

Wednesday, 28 May 2025

(10.00 am)

**LADY HALLETT:** Ms Cartwright.

**MS CARTWRIGHT:** My Lady, please could Baroness Harding be sworn.

**BARONESS DIDO HARDING (sworn)**

**Questions from LEAD COUNSEL TO THE INQUIRY FOR MODULE 7**

**MS CARTWRIGHT:** Could you please give the Inquiry your full name.

**A.** Baroness Dido Harding.

**Q.** Thank you. Baroness Harding, you've provided a witness statement to the Inquiry dated 9 April of this year. Could we please turn to page 49 within that statement, where you confirm that the statement is true to the best of your knowledge and belief. And can I ask you to confirm, is the statement true to the best of your knowledge and belief?

**A.** It is indeed.

**Q.** Thank you. Can we then start, please, with identifying your relevant background and experience, which is detailed within the statement. Plainly, the significant aspect of the evidence that we will deal with together is your role following appointment on 7 May 2020 as the executive chair of NHS Test and Trace, but can we please then identify your career history.

1

NHS Improvement, and I think it's right, isn't it, that you had that role from October of 2017 and you held the role until October of 2021?

**A.** That's correct.

**Q.** You were also, from 18 August 2020, which we'll come on briefly to deal with in your evidence, interim executive of the National Institute for Health Protection, which was a body that then became part of UKHSA; is that correct?

**A.** Yes, I was interim executive chair.

**Q.** Thank you. And you were also chair of Genomics England from 2019 until October 2020?

**A.** Yes, that's correct.

**Q.** Thank you. And I think, more broadly, you are a member of the House of Lords and have been so since 2014?

**A.** That's right.

**Q.** Now, I know one of the things you particularly want to deal with at the outset is what's dealt with at your paragraph 1.4, at page 2, where you wish to express your condolences to those who lost loved ones in the pandemic.

So if we could just display paragraph 1.4, please.

Baroness Harding, do you want to address that aspect first of all, please.

**A.** Thank you.

3

It's right, isn't it, from 2010 onwards you had

a career in telecoms?

**A.** That's correct.

**Q.** And before that, between 1988 to 2010, you also had a career in retail?

**A.** Correct.

**Q.** And do you want to give some relevant context as to those careers and skills to contextualise, then, skills that you deployed when you were chief executive in NHS Test and Trace?

**A.** So if you think of the skills that you needed to grow NHS Test and Trace, you needed people leadership experience, and I'd worked in very large organisations in both the public and the private sector, scaling them particularly in the private sector. You needed understanding of healthcare and public service and I'd been involved in our NHS Improvement.

You needed retail and logistics experience because testing and tracing was fundamentally an enormous logistics exercise. And you also needed experience of digital -- digitally-enabled large-scale citizen or consumer services, which I'd done a lot of in telecoms as well as in retail.

**Q.** Thank you.

Now, you've identified your role with us as chair of

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Yes, just before we get into the detail, my Lady, I just wanted to express my sincere condolences to everyone who lost loved ones and who suffered because of the pandemic, and just to reiterate how important I think this Inquiry is that we really learn the lessons of what happened.

**Q.** Thank you.

Now, can we then, please, start with your appointment, please, as the chief executive of NHS Test and Trace, and can we move to paragraph 3.1, please, on page 5.

You detail that on 5 May 2020, the then Prime Minister, Mr Johnson, called you and asked you to lead what was then called the Test and Trace Taskforce. You say:

"From the conversation, I understood the role was to be an operational (as opposed to a policy or political) one and involved the rapid expansion of the infrastructure to facilitate widespread testing for COVID-19 and contact tracing, which would produce in essential end-to-end population service ie a service accessible to all the population ... and to recruit a permanent leadership team to lead what would be a large organisation."

