was discussed (LB3/55 INQ000592642 and LB3/56 INQ000592643);
  - b) 15 May 2020, at which testing was discussed (LB3/57 INQ000592665);
  - c) 29 May 2020, at which plans for mass scale contact tracing was discussed (LB3/58 - INQ000592693);
  - d) 30 July 2020, at which testing strategies was discussed (LB3/59 INQ000592729);
  - e) 6 August 2020, at which border measures and testing was discussed (LB3/60
     INQ000592736); and
  - f) 2 September 2020, at which border measures, testing and self-isolation was discussed (LB3/61 - INQ000592738).

I also attended a G7 Health Ministers Summit on 3 and 4 June 2021, at which we discussed improving the interoperability of digital technology in health (LB3/62 - INQ000592841). This was the first in-person international ministerial health meeting in over two years and an opportunity to make new commitments on preparing and responding better to health security threats. This included the strengthening of surveillance and more effective and efficient clinical trials, as well as a new action to tackle the 'slow pandemic' of antimicrobial resistance (AMR). The Director of Transformation at NHSX, Tim Ferris, highlighted the importance of digital health in promoting access to care. G7 ministers engaged enthusiastically which was important for the new collaboration on both data interoperability and artificial intelligence governance to ensure better international join up and the ability to share solutions between countries. Further ministerial monthly calls were to be set up to progress the issues as well as a series of follow-up working group processes.

- 51. On 27 April 2020, I provided my comments on a TTI update for No 10 that included a summary of other TTI systems being established internationally as a comparison (LB3/63 INQ000592649 and LB3/64 INQ000566131). I again highlighted the approach being taken by Taiwan in relation to testing and isolating and how effective their system seemed to be within schools, without the need for contact tracing.
- 52. I also attended a number of bilateral meetings with our international partners where issues related to TTI were discussed, as follows:
  - a) On 31 March 2020, following an initial call on 16 March 2020, I held a call with the US Deputy Secretary of Health, Eric Hargan, in which I heard his views on US testing capacity and early transmission rates (LB3/65 - INQ000279754). I continued to hold regular calls with Mr Hargan on issues including contact tracing (LB3/66 - INQ000279780).
  - b) On 12 June 2020, I received a briefing note ahead of a call that I would hold the same day with the South Korean Vice Minister for Health and Welfare. The note set out the South Korean and other countries' approaches to QR codes in contact tracing and a short overview of considerations should a similar system be implemented in the UK (LB3/67 INQ000592702 and LB3/68 INQ000592703). On the call we discussed issues around developing a system for TTI and how to protect people's privacy (LB3/69 INQ000279776). Following the call, the British Embassy in Seoul put together a paper on the Korean QR code system, using both open source and legal information provided by the Korean Ministry of Health and Welfare which I received on 26 June 2020 (LB3/70 INQ000592712 and LB3/71 INQ000592713). The Secretary of State for DHSC and I both reviewed the paper and provided our views which were then discussed with the NHSX team the following day (LB3/72 INQ000592710). I summarise our views as follows:
    - i. I suggested there was already a great deal of potential suppliers for this work, such as Oracle and IBM, and that business impact should be framed through the lens of it being an essential tool to open up businesses, with central government not taking on the cost. I felt that, overall, the benefits of the system outweighed the concerns raised and believed the public would be supportive with the position being that it was key to returning the hospital sector to normality. I agreed that we should develop a manual alternative to address issues of inequality of

access, as well as workarounds to overcome privacy concerns. I did not believe enforcement would be an issue at that stage nor did I think interoperability would be a bar to people travelling to the UK and attending venues, as they could always download the app for their stay. I wanted to steer away from companies that sell data, such as Google, and that backwards tracing should be prioritised within the plan.

- ii. The Secretary of State for DHSC was positive about the system and thought NHSX and NHST&T should work together to scope a solution to take it forward. He thought that we should be working with tech companies to make QR codes available, as per the New Zealand model, but agreed with me that this should only be with companies that do not sell data. The recommendation to work with businesses to encourage support for contact tracing and backward contact tracing also received his backing.
- c) On 15 June 2020, I held a call with the Director General of the Swiss Federal Office of Public Health, Mr Pascal Strupler, in which we discussed the Swiss COVID-19 contact tracing app, how its voluntary use is embedded in law and how it did not use personal data. Mr Strupler expressed an interest in the UK's app development, and we agreed to ongoing engagement (LB3/73 -INQ000279775).
- d) On 29 July 2020, I attended an international roundtable meeting to discuss PCR testing and associated technology with my counterparts (LB3/74 -INQ000592731).
- 53. Despite these good efforts, I do not believe we did enough to learn from countries like Taiwan, South Korea and New Zealand on their use of contact tracing technology. I pushed hard on the Taiwanese example in particular, as set out above, which I believed could have been a realistic example to follow and am disappointed that this was not pursued with greater enthusiasm. I address this point further below as part of my lessons learned reflections.

## SECTION THREE: TESTING

My role in identifying testing systems and technologies and expanding capacity

- 54. As set out above, expanding our nationwide testing capacity was central to TTI strategy and necessarily required early and purposeful engagement with the scientific community to encourage and facilitate innovation which, in the early days, was lacking. For example, it was brought to my attention on 24 March 2024 that a lack of timely engagement from PHE on the approval of testing technologies was slowing us down (LB3/75 INQ000592871). As with much of my role, where it seemed that those responsible were not setting a hard enough pace, I engaged with the detail to better understand how and where to push the system to move faster.
- 55. For example, I was particularly keen in pursuing the technology and encouraging the roll out of Lateral Flow Device (LFD) tests:
  - a) On 27 April 2020 I was informed of plans and proposed timelines for the early rollout of LFDs through an Imperial College London pilot to test the useability of LFDs with the scaling up of tests to follow. I felt, however, that things seemed to be moving unnecessarily slow so, in response, I encouraged the team to commit to getting the programme started as soon as possible and sending greater numbers of kits of self-swab sooner (LB3/76 INQ000592644). I also pressed the issue with David Williams, reminding him that it was 'an important project', that required financial sign off as soon as possible so we could move it forward with confidence (LB3/77 INQ000592645).
  - b) On 6 May 2020, I volunteered my assistance with Abingdon Health LFD deployment, and asked Sir John Bell for his advice on how I could help move things forward (LB3/78 INQ000592661). As exhibited below, all external ministerial meetings are published, and I had held a number of discussions with Abingdon Health about the development of LFDs in April and May 2020. Sir John Bell brought the company to my attention as a lateral flow company based in Yorkshire and sent me the contact details of Chris Hand, a representative from Abingdon Health, on 1 April 2020 (LB3/79 INQ000593218). I had never heard of Abingdon Health before that point but was obviously very excited to learn of a UK-based diagnostics company who may be able to develop a valid LFD. I spoke to the company the same day and, as set out in the published ministerial meetings, the purpose of the call was 'to discuss their lateral flow tests and COVID-19'. The subsequent calls on 5 and 29 April and 13 May 2020 will also have had LFDs as a central focus of discussions. As I have told the Inquiry in previous modules, my role at the time was very much reaching out to

companies like this to ask, 'what can we [the Government] do to help you help us in fighting the pandemic?' and this would have been what I meant in my email to Sir John Bell by asking 'what can I usefully do?'.

- c) On 20 September 2020, in response to a testing validation and private sector strategy meeting, I pressed my private office for a plan for publishing the validation of antigen tests, noting that this was 'imperative' (LB3/80 -INQ000592743).
- d) On 22 December 2020, I received a submission regarding PHE's evaluation of the positive performance of LFDs on the new variant of COVID-19, conducted at Porton Down, seeking my approval to alert WHO immediately (LB3/81 INQ000592777 and LB3/82 INQ000592778). I strongly supported the recommendations and sought further work to be done on the associated analysis piece, to help boost positive public debate around LFDs (LB3/83 INQ000592780).
- 56. I had a number of meetings in early 2020 with industry representatives and experts on the subject of building up the UK diagnostics industry. As set out at paragraph 16 of my statement for Module 5, submitted to the Inquiry on 20 December 2024, DHSC published details of all external ministerial meetings at the time, including the purpose for such meetings, in quarterly ministerial returns. I exhibit these again as follows:
  - a) January to March 2020 (LB3/84 INQ000528372);
  - b) April to June 2020 (LB3/85 INQ000528371);
  - c) July to September 2020 (LB3/86 INQ000528369);
  - d) October to December 2020 (LB3/87 INQ000528374);
  - e) January to March 2021 (LB3/88 INQ000528370);
  - f) April to June 2021 (LB3/89 INQ000528373); and
  - g) July to September 2021 (LB3/90 INQ000528368).
- 57. This ministerial engagement was supported by departmental meetings, where overall TTI strategy was set. These meetings were divided into five workstreams which reflected the five pillars identified in the Government testing strategy published on 4 April 2020 (LB3/91 INQ000106325), and summarised as follows:

- a) Pillar 1: Scaling up NHS swab testing for those with a medical need and, where possible, the most critical key workers;
- b) Pillar 2: Mass swab testing for critical key workers in the NHS, social care and other sectors;
- c) Pillar 3: Mass antibody testing to help determine if people have immunity;
- d) Pilar 4: Surveillance testing to learn more about the disease and help develop new tests and treatments;
- e) Pillar 5: Spearheading a Diagnostics National Effort to build a mass-testing capacity at a completely new scale.
- 58. I set out below examples of such meetings where expansion of testing capacity was discussed:
  - a) Workstream 1:
    - i. 23 March 2020: I held a deep dive meeting with representatives from BEIS, DHSC, NHSE, and PHE working on Workstream 1. A presentation was shared which set out the details of the programme to increase the PHE and NHS lab-based testing capacity from 5,000 to 25,000 per day (LB3/92 - INQ000497112 and LB3/93 -INQ000497113). The need for ministerial engagement with Roche to secure additional testing kits was also discussed with a meeting to be set up between Steve Oldfield, Alex Sienkiewicz and me to discuss our ongoing relationship (LB3/94 - INQ000497114). This led to a meeting between Alex and me on 17 March 2020 (LB3/95 - INQ000497103), follow-up emails on the Roche/PHE partnership (LB3/96 -INQ000497120 and LB3/97 - INQ000508318), and a further meeting on 30 March 2020 (LB3/98 - INQ000508319).
    - ii. 3 April 2020: I held a stocktake meeting with representatives from BEIS, DHSC, NHSE, and PHE working on Workstream 1. A presentation was shared which set out a number of key challenges, including a shortage of swabs and other supplies. Addressing this, it sets out that a triage team had been established to manage 'offers'; an expert procurement group including industry representatives was to be set up; the lobbying of CEOs of main suppliers to increase UK allocation; exploring new supply routes; building relationships with smaller suppliers; and supporting domestic manufacturers to expand (LB3/99 -

- b) Workstream 2:
  - i. 26 March 2020: I held a deep dive meeting with representatives from BEIS, DHSC, and NHSE working on Workstream 2 to discuss coordination between workstreams. Much of the discussion centred around matters outside the scope of this module, like distribution (LB3/102 - INQ000497125). There was some discussion around procurement and supply, however, and a presentation was shared which set out a nine day forecast of testing capacity by supplier (LB3/103 - INQ000497118 and LB3/104 - INQ000497119).
- c) Workstream 3:
  - i. 26 March 2020: I held a deep dive meeting with representatives from BEIS, DHSC, and NHSE working on Workstream 3, as well as Professor Sir John Bell from Oxford University, to discuss the securing and supply of reliable antibody tests, as well as issues outside of the scope of this module, such as distribution and logistics. One of the items for discussion was the progress with procuring and assessing clinical validity of anti-body tests (LB3/105 - INQ000497115). A presentation was shared which set out the process for securing the supply of tests which included an expedited product triage process to identify the most reliable tests and buying those tests on bulk order, which then required validation before being rolled out as part of a national programme (LB3/106 - INQ000497117 and LB3/107 - INQ000508317). The triage team were told that emails that had been sent to Ministers would be flagged when sending to ensure a swift response. I also reminded the teams to be 'open minded to all companies and people who approach at the first stage' of procurement and ensure we were not taking a 'limited approach to tests' (LB3/108 - INQ000497121).
- d) Workstream 4:
  - i. 16 April 2020: I held a meeting with the Workstream 4 team in which we discussed a three phased population surveillance programme consisting of: an NHS blood donor study; a UK Biobank lateral flow test study; and an Office of National Statistics (ONS) population survey

(LB3/109 - INQ000592612; LB3/110 - INQ000592613; LB3/111 - INQ000592614) for which I received a follow-up report (LB3/112 - INQ000592615 and LB3/113 - INQ000592616).

- e) Workstream 5:
  - i. 7 April 2020: I held a Workstream 5 launch meeting in which I suggested that all companies that had been getting in touch about testing be invited to the next call (LB3/114 INQ000592601). In the meeting, I suggested that we (Government) needed to be clear with industry about what we wanted from them and what assistance we could offer, i.e., that we could provide grants but needed them to be entrepreneurial and bring us innovative ideas. I reiterated that the Workstream 5 fund should not be an innovation fund but one aimed at helping scale companies who are resilient and are providing goods that meet our needs.
  - ii. 9 April 2020: I held a meeting on stakeholder engagement strategy (LB3/115 - INQ000592606). Prior to the meeting I requested a first draft of an industry engagement plan to include a list of the British firms with which we were engaging, what they were offering and where they fit in the wider diagnostics picture (LB3/116 - INQ000592604; LB3/117 -INQ000497272; LB3/118 - INQ000592605).
  - 17 April 2020: I held a meeting with the Workstream 5 team on the industrialisation of testing (LB3/119 - INQ000592623).
  - iv. On 1 May 2020 (LB3/120 INQ000592654), 15 May 2020 (LB3/121 -INQ000592664), 21 May 2020 (LB3/122 - INQ000592668), and 29 Mar 2020 (LB3/123 - INQ000592694), I held further Workstream 5 catch up meetings to monitor the industrialisation of testing work, stakeholder engagement and the development of a lab capacity strategy.
- 59. From 8 April 2020, I attended regular meetings of the Testing Taskforce, which were chaired by the Secretary of State for DHSC and brought together other ministers, leaders and experts from across Government, industry and academia and the wider healthcare sector. The terms of reference set out how the taskforce would help drive progress, unblock barriers and find creative solutions to deliver the UK COVID-19 Testing Strategy. It would coordinate its response under the five main pillars as set out

above. Meetings were scheduled to take place three times a week, unless deemed unnecessary at the time by the SRO or Secretary of State (LB3/124 - INQ000497424).

- 60. While many of the meetings focussed on issues outside the scope of this module, such as logistics, procurement of tests and the identification of new technologies were often discussed. I therefore exhibit the readouts, and any accompanying material of the meetings that I attended below, and summarise any relevant issues discussed:
  - a) 8 April 2020 (LB3/125 INQ000497146 and LB3/126 INQ000497142);
  - b) 10 April 2020 (LB3/127 INQ000497148);
  - c) 15 April 2020 (LB3/128 INQ000497151);
  - d) 17 April 2020, where there was some discussion about sourcing new Abbot antibody and lateral flow tests and other procurement issues (LB3/129 INQ000497155; LB3/131 INQ000497156);
  - e) 20 April 2020 (LB3/132 INQ000497157 and LB3/133 INQ000497158);
  - f) 23 April 2020 (LB3/134 INQ000497159);
  - g) 27 April 2020 (LB3/135 INQ000497160);
  - h) 29 April 2020 (LB3/136 INQ000497161; LB3/137 INQ000497162; LB3/138
     INQ000497163);
  - i) 4 May 2020, where a sourcing issue for PCR machines was raised with the prospect of assistance from Thermo Fisher (LB3/139 INQ000497164 and LB3/140 INQ000497165);
  - j) 11 May 2020, where there were discussions about scaling up production and acquiring antibody tests from Roche (LB3/141 - INQ000497166 and LB3/142 - INQ000497167);
  - k) 18 May 2020 (LB3/143 INQ000497168);
  - 26 May 2020, which I co-chaired with Baroness Harding, and there was some discussion about the delivery of the Roche antibody tests (LB3/144 -INQ000497169);
  - m) On 28 May 2020, following the appointment of Baroness Harding and the restructuring of the testing programme, there was no longer a need for a standalone ad-hoc taskforce, and the decision was taken to pause the taskforce and redistribute its functions within the broader programme (LB3/145 -INQ000497170 and LB3/146 - INQ000593239).

- 61. In April and May 2020, I attended regular meetings to discuss the trials and treatments supply, and received a routine updating paper, 'COVID-19 Trials and Treatments SitRep'. I exhibit these as follows:
  - a) 24 April 2020 (LB3/147 INQ000497465 and LB3/148 INQ000497466);
  - b) 8 May 2020 (LB3/149 INQ000497467; LB3/150 INQ000497468; LB3/151 INQ000507129);
  - c) 14 May 2020 (LB3/152 INQ000497469 and LB3/153 INQ000513020);
  - d) 21 May 2020 (LB3/154 INQ000497470 and LB3/155 INQ000513021).
- 62. There were a lot of speculative technologies being explored in support of the drive to expand our testing capability and I dedicated a significant amount of time to hearing proposals that ultimately came to nothing, but it was important that all avenues were explored. One such proposal that was incredibly promising but, for reasons set out below, ultimately unsuitable, was in relation to the development of saliva-based loop-mediated isothermal amplification (LAMP) tests. These could have been a major improvement on the typical throat and nasal swab-based PCR tests that presented a particular hurdle for individuals with autism or learning difficulties, for example.
- 63. On 21 July 2020, I supported a provision of funding to help deliver LAMP tests for vulnerable and high-risk groups (LB3/156 INQ000592849), having met with the team in June 2020 to discuss the proposal in depth (LB3/157 INQ000592846).
- 64. On 20 September 2020 I received an interim report and progress update on the Southampton LAMP testing pilot (LB3/158 INQ000592739; LB3/159 INQ000592741; LB3/160 INQ000592742; LB3/161 INQ000592740).
- 65. On 25 November 2020, I received the final report from the Southampton Phase 2 asymptomatic testing pilot which focussed on testing in schools and the university, citing a positive response from participants (LB3/162 INQ000592755). In the months that followed there were a number of challenges and issues raised, resulting in a pause of the Southampton programme. One such issue, and the reason given for the pause was that 'a constraint on the processing speed of the system caused by the specific data storage architecture created a limit to the number of results that could be communicated to participants per day.' (LB3/163 INQ000592825 and LB3/164 INQ000592826).