It details that:

4

1 "[You] understood that the role would be temporary.  
 2 [And you] accepted the position, and [your] appointment  
 3 was announced publicly two days later, on 7 May 2020."  
 4 **A.** Yes, that's correct.  
 5 **Q.** I think it's right, isn't it, and it's well known, that  
 6 there has been a judicial review in 2022 of both the  
 7 Prime Minister and the Secretary of State for Health and  
 8 Social Care brought by the Good Law Project and the  
 9 Runnymede Trust in relation to a number of appointments,  
 10 including your appointment both to NHS Test and Trace  
 11 and then latterly to the role of the NAHP, but I'm  
 12 referencing that at this stage because it's right, isn't  
 13 it, more factual context was given to the lead-up to the  
 14 telephone call with Mr Johnson on 5 May within that  
 15 judicial review?  
 16 And is it right that the background that's detailed  
 17 within the judicial review includes essentially that  
 18 there was a shortlist of candidates that had been  
 19 identified to be approached in respect of the ask to be  
 20 the chief executive, and then the role as to how it was  
 21 you were then identified as the ultimate candidate and  
 22 approached by Mr Johnson?  
 23 **A.** Yes, I don't have any more knowledge than that which any  
 24 of us would have reading the outcome of the judicial  
 25 review. So I've read that and that was the first time

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1 And the brief that I received from the  
 2 Prime Minister and from the Chancellor in that first  
 3 week was to do everything possible to launch and then  
 4 scale a -- in their words, not mine -- world-class  
 5 testing and tracing service to support the country as  
 6 lockdown measures were released.  
 7 **Q.** Thank you.  
 8 Now, you've referenced that the Chancellor was also  
 9 in that initial meeting. I'm going to deal with it at  
 10 this stage because one of the reflections that you've  
 11 provided in comments for future pandemic planning is the  
 12 need to essentially have regard to the most vulnerable  
 13 in society and the need to be essentially money there to  
 14 assist with isolation.  
 15 Was anything said in that initial meeting around  
 16 that problem in terms of an identified issue that those  
 17 individuals who perhaps were vulnerable or most needing  
 18 were not isolating because -- and not testing, because  
 19 essentially they had to feed their families?  
 20 **A.** To be honest, in that first meeting, no. At that stage  
 21 the brief I was receiving from the Prime Minister and  
 22 the Chancellor was all about scale. And it became clear  
 23 to me as I spoke to public health experts and people  
 24 from local government, from Public Health England, from  
 25 my colleagues from NHS England, that it was really

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1 I was aware of the detailed process that went on before  
 2 I received the phone call from the Prime Minister.  
 3 **Q.** Thank you.  
 4 So can you give us some idea as of 5 May, because  
 5 we're going to look at the scale of the task ask that  
 6 faced you, having said yes to the Prime Minister. Can  
 7 you perhaps just give a bit more of an idea of, when the  
 8 Prime Minister had that conversation with you on 5 May,  
 9 what was really the detail of what was being asked of  
 10 you and what was required.  
 11 **A.** So by 5 May the government had already announced the  
 12 intention to launch a citizen-level mass testing and  
 13 tracing service. It had already been decided how many  
 14 contact tracers were needed to do that, and the teams  
 15 were working flat out to stand that up, several of the  
 16 Lighthouse laboratories had already got started, and the  
 17 team that existed had delivered 100,000 tests at the end  
 18 of April, which was the first target that the National  
 19 Testing Programme had been set by the Secretary of  
 20 State.  
 21 So there was the beginnings of what became NHS Test  
 22 and Trace, with a relatively small team in the  
 23 Department of Health and Social Care working, sort of,  
 24 20 hours a day, seven days a week, trying to scale this  
 25 and launch the service as fast as they possibly could.

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1 important to build a service that supported the most  
 2 vulnerable. But that wasn't in the brief that  
 3 I initially received at all.  
 4 **Q.** Thank you.  
 5 Now, it's clear from your statement that that is  
 6 something that became a real concern for you. If my  
 7 summary of it is inaccurate, please correct me,  
 8 Baroness Harding. But can you help us then on the  
 9 timeline once you were in post and dealing with the  
 10 issues to scale up testing and contact tracing when you  
 11 realised that was a big issue relating to there not  
 12 being support payments there to assist those most  
 13 vulnerable to isolate?  
 14 **A.** For isolation support specifically?  
 15 **Q.** Yes.  
 16 **A.** So I think through May and early June, as we work  
 17 through what makes for a really successful testing and  
 18 tracing service, it's obvious -- and I know others have  
 19 said this -- it's only useful if the service enables  
 20 people to actually isolate and break the chains of  
 21 transmission.  
 22 And through the course of early June, as we got  
 23 early feedback from people using the service, it became  
 24 increasingly clear that one of the main reasons people  
 25 didn't come forward to get a test in the first place,

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1 why they didn't come into the system at all, was because  
2 they were afraid of the consequences of needing to  
3 isolate, both financial and non-financial.