- 66. Following the introduction of Optigene and LAMP technology, LFD tests were approved and deployed at scale for asymptomatic testing purposes and so the demand for LAMP technology diminished. As set out in Chapter 6 of the Technical Report on the COVID-19 pandemic in the UK, published by DHSC on 1 December 2022, (The Technical Report) it was challenging to deploy LAMP testing at scale (LB3/165 -INQ000592867). Although it could produce rapid results (less than 20 minutes) and performed well in both the pre-infectious and infectious phase, direct LAMP testing was not widely used because the machines to process the tests were too large and required regular maintenance and staff training to use. Ultimately, LAMP testing was deployed on a small scale for asymptomatic testing in NHS staff as well as mobile units to respond to outbreaks in care homes, hospitals, prisons and town centres. On 13 August 2021, the Secretary of State for DHSC agreed to the cancellation of future LAMP assay production based on the new demand profile, which included a portion of tests for individuals with Special Educational Needs and Disabilities (SEND), confirmed by the Department of Education (LB3/166 - INQ000592851 and LB3/167 -INQ000592852).
- 67. Another example of a promising technological advance that I was made aware of but that was, ultimately, not viable was in relation to a new type of breathalyser test. At paragraphs 90 to 99 of my statement for Module 5, submitted to the Inquiry on 20 December 2024, I set out my involvement with a proposal for BioSafety COVID-19 test system being supplied by the Tera Group. I had a number of exchanges with David Meller, who was in contact with the Tera Group, and put him in touch with officials who might help progress the new test through MHRA approval, ensuring the extent of the technological information was received. I understand that the performance data ultimately failed to meet expectations but again, it was important that these advances be considered in detail.
- 68. One further example of promising technology that was drawn to my attention was a 'cough test'. On 2 November 2020, I received an email from Tim Leunig at HMT sharing a link to an MIT article about a new AI technology that was able to identify COVID-19 from a cough. I responded with enthusiasm, noting that we had looked into cough tests before using a different technology as seen in Taiwan, which we'd sought to roll-out in social care settings. I told him I would look into it and 'push it through the system' (LB3/168 INQ000497397). I passed this on to the relevant teams and continued to monitor progress which resulted in a research project being commissioned in January 2021 to assess the algorithmic feasibility of screening for COVID-19 using vocal

biomarkers from audio data (LB3/169 - INQ000592766 and LB3/170 - INQ000592767). Although I provided my support for the research project, by this point I was aware of some scepticism as to any successful outcome so noted the importance of careful handling of press activity (LB3/171 - INQ000497412). There was often a careful balance to be struck between pursuing all possible innovative solutions and raising public expectations unnecessarily.

## Expert advice

- 69. As we explored every avenue for broadening our testing capability, I took advice from officials at every step of the way. Ministers often led in discussions and showed initiative, asking questions and convening meetings to challenge orthodoxy. There was full ministerial leadership, but expert advice and guidance was integral to decision-making. This would necessarily involve the opinions of scientific experts and those able to distil performance data of new testing technologies, but we also relied heavily on the advice of experts in practical areas such as supply-chain and logistics to understand whether each test was in fact feasible to produce and roll-out at the scale required.
- 70. As can be seen from ministerial meetings exhibited above at paragraph 56, I conducted a number of meetings in March 2020 with representatives from the pharmaceuticals industry to discuss COVID-19 testing. Often these meetings would combine strictly scientific advice with more practical knowledge and expertise. For example, I recall a meeting to discuss home testing for COVID-19 on 18 March 2020 which was attended by Sir John Bell and representatives from Amazon, PHE, MHRA, Wellcome Trust and NHSX (LB3/172 INQ000592585). It was the concurrent balancing of such expertise and advice in meetings such as these, that enabled us to get out of 'groupthink' and pursue and support ideas that had a realistic chance of success more quickly.
- 71. On 26 March 2020, following our meeting, I wrote to Sir John Bell regarding the establishment up of the COVID Testing Scientific Advisory Panel (CTSAP) under his leadership and provided the draft terms of reference (LB3/173 INQ000592594 and LB3/174 INQ000546878). CTSAP were to support the testing triage process being led by Dr Sam Roberts in NHSE. The CTSAP were invited to conduct an initial review of new and complete testing solutions and make subsequent recommendations on whether they should be approved, with or without high priority, or rejected .

### Accessibility of testing

- 72. The needs of the vulnerable, disadvantaged and at-risk groups were always part of discussions in relation to testing strategy and accessibility of testing. This was not necessarily as a result of any inclusivity agenda, but because all epidemiological thinking starts with the disadvantaged. Health is inherently unequal with the highest density of disease often striking the poorest members of our community. This concern was intrinsic to our work, and we made huge efforts to bridge gaps in accessibility to meet people where they were. I set out some examples with which I was directly involved below.
- 73. On 20 May 2020, I received an update on the plans to open our first walk-through local testing site for COVID-19 in Leeds (LB3/175 INQ000592667). The purpose was to provide testing closer to where people lived and worked, to provide an option for people who did not have a car and for vulnerable people such as the homeless or those with lower digital literacy to access testing booking systems. Further pilot sites were to follow in Birmingham, Newcastle, Manchester and London.
- 74. On 9 June 2020, the Secretary of State for DHSC and I both raised our concerns with officials working on NHS T&T about the health and financial impact of COVID-19 on groups of people whose touchpoints with the system may have ceased, for example, homeless people, Roma communities and sex workers. We sought an update on the work that was being done to ensure that these groups would not be left behind **(LB3/176 INQ000592701)**.
- 75. On 8 July 2020, I held a meeting with officials from DHSC on the subject of equality and inclusion communications within NHS T&T (LB3/177 INQ000592714; LB3/178 INQ000592715; LB3/179 INQ000592717). I asked the team to design a risk register to understand how to engage with groups who had poor engagement with NHS T&T and to help guide our targeting of communications. I received a submission on 14 July 2020 setting out a communications and engagement strategy for hard-to-reach communities both at a national and local level (LB3/180 INQ000565921 and LB3/181 INQ000592720).
- 76. I held a number of meetings with the then Minister for Equalities, Kemi Badenoch MP, to discuss access to NHS T&T for hard-to-reach groups. For example:

- a) On 15 July 2020, I summarised that our analysis of NHS T&T engagement showed a broad spectrum of vulnerable groups were not being reached, in particular, groups such as the disabled, communities that did not speak English as a first language and those working outside mainstream work conditions. I said this lack of engagement was of particular concern where such communities also present a risk of high prevalence of the disease and potential outbreaks. Ms Badenoch and I agreed to continue discussions and that we needed to go further than the work currently being undertaken by PHE. She also agreed to coordinate with the proposed No 10 Racial Disparity Commission (LB3/182 - INQ000592721).
- b) On 22 July 2020, we discussed both local data from PHE Directors and Local Authorities and national data received through the then, Joint Biosecurity Centre (JBC). Although it was clear that the 'priority audience' groups identified by NHS T&T fell largely within the umbrella ethnic minorities category who were also subject to disproportionately high positivity rate, I noted how the data showed it was less to do with ethnicity so much as cultural and socio-economic factors; we needed to understand how groups were behaving to understand how to target NHS T&T communications (LB3/183 INQ000592722).
- c) On 24 July 2020, I received a suggested brief for Sir Trevor Phillips proposing that we work with him and his organisation to conduct a localised trial in an area such as Blackburn or Bradford (LB3/184 - INQ000592723). As a result, I met with Ms Badenoch on the same day to discuss work on improving NHS T&T communications in harder-to-reach communities. We agreed to seek the assistance of Trevor Phillips to conduct a localised trial using his sophisticated database and algorithms to break through Government COVID-19 messaging to certain ethnic minority communities in areas such as Blackburn or Bradford over the course of 10 to 15 days in the build-up to the Eid period, being careful to ensure that such communities did not feel aggressively targeted, potentially putting strain on community racial relations (LB3/185 - INQ000592725).
- d) On 29 July 2020, Ms Badenoch and I discussed the Government's 'broadcast sprint' communications plan for engagement with hard-to-reach groups including ethnic minority communities. I raised my deep concerns about our communications with these communities and said that we need to do more to

ensure we were engaging with stakeholders (LB3/186 - INQ000592726; LB3/187 - INQ000592727; LB3/188 - INQ000592728; LB3/189 -INQ000592730).

- e) On 31 September 2020, Ms Badenoch and I discussed her forthcoming report which would highlight the important issues that we needed to focus on, using the 'on the ground' lessons learned in the last quarter. She agreed that we were not reaching people on this crisis which underscored the inequality of opportunity. I agreed to link Ms Badenoch with Baroness Barran who was proposing a community engagement network on hard-to-reach groups (LB3/190 - INQ000592744).
- 77. On 4 August 2020, I held a deep dive meeting with NHS T&T communications team to discuss the Government's approach to communications with ethnic minority communities (LB3/191 INQ000592733 and LB3/192 INQ000592734). I reiterated my concern that we should reframe this away from ethnic minorities; that this was not just a question of ethnicity but also those that we were finding it hard to target via the main communication channels. We discussed how to engage with non-mainstream media, and I agreed to pick this up with senior advisors at No 10 to help address some of their concerns on the issue (LB3/193 INQ000592735).
- 78. As set out above at paragraph 76(c), on 24 July 2020 I received a suggested brief for Sir Trevor Phillips in relation to utilising his organisation to conduct a localised trial. On 7 August 2020, I met with Sir Trevor Phillips to set out our proposal, seeking his help on mitigating the issues we were facing with reaching certain groups and how to fill these communication gaps. I emphasised how critical this work was to help stop a second wave of the virus (LB3/194 - INQ000592737).

#### Testing targets

79. The announcing and meeting of testing targets were always in sharp focus and we were therefore constantly identifying and removing barriers to our ability to meet projected capacity. In the early days, supply of tests was our greatest challenge. As the Inquiry is aware from questions put to me in previous modules, I think that HMT were sometimes late to approve purchase orders, and this was particularly true in relation to the vital supply of tests. I have also been asked to comment on the evidence of Lord Agnew from Module 5 about the approval of a large testing contract (LB3/195

- **INQ000471020**). In the email, Lord Agnew references comments from CCO Gareth Rhys-Williams taken from another email thread that I was referred to by the Inquiry for comment as part of my Module 5 witness statement preparation **(LB3/196 - INQ000477938)**. In response, and for further background to the misalignment between DHSC and HMT on spending controls and the intermediary role that I sometimes took in response, I direct the Inquiry to paragraphs 38 to 39 of my Second Witness Statement to the Inquiry for Module 5, dated 20 December 2024:

38. Where there was misalignment between DHSC and CO and HMT on their approach to spending controls, I sometimes took on an intermediary role. With the expansion of DHSC procurement during the pandemic came a greater need for collaborative mechanisms to draw on expertise of CO but also help DHSC respond at pace at the unfolding emergency. In my experience, however, there was often a lack of formal and thoughtful dialogue; we received a lot of push back from CO and HMT but did not always receive a detailed response with their refusals. It was very difficult to know what they were thinking and therefore how we could address their concerns. I had some intermittent engagement with Lord Agnew, who was Minister of State at CO and HMT at the time. He and I have known each other for many years and have a frank but respectful way of working together. I remember having informal discussions with him where I would listen to his concerns, which were often a reflection of wider view, and attempt to reassure him with reference to the extensive material already being provided by my colleagues.

39. HMT seemed to me to be making decisions without fully engaging in the information that had been given to them. There also seemed to be a resistance in central government to the idea of an impending second wave which resulted in a lack of clear decision-making. Protecting the taxpayer from fraud or waste and ensuring value for money was obviously extremely important but I do not think that was the issue. In any case, any hesitancy in the name of securing a good deal for the taxpayer was often counter-productive; leaving so many decisions to be made in haste, inevitably incurring additional cost. In future, I think there would need to be a fundamental overhaul of the capabilities and scope of CO to ensure that mechanisms were in place for reacting to emergencies. Without this, there is little appetite for engaging with the reality of the unfolding situation and applying the appropriate spending controls.

80. With such limited supply of tests in the early months of the pandemic, testing targets were set in the context of prioritisation. Tests would initially be limited to those who were seriously ill and then expanded through a phased approach of prioritisation of frontline workers, to eventually providing a test to anyone who needs one, as set out in DHSC's Five Pillar Testing Programme (LB3/91 - INQ000106325). As the criteria expanded in line with capacity, addressing inequality in access to tests became an

important part of our ability to meet targets. Increasing access to tests for certain groups with identifiable physical or technological barriers, such as with the introduction of walk-in testing sites from May 2020 as set out above, helped ensure we were maximising testing capacity for all cohorts. I have been asked to consider my interaction with the Crick institute and their offers of assistance with the national testing effort. I recall a number of early interactions with Paul Nurse from Crick, both as part of the public meetings in April 2020, and also directly to discuss how they may contribute to the national testing programme. As with Abingdon Health and other small UK-based diagnostic firms, I was enthusiastic about any possibility to expand our domestic supply and was extremely grateful for the hard work and creativity shown by Crick and others through their offers for support. Ultimately it came down to turnaround times and capacity that we required.

81. This approach continued throughout the testing programme, such as in February 2021, when the NHS T&T programme announced significant accessibility improvements to the home testing service, a service for people in the UK not willing or able to travel to a physical test site. This included a new option to order test kits over the phone for those with limited digital access and a partnership with the Royal National Institute for the Blind to improve home testing service for the visually impaired. I received a press notice summarising the new improvements ahead of its announcement on 14 February 2021 (LB3/197 - INQ000592803).

### Barriers to an effective testing and tracing system

82. As is clear from the expert advice on technology above, issues around data and privacy were identified early on as potential barriers to effective contact tracing. These issues were therefore central to which tracing system and supporting technology would be used. We were aware that the public would likely have concerns about how such data would be managed, given the use of such sensitive information such as location and health and care data. As part of the proposals discussed at the meeting with NHSX officials on 15 April 2020, we discussed the privacy and data impacts of the various options for location data being considered such as, for example; continuous tracking, proximity event location tracking, or anonymous Bluetooth proximity event data (LB3/35 - INQ000592611). We discussed the pros and cons of the various data collection options including the impact this would have on public trust and take-up. The most accurate contact tracing technology or most wide-reaching data collection would

not necessarily correlate with the most effective system; if the public did not trust us with their data, fewer people might choose to install the app and therefore undermine its potency.

- 83. Behavioural insights in relation to the likelihood that individuals would take a test in the first place were also key to our understanding of the barriers to an effective tracing system. These were explored in a polling and focus group in the context of a new advertising campaign in June 2020, for which I received summary findings (LB3/198 INQ000592696). I raised the apparent 'branding' issues with James Sorene from the NHS T&T communications team, who noted that this could be resolved through increasing messages about the convenience of access to a test and the speed of result (LB3/199 INQ000592698).
- 84. There were also questions being raised as to whether a centralised system was more effective than a decentralised, or local, system of tracing. For example, on 4 May 2020, I received a submission from NHSX on the next stages of the app with reference to the centralised approach being taken (LB3/200 INQ000592657 and LB3/201 INQ000575874). In an ideal world, where the UK had invested in a strong local public health infrastructure with trained personnel familiar with their communities, a national data-sharing spine and a consistent set of guidelines on good practice, it would have been *much* better to have a local response with local tracing and local testing, like they did in South Korea. But this was not the case in the UK. Therefore, given the dire state of local public health in the UK, the advice, with which I agreed, was that the centralised approach provided substantial additional benefits over and above what was possible under a decentralised version but that NHSX would establish a quick technical review of the advantages and disadvantages to the two approaches and work closely with Apple and Google to ensure there would be optionality to switch approaches further down the line (LB3/202 INQ000592660).
- 85. This issue of decentralisation has been addressed more generally in Chapter 7 of the Technical Report, which noted that, 'feedback from local authorities and the public indicated that the centralised, national contact tracing model did not always make best use of local expertise, and the focus of national tracing teams might have constrained the timely identification and management of local clusters and outbreaks'. The resulting partnership with local authorities from summer 2020 had some positive impact, particularly with more 'hard to engage' cases.' I also address this point further below as part of my lessons learned reflections.