4 So from June onwards, from a purely operational  
5 perspective, and my brief was operational, not policy or  
6 political, but in order to make the service I was being  
7 charged with building more effective, it was clear that  
8 one of the biggest levers you could pull would make it  
9 easier for people to isolate. That we were only finding  
10 a relatively small proportion of the people who had  
11 Covid at the time. And we could assess that through  
12 comparing with what the ONS survey was telling us the  
13 prevalence of the disease was with the number of people  
14 who were testing positive each week.

15 So all of the economic modelling showed you that the  
16 most effective thing you could do was make it easier for  
17 people to isolate. And then all of the human lived  
18 experience told us the same.

19 So I'm a retailer by training, as you've said, and  
20 retailers, we go out to our shops and we talk to our  
21 customers and we talk to our staff and they always know  
22 what's really happening.

23 So I went out in June, July, August, all the way  
24 through, really and I talked to staff in testing sites,  
25 I would do virtual listening groups with a variety of

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1 the pandemic response. The policy decisions were all  
2 taken by Ministers and as indicated above, Ministerial  
3 accountability for the programme remained with the  
4 [Secretary of State for Health and Social Care]. My  
5 role was an operational one. I had to take Ministerial  
6 policy decisions and the scientific and medical guidance  
7 that the Scientific Advisory Group for Emergencies and  
8 [Chief Medical Officers] provided and then advise  
9 ministers as to the best operating system and service to  
10 meet those requirements. Following Ministerial steers,  
11 I was then charged with implementing and running this  
12 operating system and service."

13 So, it's clear what you're saying there as to your  
14 remit, your role, and plainly it required also input  
15 from ministers for decisions you were to make; is that  
16 correct?

17 **A.** Absolutely.

18 **Q.** I think one of the things that we'll come on to as we  
19 move through is the limits you had on procurement that  
20 was also a fetter on your ability to operate  
21 operationally; is that a fair summary?

22 **A.** At certain times during my tenure, yes.

23 **Q.** Thank you. We heard yesterday from Mr Munn from the  
24 Cabinet Office, who effectively said, when asked who was  
25 responsible for NHS Test and Trace, that it was you.

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1 different groups of generally unheard, disenfranchised,  
2 disenchanted groups in society, who didn't feel like the  
3 system was working for them, and they all said the same  
4 thing, which was that isolation was really hard to do,  
5 and we weren't doing enough to support them.

6 So I started trying to fight for this in June 2020  
7 and, to be honest, my Lady, I feel like I still am, and  
8 I think it's one of the most important learnings for  
9 this Inquiry, that a mass testing and tracing system can  
10 have a huge impact in reducing the harm of a pandemic  
11 but it is so important that we support the most  
12 vulnerable. They're the most exposed to every  
13 infectious disease and that means you have to put  
14 isolation support at the forefront of your testing and  
15 tracing system.

16 **Q.** Thank you. Baroness Harding, we will come back to that  
17 issue and topic as we work through the chronology. Can  
18 we then, please, deal with what you've told us about  
19 your role being an operational one. Please could we  
20 display your paragraph 4.2 at page 7. You tell us that:

21 "[NHS Test and Trace] was an operational  
22 organisation implementing UK government policy when  
23 first created, [NHS Test and Trace] operated effectively  
24 as a new operating directorate of the [Department of  
25 Health and Social Care] with a specific remit as part of

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1 I'd like to give you an opportunity to respond to that  
2 in the context of what we've just looked at, by  
3 reference to your operational role, please.

4 **A.** Well, I've tried to describe I was operationally  
5 accountable for the organisation, but the strategy was  
6 set by the government, policy decisions were therefore  
7 made by ministers. The accounting officer was  
8 David Williams, the second permanent secretary in the  
9 Department of Health and Social Care. It's important  
10 I didn't have any spending authority. So although  
11 I very much felt accountable for the operational  
12 performance and delivery of NHS Test and Trace, I don't  
13 think you could say that I was single-handedly  
14 responsible and accountable for everything because it  
15 sat, as it properly should do, within the system of  
16 ministerial and Civil Service responsibilities.

17 **Q.** Thank you.