## SECTION FOUR: ISOLATING AND ENFORCEMENT

#### The development of an isolation strategy and consideration of alternatives

- 86. The development of an isolation strategy, as set out in detail in the DHSC corporate Statement C for this module, was based on advice from the CMO and DCMO and further supported by consultation with scientific advisory groups.
- 87. On 20 May 2020, I received a submission to confirm the policy on contact tracing and self-isolation ahead of the announcement of the overall NHS T&T strategy on 27 May 2020, including which non-household contacts need to self-isolate and for how long (LB3/203 INQ000592692 and LB3/204 INQ000565517).
- 88. As part of the developing strategy, alternatives to isolation were always being considered. For example, as referred to in the Technical Report, we regularly engaged with surveillance studies such as the Real-time Assessment of Community Transmission (REACT) study which provided vital information on COVID-19 prevalence, while avoiding the bias often present in national testing data. This was particularly helpful to support policy decision-making and in consideration of alternatives to isolation.
- 89. Within the REACT studies, a lot of research was undertaken into finding alternatives to isolating children, which we were always desperate to avoid. On 13 June 2020 I received an update from Lord Darzi on the REACT studies (LB3/205 INQ000592704), with reference to the REACT 2 study, Part B on children (LB3/206 INQ000592707). There was limited data available regarding past infection of children or their contribution to community transmission. The plan for the next wave of the study was to prioritise usability and feasibility of a home-based antibody testing in children aged 5-17 to help inform policy on schools. I agreed to the suggestions the following day (LB3/207 INQ000592709).
- 90. On 2 June 2020 the Secretary of State for DHSC and I received advice in relation to the testing of asymptomatic passenger arrivals at UK airports as a potential alternative to mandatory self-isolation (LB3/208 - INQ000592699 and LB3/209 - INQ000592700). The advice, requested by the Secretary of State, set out that the CMO and DCMO did not recommend such a strategy. Clinical studies had shown that mass testing of the

asymptomatic population was of little value in reducing transmission risk. Further, there was a risk that some people could receive a 'negative' PCR test result despite being an earlier carrier of the virus and therefore pass on the virus if not advised to self-isolate for the full 14 days. There was a further practical barrier of capacity; even a small increase in daily arrivals could put pressure on testing capacity that would require a reduction in testing elsewhere. It was recommended that we continue to look at it, with international comparisons to be considered. I set out further points to explore in follow-up with my private office on 26 June 2020, addressing some of the issues raised in the advice (LB3/210 - INQ000592711).

- 91. Following further advice, a 'test to release' policy was instead developed for arrivals to UK airports. I received a submission on the policy on 16 October 2020, to which I responded, highlighting some administrative issues and urging stronger support for the police to assist with enforcement (LB3/211 INQ000592745 and LB3/212 INQ000592748). I suggested that we needed to support the police's point that people need to definitively commit to opting in to a 'test and release' when they complete the passenger landing form. I also suggested we needed much better enforcement of isolation during the period of isolation. I highlighted an anecdotal example from Australia where a friend received a phone call and police visit every day and suggested the police be supported to provide this level of intervention. Test to release was ultimately made available from December 2020, as set out in more detail in the DHSC corporate Statement C for this module.
- 92. On 10 February 2021, I received details on isolation enforcement options including the early stages of an idea for a 'Quarantine App' to support the Managed Quarantine Service, as commissioned by COVID-O (MQS) (LB3/213 INQ000592790 and LB3/214 INQ000592792). The purpose of the app was to support compliance with of the MQS process, as well as to support enforcement through GPS tracking, potentially negating the need for random checks or enforcement targeting for higher-risk groups. In response, I noted that I supported the concept of the app but raised my concerns about the number of apps that we were generating and asked that further ideas such as geo-location wearable tech be scoped in the paper (LB3/215 INQ000592794).
- 93. On 12 February 2021, I received a draft of the note on tech options for enforcement of quarantine in response to the commission from COVID-O (LB3/216 INQ000592798 and LB3/217 INQ000592800). I provided my comments on 13 February 2020, highlighting my support for the idea of wearable tech and asking that sufficient effort

be put into investigating the latest developments in this area (LB3/218 - INQ000592804).

- 94. The idea of wearable tech as an alternative to hotels was further discussed at a meeting for tech options for self-isolation on 18 February 2021, where questions were raised as to the political appetite for 'tagging' people (LB3/219 INQ000592809).
- 95. On 22 February 2021, I received a further draft of the COVID-O note (LB3/220 INQ000592811). I provided my comments on the note the next day, accepting that wearable tech was more palatable as an alternative to hotel quarantine but may still work for returns from Amber list countries in certain circumstances. I highlighted the point that optionality was key (LB3/221 INQ000592810). Although I was not party to any further decision-making on this issue, I understand that these options were not pursued further at the time.
- 96. I summarised our work on the issue in comments to another draft COVID-O paper on 8 September 2021, noting that I was optimistic about technological opportunities to improve home-quarantine, and such wearable technology, which may still prove useful in the event of vaccine-resistant variants (LB3/222 - INQ000592860).
- 97. On 13 February 2021, the Secretary of State for DHSC and I received a submission in relation to a decision taken by COVID-O following advice from SAGE in November 2020 that, subject to piloting, Daily Contact Testing (DCT) should be rolled out as an alternative to self-isolation for close contacts of confirmed cases (LB3/223 INQ000592801 and LB3/224 INQ000592802). The background to this policy is set out in more detail in the DHSC corporate Statement C for this module. I set out my involvement with DCT in the following paragraphs.
- 98. I provided my comments to the submission on 14 February 2021 (LB3/225 INQ000592805), noting that the policy raised issues of proving identity for the purposes of enforcement, as well as the benefit to surveillance data. The submission was approved by the Secretary of State for DHSC on 15 February 2021, subject to further concerns including how household contacts should be treated (LB3/226 INQ000592807).
- 99. On 11 March 2021, I received a submission updating me on progress and policy decisions made since 13 February 2021 and seeking my approval of updates to the

policy, including the compliance model for institutions and workplaces (LB3/227 - INQ000592819 and LB3/228 - INQ000592820). The submission also dealt with issues around household contacts and those living in an area where there is a new Variant of Concern (VoC). I agreed to the submission, noting that I was keen to make this happen at pace (LB3/229 - INQ000592823).

- 100. On 16 April 2021, I received a further update on DCT and general public trials (LB3/230 - INQ000592827 and LB3/231 - INQ000592828). I was supportive of the trials, but with the caveat that we should keep a close eye on the VoC; should the situation deteriorate, we would have to rethink our approach (LB3/232 -INQ000592829).
- 101. Although DCT seemed to be a promising alternative to self-isolation, as the pilots continued to be rolled out in early 2021, the emergence of the Alpha VoC potentially affected the balance between any risks and benefits that could be obtained. Ultimately, the need for widespread DCT was largely negated by the August 2021 decision to exempt contacts who were fully vaccinated or under the age of 18 from the requirement to self-isolate. It was, however, used as an additional precaution for fully vaccinated contacts in response to the Omicron variant in December 2021, avoiding a return to self-isolation.

## Support for those isolating: my role

- 102. I refer the Inquiry to the DHSC corporate Statement C for this module for a detailed summary of the financial support measures introduced to assist individuals to self-isolate. HMT worked specifically with DHSC on the Test and Trace Support Payment (TTSP) Scheme, which is also set out in detail in the DHSC corporate Statement C for this module. My limited involvement with the scheme, and support for those isolating more generally, is set out below.
- 103. Work-related benefits were largely within the remit of HMT, DWP and HMRC. However, across government, we were always exploring creative ways in which we could offer support to those most severely impacted by the need to self-isolate. For example, on 24 March 2021, I hosted a roundtable with colleagues from DHSC as well as OGDs on support for those isolating (LB3/233 - INQ000592824). A number of challenges were raised at the meeting with particular reference to the disproportionate impact of self-isolation rules upon certain sections of society. Action points were taken

forward by representatives from DCMS, BEIS, HO, MHCLG and NHS T&T to address the issues raised.

104. As another example, on 28 May 2021, as part of a wider TTI strategy meeting, we discussed the progress of TTSP including its promotion through community-tailored engagement and increase accessibility through a simplification of the evidential criteria **(LB3/234 - INQ000592838)**.

## Rule, regulations, guidance and powers for enforcement: my role

- 105. I was occasionally copied into advice to the Secretary of State in relation to the development of self-isolation regulations, which, given my role as Lords Minister, necessarily required my understanding in bringing such legislation through the House of Lords. As Parliamentary Under Secretary of State, I occasionally received signing submissions for statutory instruments or submissions seeking my comments on the introduction of, and changes to, regulations, before approval by the Secretary of State for DHSC, or my approval where appropriate. I always followed the advice of experts and officials in relation to providing my approval but on occasion provided comment or sought further clarification.
- 106. I have been provided with examples of such advice from 21 October 2020 in relation to the issuing of fixed penalty notices (FPNs) (LB3/235 INQ000203681) and from 23 October 2020 in relation to proposed amendments to self-isolation and contact details regulations (LB3/236 INQ000203841). Although I was in copy on both submissions, I can find no record of actually receiving the 21 October 2020 submission, which I understand was sent to Nadine Dorries MP instead. I was, however, sent submissions between November 2020 and March 2021 that related to the issuing of FPNs and further amendments to the same regulations which I set out below, along with my comments on the 23 October 2020 submission, of which I was in receipt.
- 107. I set out examples below of submissions I received regarding development of the regulations and guidance to which I provided comment and/or sought further clarification.
- 108. On 23 May 2020, I received a submission regarding health measures to be implemented at the border, in particular a 14-day self-isolation policy (LB3/237 -

**INQ000592669 and LB3/238 - INQ000592684)**. I responded on 24 May 2020 with a note of my comments and concerns for consideration by the Secretary of State for DHSC (LB3/239 - INQ000592691).

- 109. On 23 October 2020 I received the submission referred to above on proposed amendment to the self-isolation and contact details regulations to which I provided my comments the following day (LB3/240 INQ000592749). The Secretary of State for DHSC's readout, approving the regulations, followed on 27 October 2020 (LB3/241 INQ000203813)
- 110. On 26 November 2020, I was copied into an email chain between lawyers and officials at DHSC, HO and the Government Legal Department (GLD) about proposed changes to self-isolation regulations that would address an issue with enforceability and issuing FPNs (LB3/242 INQ000592757).
- 111. On 29 November 2020, in response to an update on the issue with enforceability and issuing FPNs, I provided my comments, asking for a note linking the issue to data and the use of NHS-login and NHS-number (LB3/243 INQ000565565). I received a further email note with an update on the issue on 1 December 2020 (LB3/244 INQ000592758) to which I provided further comment (LB3/245 INQ000592765).
- 112. On 10 December 2020, the Secretary of State for DHSC and I received a submission on a proposal for increasing police enforcement of self-isolation for people who had tested positive and been instructed by NHS T&T to self-isolate (LB3/246 INQ000566260 and LB3/247 INQ000592771). The proposal sought to address the evidential issues raised by the CPS without requiring a fundamental overhaul of the NHS T&T system. The proposal presented a further issue in relation to the sharing of personal data with the police which may go against assurances I had given to Parliament and the public. As such I responded to the submission noting my concerns and sought reassurances in the event that I would have to address this again in Parliament (LB3/248 INQ000592775).
- 113. On 25 January 2021, I received a submission in relation to the police enforcement of self-isolation issue as raised in November and December 2020 (LB3/249 - INQ000592785). I provided my comments to the Secretary of State for DHSC the following day, suggesting we explore related arguments based on uptake

and public support of lockdown in order that I may defend the policy from the despatch box (LB3/250 - INQ000592787). This resulted in a Written Ministerial Statement being published on 27 January 2021 to clarify the purpose of the changes and address the information-sharing issue (LB3/251 - INQ000592788 and LB3/252 - INQ000592789). The changes to the regulations were approved by the Secretary of State for DHSC and made on 29 January 2021.

- 114. On 8 March 2021, I received a submission on further amendments to the selfisolation regulations to create a new exemption to the duty to self-isolate for those undertaking DCT, among other changes (LB3/253 - INQ000592812 and LB3/254 -INQ000592815). I provided my comments on the same day which fed into the Secretary of State's approval readout on 10 March 2021 (LB3/255 - INQ000592816 and LB3/256 - INQ000592818).
- 115. On occasion, I would receive a signing submission that I approved without comment, such as for The Health Protection (Coronavirus Restrictions) (All Tiers) (England) (Amendment) 2021 with Explanatory Memorandum setting out its purpose (to clarify certain exemptions to the All Tiers Regulations) (LB3/257 INQ000592784; LB3/258 INQ000592782; LB3/259 INQ000592783). A list of the Health Protection Statutory Instruments signed by me can be found at the legislation.gov.uk website, which I exhibit (LB3/260 INQ000592870).
- 116. I have been asked about how the rules, regulations and guidance in relation to obligations to test were communicated to the public. I believe this has been fully addressed by DHSC it its corporate Statement D for this module.

## Monitoring enforcement

117. The monitoring of enforcement powers, such the issuing of FPNs and criminal prosecutions, would naturally fall within the remit of the HO and Ministry of Justice (MOJ). I am not sure to what extent any data on the compliance of vulnerable, disadvantaged or at-risk groups were available. I was occasionally provided with updates and advice on compliance and effectiveness of enforcement measures more generally that would, in turn, feed into further decision-making on the making or refining of enforcement powers. I provide examples of such advice and updates below.

- 118. Following one of the fortnightly update calls on Trace and Self-Isolation that I had with DHSC officials on 18 November 2020, I requested a note on the number of cases that were being transferred to law enforcement (LB3/261 INQ000592753). The note, provided to me on 20 November 2020, set out that, to date, 79 FPNs had been issued in England for breach of the self-isolation regulations (LB3/262 INQ000592754). The main issue raised by the CPS was that the information provided by NHS T&T did not meet the evidential threshold for prosecution. A working group with representation from DHSC, HO, CPS and National Police Chiefs Councils (NPCC) had been set up to identify how to address the issue, which resulted in the amendments to the regulations as set out at paragraphs 105 to 114 above.
- 119. On 14 June 2021, I was provided with a submission on the results of a mystery shopping exercise designed to access venue compliance with the Collection of Contact Details Regulations (LB3/263 INQ000592844). On 21 June 2021, I agreed to the recommendations, including that the data be shared with local authority enforcement officials so they were aware of compliance rates across different sectors in their region and could take targeted enforcement action. I also commissioned a further piece of work on how to communicate to the public that venue check-in leads to a test and not necessarily isolation (LB3/264 INQ000592842).

## SECTION FIVE: PRIVATE SECTOR COLLABORATION

#### 'Priority Lane' for securing TTI contracts

- 120. As set out in my statement to the Inquiry for Module 5, submitted on 20 December 2024, and in relation to contracts for the supply of COVID-19 tests in particular, a large number of offers of support came in but, contrary to the approach to receiving offers of support for PPE, there was no separate VIP route or channel. This was, in part, due to the fact that, contrary to the public 'call to arms' for PPE, the call for support for tests was targeted towards the industry, using pre-existing government networks and relationships. Further, the specialist nature of their production meant that manufacturers could not simply pivot from the production of one product to another, as they could with some types of PPE, so it was much less likely that we would receive so many well-meaning, but ultimately, unsuitable offers. as we did with PPE.
- 121. All offers were received through the purpose built GOV.UK portal and four dedicated DHSC mailboxes: 'COVID testing priority contacts', 'COVID19 innovation',

'COVID testing triage' and 'COVID19 offer triage'. Some suppliers emailed their offer directly to one of the mailboxes, others contacted ministers, parliamentarians and other individuals within Government who forwarded the offers on to one of the same mailboxes. As with PPE, civil servants were managing the increasingly overwhelming volume of offers from all corners of industry, searching for viable offers that could support the scaling up of the UK's testing network as quickly as possible.

- 122. Although there was no separate VIP route or channel for testing suppliers and ministers were not involved in the evaluation or procurement process for contracts, where emails came from a supplier with an established reputation in diagnostics or related to products or services of which there was an acute shortage, the email could be tagged by the triage team as 'VIP, 'Fast Track' or 'Priority'. As set out in the email referred to above that I received on 6 April 2020, we were also invited to pass offers on to the same 'COVID testing triage' inbox for the triage team to manage but marking 'FASTTRACK' in the subject line. We were invited to mark the email as fast track in order that it could be tagged as such and to help officials to provide progress reports. Instructions were later updated to direct such offers to the dedicated 'COVID testing priority contacts' mailbox for processing as priority stakeholder enquiries by the pillar 5 stakeholder engagement team. The team would later provide access to a log of stakeholder interactions as well as regular updates detailing significant developments (LB3/265 - INQ000497147; LB3/266 - INQ000497152; LB3/267 - INQ000497153). | understand that one of the reasons for tagging the offers as 'VIP, 'Fast Track' or 'Priority', or processing them as priority stakeholder enquiries, was on the basis that corroboration from third parties increased the chance that the offer would be viable. It also ensured that progress reports could be shared with ministers and senior colleagues who were the initial point of contact. If an email was processed by the stakeholder engagement team, this was not a reflection of the status of the referrer but rather the content and/or provenance of the offer. As far as I am aware, suppliers were not aware of the tagging system.
- 123. As set out above, on 6 April 2020, an email I received from CO set out the routes through which referrals should be directed, according to whether the offer related to the provision of PPE, tests or ventilators. As with many of the private offices of other ministers at the time, I received offers of help directly from contacts which, for a number of reasons as outlined above, seemed credible and warranted a swift response. I was keen to ensure these opportunities were not missed by getting lost in any backlog of correspondence. For example, on 7 April 2020, I put Will Field from

BEIS in contact with Pete Digger who is a well-known public affairs representative and who represented Avonchem, a company with a track record of delivery of diagnostic tests with established partnerships with organisations including the UN and WHO. Avonchem were progressing trials of a diagnostic test which they believed would be able to successfully test for COVID-19 antibodies and were seeking further information on the parameters of evidence required, to ensure their trials were not rendered irrelevant. In the following days, my office and I sent further emails enquiring as to whether a response had been given which led to the creation of a working spreadsheet into which updates on referrals could be inputted and reduce the need for the already overloaded team to respond to ad hoc chaser emails (LB3/268 - INQ000497150).