18 Can I then, please, identify what already existed,  
19 which the Inquiry has heard some evidence from. We know  
20 that by the time of your appointment of May 2020 the  
21 first four Lighthouse laboratories had opened in  
22 April 2020, and the Inquiry has heard some evidence  
23 about the taskforce that had put that together and  
24 I think, on your appointment, was stood down from their  
25 role under the operation of the Lighthouse laboratories.

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1 Did you have any handover from those teams that had  
2 scaled up the first four Lighthouse laboratories when  
3 you took on the role in May 2020?

4 **A.** Yes, absolutely. So the senior team who comprised the  
5 National Testing Programme, who had come from --  
6 variously from the Office of Life Sciences, from the  
7 Department of Health, from the military, they  
8 transitioned -- most of them, the senior leadership,  
9 transitioned off by the end of May and we recruited in  
10 to replace them. Some stayed throughout the whole  
11 duration of the whole pandemic. So we tried, wherever  
12 possible, to maintain the knowledge that they had built  
13 as they'd done that first phase of scaling testing.

14 **Q.** Thank you. Now, you've already mentioned that at the  
15 time of your appointment there were these -- I call them  
16 call centre, or virtual call centre contact tracers that  
17 had already been appointed, but certainly what seems to  
18 follow from May onwards, and certainly towards  
19 July 2020, under the contain framework was more input  
20 from the local resources on contact tracing and in  
21 particular the directors of public health.

22 We can see that one of those that I think was  
23 appointed as part of your team was Mr Tom Riordan from  
24 Leeds City Council.

25 **A.** Yes.

13

1 government, regional government and national government,  
2 in testing, tracing and isolating. So Tom worked really  
3 hard to set that out, and present that for approval to  
4 a Covid-O, I think it was approved at some point in  
5 June.

6 So it was very clear to Tom and I we needed to get  
7 more local. We also had to have scale. So you  
8 mentioned the 15,000-odd contact tracers that were being  
9 recruited. They were literally being recruited live and  
10 trained during that three-week period from my starting  
11 and the service launching. That was a non-trivial and  
12 enormous task that was being run by NHS Business  
13 Services and Michael Brodie, as part of a virtual team  
14 with Public Health England.

15 So this was lots of different moving parts but, from  
16 the very beginning, I felt that I needed to be, the  
17 phrase we used was a team of teams, that you needed both  
18 the scale of a national call centre to provide surge  
19 capability if you had an outbreak in one part of the  
20 country or another, you needed a national data spine,  
21 a lot of the contact tracing we did ourselves when we  
22 filled in the information ourselves on the webform. You  
23 needed that all to be consistent but you also really  
24 needed the local knowledge and expertise.

25 Just by way of context, when I started, there were

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1 **Q.** So can you help us in terms of what you did in your role  
2 around the central to local, and acknowledging or  
3 realising the need for more input from the local  
4 contract tracers' expertise, please.

5 **A.** Yes, so when -- as I say, that first week I was  
6 appointed, I made a number of calls to people that  
7 I knew in the NHS and in local government, and I've  
8 listed some of them in my statement, and had pretty  
9 universal feedback that local authorities were feeling  
10 excluded from the plans to scale up contact tracing, and  
11 that we needed to make much greater use of their  
12 expertise and relationships and capability. So the  
13 first weekend I worked with Mark Lloyd -- at the time,  
14 was the chief executive of the Local Government  
15 Association -- with others to find a respected local  
16 authority chief executive to come into the test and  
17 trace leadership team, and that was Tom Riordan. And  
18 Tom, in turn, recruited a team of mainly ex-local  
19 authority chief executives to act as regional  
20 coordinators to help us coordinate better with local  
21 authorities. And Tom held the pen on developing  
22 the contain framework.

23 So one of the things, my Lady, that wasn't in place  
24 at the beginning of the pandemic was a clear sort of set  
25 of the relative responsibilities between sort of local

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1 290 trained contact tracers, as -- in the director of  
2 public health teams and the PHE regional teams, in the  
3 whole of England. So -- and we needed 15,000.

4 So you had to have some form of virtual national  
5 call centre but you needed the local expertise as well  
6 and, through the course of 2020, we shifted more and  
7 more towards that local and national team of teams.  
8 Maybe one fact that's not in my statement, that probably  
9 should have been before is, if you look at the budget  
10 for contact tracing for 2020 -- the year 2020/2021, we  
11 spent £1.8 billion in the local outbreak containment  
12 fund, which was all money that went to local authorities  
13 for their local contact tracing and isolation support,  
14 and we spent 900 million, so roughly half, on national  
15 contact tracing.