#### **Conflicts of interest**

124. As set out in my statement to the Inquiry for Module 5, submitted on 20 December 2024, I read and understood the Ministerial Code which I was required to adhere to and which covers actual or perceived conflicts of interests. As required by the code, I had given DHSC a full list of all my and my wife's interests which can be found at page 23 of the July 2020 List of Minister's Interests (LB3/269 - INQ000477162) and pages 77 to 79 of the DHSC Annual Report for 2020-2021 (LB3/270 - INQ000235008). When I became a peer, I had sold my company and, as can be seen in the above lists, by the time I became a minister, I had already backed off all my previous interests. I had absolutely no conflicts of interest with any of the companies or consultancy firms that I dealt with.

### Westbourne Communications and Deloitte

- 125. I set up a communications agency in 2009 called Westbourne Communications, which I owned outright until I sold it in 2019.
- 126. In 2011 Westbourne Communications represented Deloitte and Deloitte's join venture with Ingeus (also known as Ingeus-Deloitte). During the period of representations, Ingeus-Deloitte secured a series of 'Work Programme' contracts derived from a UK Government scheme to help individuals in receipt of Jobseeker's Allowance or Employment Support Allowance back into work. The scheme awarded contracts to the private, voluntary and public sectors to provide support for people at risk of becoming long-term-unemployed and to help them find work. Westbourne Communications supported Deloitte-Ingenus in securing a contract to provide

communications support for the programme. Following this discrete piece of work, Westbourne Communications had no further dealings with Deloitte or Ingeus-Deloitte.

127. I had some interaction with Deloitte at the time and would meet with consultants on occasion to ensure we were coordinating work effectively, such as a testing workstream 2 deep dive meeting I held on 25 March 2020 which was attended by a number of Deloitte consultants (LB3/271 - INQ000592591). Although I attended an earlier meeting with Deloitte on 18 March 2020 to discuss testing more generally, I had no involvement in their instruction or any work that was commissioned. I had no involvement in any negotiations or subsequent decision to award Deloitte their contract, or any subsequent negotiations or decisions to extend, renew or terminate such contracts. As set out above, the award of contracts was in line with government award processes, based on official advice and subject to value for money considerations and conflict of interest checks. I had no reason to declare such an unrelated historical connection to Deloitte nor would any such connection have been capable of influencing such a decision to award them their contract.

## SECTION SIX: REFLECTIONS

## The scaling back and ending of TTI

- 128. Due to the success of the UK 's vaccine programme, people who were fully vaccinated or aged under 18 no longer had to self-isolate after 16 August 2021. In most cases, therefore, contacts no longer needed to be instructed to self-isolate, which significantly changed the nature of TTI. There was, of course, still a need for contact tracing, for example, to remind contacts of the importance of taking a PCR test and self-isolate upon a positive result, or in cases of unvaccinated adults, to remind them of their continued legal duty to self-isolate, and to check whether those who still needed to self-isolate had access to support. It was around this time, and towards the end of my role, that TTI started to be scaled back as part of the developing strategy for Autumn/Winter 2021/2022. I set out my involvement in the process in the following paragraphs.
- 129. On 1 September 2021, I received a submission on the draft Test Trace and Isolate Autumn/Winter 2021/2022 Plan due for discussion at a Small Ministerial Group (SMG) on 6 September 2021 (LB3/272 INQ000592853 and LB3/273 INQ000575324 ). At the meeting, Ministers were being asked to agree the strategic

purpose and objectives of TTI through the period including its approach to asymptomatic testing and self-isolation.

- 130. On 2 September 2021, I provided my comments on the draft plan to the Secretary of State for DHSC (LB3/274 INQ000592856). I said that, while I accepted that we should be enjoying the freedom and savings that the vaccine miracle gave us and that backing off the testing regime would give a clear 'back to normal' signal to the country, on balance, I thought that following such a plan, as presented, was a mistake.
- 131. As the plan to scale back TTI progressed, on 9 September 2021, I received a note seeking assurance to be provided to HMT that we had a plan in place to gradually taper down asymptomatic testing (LB3/275 INQ000562700 and LB3/276 INQ000562701). The paper sought answers to questions related to the transition from testing in a COVID-19 pandemic to the future of UKHSA testing to help develop a full symptomatic and asymptomatic testing transition plan. I provided my comments on 13 September 2021 (LB3/277 INQ000592863), raising my concerns, which I summarise as follows:
  - a) It was right to focus on the scaling back for consumables (e.g., LFDs and PCRs) but this should not be matched by a reduction in important infrastructure build, particularly in relation to closing gaps in our data system;
  - b) We were still a long way off returning to normal but there did not seem to be a working model for restoring public confidence;
  - c) The plan did not include genomic testing which was important and needed improving for long-term resilience;
  - d) There was no mention of how testing capacity can be used to support the NHS by keeping COVID-19 and flu patients out of hospital.
- 132. As I set out in my comments to the Secretary of State, the opportunity to save billions of pounds of taxpayers' money was rightly an important consideration which I strongly supported and this needed to be balanced with the risk of dismantling our testing capabilities without a clear exit strategy with the highest level of political signoff. It is important to remember that, even as late as September 2021, there remained a significant degree of uncertainty. There were still spikes where prevalence of the disease was considerably higher and was hitting people previously thought to be immune. COVID-19 had shown creativity and energy in the way it had mutated. Although we often heard that viruses tend to get less fatal and more transmissible,

there was every chance this virus could have taken a different direction and become more fatal and more transmissible. There were precedents for this possibility and the risk seemed high with such a large amount of virus in circulation around the world; hundreds of millions were infected, some of whom had massive viral loads. It is important to remember that even in late 2021, we were always bracing ourselves for another setback.

- 133. In the face of uncertainty our testing system needed flexibility to respond to sudden surges in demand. Not every part of the testing and tracing system is as flexible as the rest; where contact tracers may be stood up relatively quickly, it is not so easy or cost effective to rapidly increase or decrease laboratory capacity. I have been asked about evidence in a previous module, criticising a low utilisation rate of 5% within the contact tracing call centres. This is not representative of the overall position, particularly during forecasted spikes in community transmission. The initial contract between DHSC and suppliers involved a fixed capacity of 18,000 staff which was sufficient for the forecast spike, but as COVID-19 cases declined, the call agent utilisation rate fell. It should also be remembered that at the time the workforce was stood up, work-from-home had not really been done before. There were early hurdles to overcome in areas such as training, logistics, IT and cyber security. In July 2020, in order to respond to future volatility and maintain value for money, capacity flexibility was recommended as a key component of any contract extension, as set out in the following presentation (LB3/278 - INQ000608177 The dramatic rise and fall of the demand profile presented a real staffing challenge, and there will always be some acceptable level of underutilisation during quiet periods. This would be better managed with a base capacity and an option to have further staff on 'stand-by' and further recruitment where needed, as recommended in the slides. I think it important to note that, even with a more flexible staffing system as proposed, the ideal utilisation rate for periods of low demand is still set at (circa) 50% utilisation.
- 134. Although testing contracts accounted for the overwhelming majority of NHS T&T variable costs, the fixed costs of the system included the use of consultants. In the beginning, we used consultancy to build the staff base at pace. In part because many of the skills and sheer quantity of manpower required were not readily available from within the civil service and civil service recruitment and procurement rules were an insuperable barrier to using the formal civil service framework as an urgent response to the pandemic, In addition, there was also a need to build up flexible, short-term capacity.

- 135. Consultants play a supportive role in many aspects of government, and the procedure for onboarding or retiring such a workforce was therefore well established, and not something that I was directly involved with. Even if I were confident that the decision to drastically reduce our workforce would not backfire, it was not my role to start cancelling large contracts at short notice.
- 136. Contract spend and management was, however, an issue that we were always live to. For example, on 17 December 2020 at a fortnightly commercial review of Test and Trace meeting I raised concerns about consultancy spend and asked for a further breakdown to provide rationalisation of the budget spend on consultants (LB3/279 -INQ000592776).
- 137. On 8 September 2021, just prior to leaving my post, and following concerns that had been raised by HMT about spending on NHS T&T, I was copied into an email from the Secretary of State for DHSC seeking a breakdown of the budget, including the amount spent on consultants (LB3/280 INQ000592859). The response, on 13 September 2021, set out a breakdown of spending by staffing type (permanent staff, contractors and consultants) (LB3/281 INQ000592862). I thanked the team for the summary and asked for further detail on the actual staffing spend position by the three categories (LB3/282 INQ000592865). On 15 September 2021, I was informed that the summary would need to be amended before being sent to the Secretary of State, due to some issues with the way that figures for spending on consultancy staff were calculated (LB3/283 INQ000592866). I left my role two days later, before receiving any further communication on the issue.
- 138. The scaling back of TTI and saving costs was not a simple matter of cutting consultant capacity. Many of the consultants had developed core skills and were running teams within it. There was no 'B team' with enough corporate memory to pick up the baton. Even gradually replacing these consultants with 'in house' civil servants presented serious challenges. Shortages in specialist skills, such as data scientists and technical architects, and the comparatively low salaries in the civil service did not help. The civil service framework contracts and pay-scales are totally inadequate for such situations. These are problems, however, that will often be felt across government where consultants play a large role, and they should not have come as a surprise. I do believe that more could have been done to create an exit strategy for backing out of financial commitments. This would have required the kind of coherent

strategic decision making at the highest level that I believe was lacking at the time. In future, were the government workforce to expand and contract at such a rate that the support of consultants is needed to that extent again, it would benefit from a workable plan with identifiable targets or milestones and clear steps necessary to exit contractual agreements accordingly.