16 So it took time and, with the benefit of hindsight,  
17 you'd do it earlier, but we worked really hard from May  
18 onwards to get this balance right of local and national  
19 working together.

20 **Q.** Thank you.

21 Can I ask you, with identifying the budget that was  
22 then provided I think in the July of 2020 to local  
23 authorities, was there any discussion around why there  
24 had been the under-utilisation of the directors of  
25 public health before you had been in post in the May of

16

1 2020?

2 A. I think that -- I think that this is quite a Whitehall

3 disease to not understand's how local government works,

4 and I think it actually can be quite a local government

5 disease not to understand how national government works,

6 and so it wasn't discussed.

7 Q. If I can ask you to slow down, I'm sorry, for the

8 stenographer. I'm sorry for interrupting you.

9 A. Sorry, I'll try and speak slower.

10 I think it's quite an institutionalised disease for

11 the national teams not to really understand the

12 strengths and benefit that the local teams bring, and

13 vice versa, which is why I think it's so important to

14 have both.

15 So, from memory, Tom was widely respected amongst

16 his local authority colleagues but also widely respected

17 in Whitehall. He'd done a job in what was -- what's now

18 the -- in the -- what was then the Department for

19 Levelling Up, so he had relationships at both national

20 and local level, and therefore was heard, but I don't

21 think it was something that had -- the discussions had

22 happened before we brought him in.

23 Q. Thank you.

24 Can we then, please, move to your paragraph 4.22 on

25 page 16 of your statement. You detail the following:

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1 seconded from their permanent organisation or on

2 gardening leave from commercial jobs, and therefore

3 immediately available. I asked them to serve for

4 3 months initially. This process is obviously not

5 standard for public or private sector recruitment, but

6 was essential given the urgency of the problem at hand."

7 Can I ask you then, in terms of that and also what

8 you go on to deal with, which was essentially after that

9 first three months, that, again, a number of the staff

10 you lost in the August/September time, so were the

11 urgent measures you outlined there necessary because of

12 the absence of planning before you being in a role?

13 A. Yes, but I think it's also the reality of a crisis that,

14 no matter how well you've planned, you will need to do

15 some form of urgent recruitment for skills that you

16 hadn't thought about before, but the reality was there

17 was no plan for scaling a national level testing and

18 tracing service, so the fact that there was nothing at

19 all obviously meant that we were having to start from

20 scratches in recruiting people.

21 Q. And you say no plan. The evidence the Inquiry has heard

22 is as to what was being done to scale up the Lighthouse

23 laboratories, and so can you just contextualise what you

24 say there, that there was no plan still, notwithstanding

25 the existence of the Lighthouse laboratories?

19

1 "I recruited the majority of the first executive

2 committee of [NHS Test and Trace] over the first weekend

3 after I was appointed. Whilst the leadership team

4 (mainly comprised of secondees from [the Department of

5 Health and Social Care], NHS and Office for Life

6 Sciences) I inherited at the beginning of May 2020 had

7 done an extraordinary job scaling PCR testing to 100,000

8 a day. They were utterly shattered and did not have the

9 operational experience that was needed to lead [NHS Test

10 and Trace] to the scale required. Although a small

11 number of the senior team stayed on with [NHS Test and

12 Trace], most were exhausted and took leave before

13 returning to their home departments. I therefore set

14 out to bring into [NHS Test and Trace] experienced,

15 seasoned leaders from the NHS, local government and the

16 private sector. I sourced candidates by headhunters,

17 the Chair of the Local Government Association, the

18 Cabinet Secretary and the Deputy Chair and Chief

19 Operating Officer of NHS England and, where it was

20 possible to identify multiple candidates, interviewed

21 them over the weekend and first week wherever possible,

22 together with the Second Permanent Secretary at [the

23 Department of Health and Social Care] or [NHS Test and

24 Trace's] Chief People Officer once the latter was

25 appointed. The individuals we appointed were either

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1 A. So I was really referring to January, February, March,

2 that there was no plan before the start of the National

3 Testing Programme.

4 So the team I inherited were necessarily focused on

5 a very, very short-term objective, which was to stand up

6 the first phase of Lighthouse labs to get to 100,000

7 tests. I think within a week of my arriving, the

8 Prime Minister announced the 200,000 test target for the

9 end of the month, and we had a goal of launching the

10 end-to-end testing and tracing service by the end of the

11 month.