## The legacy of TTI

- 139. I have been asked about comments that I made in an interview for the Institute for Government on 7 June 2023 (LB3/284 - INQ000592869). It is still my view that, in many ways, the system that we built was 'the envy of the world' and many aspects made us 'the best in the world at what we did'. As I set out in my interview, I credit much of this to our rapid expansion of mass testing from a relative standing start. In particular, the data available to the UK Government to support research into the virus and policy-making was the best in the world. As I have already said, the depletion of public health capability left us at a huge disadvantage. It is all the more impressive then, that we were able to harness the enormous potential that our domestic diagnostic industry has to offer.
- 140. Although we were able to begin testing quickly for COVID-19 from the publication of genetic sequencing of SARS-Cov-2 in January 2020, we were extremely limited by our use of multiple small laboratories, and further constrained by global shortages in testing supplies, such as swabs. Dependent on skilled technicians and specialist equipment, early testing could take up to five days to obtain a result. Within weeks, by mid-February capacity had reached 2,000 per day with a 24-hour turnaround. The partnership between PHE and Roche in mid-March enabled us to scale up testing further. To hit our target of 100,000 tests-a-day by 1 May 2020, and to have further doubled that capacity by the end of May 2020, was a colossal achievement.
- 141. As set out in the Technical Report, we went on to lead the world with our genomic sequencing, contributing around half of the world's registered output by March 2021. Our ability to monitor the emergence of new variants was vital to the international effort to track variants and address potential risks early but it was also key to our domestic response. Genomic surveillance supported our research into therapeutic effectiveness and, where genetic mutations caused the virus to be more transmissible or less responsive to treatment, it allowed us to adjust public health

measures to target the changing virus more effectively. For example, in response to the identification of the Omicron variant in November 2021, confirmed cases and contacts were tested and told to isolate and testing capacity to the impacted communities increased. Countries affected by the variant were also added to the travel red list.

- 142. Our leading role in genomic sequencing also extended to the development of the New Variant assessment platform (NVAP) in collaboration with G7 partners, as discussed at a NVAP routable meeting on 14 April 2021 (LB3/285 - INQ000592848). The purpose was to facilitate the early detection and characterisation of new variants and to collaborate on data sharing and analysis through a systematic surveillance system. This work was supported by Palantir who could build on their work with the United States and NHSE to provide the bioinformatic software underpinning a domestic and international COVID-19 surveillance system (LB3/286 - INQ000592831 and LB3/287 - INQ000592832).
- 143. Testing innovations were developed and delivered at speed thanks to our collaborative response, from across the private sector, academia, government, the NHS, PHE and other public health bodies. The sharing of resources and data across the testing system was vital to our ability to offer surge capacity, responding quickly to spikes in need, and encourage the population to test and adjust public health guidance.
- 144. The effectiveness of NHS T&T was supported by our continued improvements to the speed, capacity and accessibility of testing. There were also contributory factors outside of our direct control, such as public behaviours and, crucially, overall levels of infection. Contact tracing has the most impact where such levels are lower, and interventions can be targeted at specific outbreaks or areas or groups with a higher risk of infections.
- 145. It is, therefore, difficult to accurately measure the impact that NHS T&T will have had on the spread of the virus but there are positive findings from numerous studies. For example, on 12 May 2021, peer-reviewed research which looked into the impact of the NHS COVID-19 app from its launch in September 2020 to the end of December 2020 concluded that, *'on average, each confirmed COVID-19-positive individual who consented to notification of their contacts through the app prevented one new case'* (LB3/288 INQ000562944). The paper also estimated the number of cases averted during that period as between 284,000 and 594,000 and the number of

deaths between 4,200 and 8,700. Further research by the University of Oxford published in February 2023, suggests that the app saved an estimated 10,000 lives in its first year (LB3/289 - INQ000592868).

146. NHS T&T was never going to kill the virus. Public health is about percentages and the lowering of risk. We were trying to bring the R rate down. The peer-reviewed paper from 2021 cited above also concluded that 'for every percentage point increase in app uptake, the number of cases could be reduced by 0.8% (using modelling) or 2.3% (using statistical analysis). These findings support the continued development and deployment of such apps in populations that are awaiting full protection from vaccines.' I would not suggest that the impact of NHS T&T on containing the virus was world beating, but I do believe we made a significant impact on slowing it down while we waited for the vaccine.

#### Lessons Learned

- 147. As will be clear from reading this statement, I believe there are doctrinal lessons to be learned from the strong 'contain' approach taken by countries like Taiwan and New Zealand. These countries show that it is possible to stop the progress of the disease with strict protective policies and early, coordinated contact tracing supported by an integrated national health database.
- 148. New Zealand's early test-trace-isolate strategy benefitted from strong leadership, coordinated response and transparent communication. Both countries were able to leverage their island-nation status to contain the spread of the virus early and target testing for symptomatic individuals with travel history. According to a Data Evaluation and Learning for Viral Epidemics (DELVE) report from May 2020, Taiwan effectively delayed and contained community transmission as a result of its preparedness following the SARS outbreak (LB3/290 INQ000194035). Given their lived experience, there was wide public acceptance of Taiwan's strong protective policies facilitated by their multisectoral response, transparent communication, big data analytics, and digital tracking. We have the same opportunity to learn from our own experiences of COVID-19, and it would be a mistake to ignore such international examples of success, particularly given our geographical similarities.
- 149. As an island, the UK should have closed its borders and locked down sooner. We should have had a system in place to ensure it could happen overnight. The

benefits of test and trace can only be felt where there is a relatively low prevalence of the disease, or when the focus is on rapid detection of clusters and outbreaks. The public were, generally speaking, much more committed to the whole process than ever imagined. Had we not made mistakes about lockdowns we might have been able to harness public support for longer. We were not given a good shot because we locked down too late.

- 150. Another key lesson to this Module is one that I have raised before in oral evidence to the Inquiry in previous modules, and that is the need to have 'warm assets'. We need to have, ticking over in the background, the components of a pandemic response, in accordance with any doctrinal lessons learned above, with a throughput of people and expertise. This means building resources that are in play on a day-to-day basis and that could be further scaled up on a national basis when needed. To use the example of Taiwan again, as a result of the SARS breakout, they had been running outbreak simulations and building effective digital tracking infrastructure which gave them a significant advantage to deal with COVID-19 in the early days of the outbreak when every second counts. This also applies to testing. We need to build our capacity for mass testing and not rely solely on pathology laboratories. In 'peace times', we should be doing more public health screening, tracking people down, testing them and building our population health data.
- 151. As part of our ability to scale up at short notice, there needs to be stronger collaboration with the private sector early on. As I have already said, in my experience, PHE were reluctant to seek early support from industry when it came to testing and this set us back. Our later success in rapid expansion of testing, and the success of the vaccine project has shown us that harnessing early innovation from industry and supporting businesses to take risks is key to scaling up our capabilities fast.
- 152. Effective local and national collaboration is also essential to any successful contact tracing system. Local teams will have important intelligence and better understand the complexities of their own communities. National teams are best placed for providing scientific advice and producing guidance to support local and regional contact tracing teams. Local Resilience Forums (LRFs) may have been better placed to tailor support for individual cases and contacts, but they lacked the power and resources to coordinate any targeted local response. I do not think this view is controversial; it was reflective of my experience and supported by the views and advice of officials at the time. The statutory role of LRFs at the time, as set out in the Civil

Contingencies Act 2004 (CCA), was ill-suited to the task at hand. I believe this is reflected in the proposals for the Government's 2021 review of the CCA, which it is legally required to do every 5 years. These included the strengthening of roles and responsibilities of LRFs and granting them wider emergency powers. In its December 2020 business plan, NHS T&T planned to strengthen its partnerships with local authorities and allow more local direction and control which eventually led to public health teams being brought into tracing 'hard to reach' cases and, from spring 2021, managing local outbreaks (LB3/291 - INQ000059228). This should be built into future pandemic preparedness, with a strengthening of local public health powers and infrastructure that can be stood up early, in coordination with the national response.

## 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.

Name: Lord James Bethell

Date:	16 April 2025
Signature:	PD