12 So the time -- it almost seems crazy describing it

13 here now -- you had three weeks to launch a national

14 citizens service, and the management team for the

15 National Testing Programme had literally been working

16 all the hours that they had, and in my first meeting

17 with them, in the first week, most of them told me how

18 they were just about to finish and go back to their home

19 department.

20 And that's no criticism of them at all, my Lady.

21 They did an amazing job. But we needed, in literally

22 a matter of hours or days, to have really experienced

23 leaders to tackle this enormous task. And inherently,

24 you could only plan towards that first objective, which

25 was getting the service up and running.

20

1 My first chief people officer, her primary objective  
 2 in the three months that she was seconded to us was to  
 3 recruit a permanent leadership team. You couldn't  
 4 recruit a permanent leadership team over a weekend; you  
 5 could only recruit people to come in on secondment or  
 6 free of charge on loan from another government  
 7 department or from a company, and you couldn't ask them  
 8 to stay indefinitely. The only way I could persuade  
 9 great leaders like Tom Riordan to come,  
 10 Sarah-Jane Marsh, who came from Birmingham Women's and  
 11 Children's NHS Trust, for example, was to promise their  
 12 respective chairs that I would send them back after  
 13 three months.

14 Some of them stayed longer than that, for which we  
 15 should all be eternally grateful, but it was an exercise  
 16 of gentle arm twisting to persuade experienced leaders  
 17 from across society to come and help.

18 **Q.** And perhaps this appropriate opportunity to ask also,  
 19 did you receive remuneration for your role as chief  
 20 executive of NHS Test and Trace?

21 **A.** No, though I was executive chair -- not that it makes  
 22 a huge difference --

23 **Q.** No, it does.

24 **A.** -- but, no, I was paid as the chair of NHS Improvement,  
 25 I continued to be paid as chair of NHS Improvement,

21

1 appealing to those in permanent civil service roles who  
 2 understandably looked beyond the pandemic."

3 So can I ask you, in terms of the gap in staffing  
 4 that certainly you detail in the statement was acute in  
 5 the third week of August of 2020, can you help as to  
 6 what accounted for that gap?

7 **A.** So, in a crisis, there are two places that government  
 8 goes to get resources. So the first place is you look  
 9 to second civil servants from non-crisis departments or  
 10 functions. So that's the first place. The second place  
 11 you go is to the military, to use military resources to  
 12 urgently stand up services. They're particularly  
 13 brilliant at logistics.

14 And NHS Test and Trace and the National Testing  
 15 Programme had used those two sources to in extremis, to  
 16 the extent that we were using all that we could from the  
 17 public sector by civil servants and the military. So  
 18 you have to then fill the gap with short-term  
 19 consultants or contractors, and that was how the Vaccine  
 20 Taskforce was stood up, it was how the Ventilator  
 21 Challenge was stood up, it was also how the National  
 22 Testing Programme was stood up.

23 So when I arrived in May, a substantial proportion  
 24 of the operating workforce were consultants and  
 25 contractors, and we recognised from an early stage, as

23

1 I took no additional remuneration for test and trace.

2 **Q.** Thank you.

3 Can we then, please, move to paragraph 4.29, please,  
 4 at page 18. Thank you.

5 You detail that:

6 "Once [NHS Test and Trace] had been launched and it  
 7 was clear that the service would be required for more  
 8 than a few months, the then-Chief People Officer  
 9 launched several concerted efforts in the summer of  
 10 2020, including a 2-week resourcing 'sprint' in late  
 11 August and early September to fill vacancies and to  
 12 recruit civil service staff to replace consultants,  
 13 especially in management roles, on the basis this would  
 14 be both less expensive and provide greater long-term  
 15 continuity and therefore be better value for money.  
 16 This proved extremely difficult to achieve, partly  
 17 because some of the skill sets were in very short supply  
 18 across the civil service (eg programme management,  
 19 digital development) and partly because working in [NHS  
 20 Test and Trace] was inherently a short-term assignment  
 21 under enormous scrutiny and pressure, which certainly  
 22 deterred some candidates. Given the frequently changing  
 23 course of the pandemic, it was difficult to provide  
 24 certainty to colleagues for more than a few months and  
 25 as the pandemic progressed this became less and less

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1 the statement says, that you want to have more permanent  
 2 expertise and knowledge, and it will be cheaper to have  
 3 people in permanent roles.

4 So the work that went into trying to replace  
 5 temporary consultants with permanent civil servants  
 6 began in real haste and scale in that summer under the  
 7 then chief people officer, using the full support of the  
 8 chief people officer of the Civil Service and the team  
 9 in the Cabinet Office, but to be honest we didn't move  
 10 the dial at all, because as fast as we recruited  
 11 permanent civil servants to come in, new tasks were set  
 12 us, either by the disease or by ministerial decisions  
 13 because of the disease, to build new services.

14 So as fast as we filled vacancies with permanent  
 15 staff, we ended up recruiting more consultants, such  
 16 that by the time I handed over to Jenny Harries, the  
 17 numbers were not that dissimilar to the way they were in  
 18 the summer. And I know that she then led similar  
 19 exercises to replace temporary consulting staff with  
 20 civil servants.

21 **Q.** Your statement identifies volatility in the laboratory  
 22 workforce, including staff as a factor affecting  
 23 capacity in September of 2020 which continued into the  
 24 autumn. Should there have been a more robust approach  
 25 to recruiting competent and reliable staff in the

24

1 preceding months of May to September rather than  
 2 recruitment to generalist consultants?  
 3 **A.** I think the thing to remember about people working in  
 4 the laboratories is that they were working on a shift  
 5 system, 24 hours a day, seven days a week, and they got  
 6 Covid too. So when we refer to volatility, it was  
 7 volatility from absence because of Covid illness and  
 8 Covid isolation rather than any lack of capability to do  
 9 the role.

10 I think that the combined teams of biomedical  
 11 scientists and students who worked in those laboratories  
 12 did an extraordinary job. And if anything, one of my  
 13 concerns I have, my Lady, is that it's tempting to  
 14 assume that because they were temporary they weren't  
 15 good; they worked really hard and they deserve our  
 16 thanks, I think.

17 **Q.** Thank you. Can I ask then, in terms of this shortage of  
 18 staff in the autumn time, is the lesson for the future,  
 19 then, that there needs to be planning and trained and  
 20 exercise specialists who can rapidly stand up such  
 21 agencies and recruit relevant competent staff at pace?

22 **A.** Yes, I have been doing lots of thinking around how do  
 23 you have that surge capability because it's plainly not  
 24 economically sensible to have all of these people  
 25 waiting with nothing to do and so, for both scale

25

1 specialists, you said that you could use, deploy them as  
 2 a reserve force who could then scale up. How do you do  
 3 that with the limited number of public health experts?  
 4 As you'll appreciate, every time I make  
 5 a recommendation, I've got to work out how much will it  
 6 cost --

7 **THE WITNESS:** I understand.

8 **LADY HALLETT:** -- because I'm not going to get  
 9 recommendations past a government strapped for cash  
 10 unless I can make it cost effective. So how do you have  
 11 the kind of reserve force you're talking about and then  
 12 maybe move on to the project management teams and the  
 13 other teams -- how can you make them able to have the  
 14 surge capacity but not cost a fortune in ordinary times?

15 **A.** I think you have to use the existing health and social  
 16 care ecosystem that we have. So we spend 150 billion on  
 17 our health and care system, so I think we need to think  
 18 about how we are pandemic prepared in the way we spend  
 19 all of our money in health and social care. So, for  
 20 example, on the laboratory side, if you think about how  
 21 we have scale pathology labs in the NHS, as opposed to  
 22 lots of small labs in individual trusts, one of the big  
 23 differences between Germany and the UK, as we went into  
 24 the pandemic, is that Germany had regionalised pathology  
 25 networks. Lord Patrick Carter actually recommended

27

1 testing and contact tracing, working through how you  
 2 have some form of reserve force, it's almost easier to  
 3 see in contact tracing, where the local authorities,  
 4 directors of public health, but also people working in  
 5 local authorities, could easily be a public health  
 6 reserve force, able to contact trace if needed at scale,  
 7 just in the same way we think of military reservists.

8 So that's I think an easier way of thinking about  
 9 it. For the setting up of laboratories, clearly you  
 10 need more specialist expertise but, again, thinking  
 11 about how do you have more of the sorts of things like  
 12 the government -- that the Government Commercial Office,  
 13 who actually did fantastic work, the GCO, a small team  
 14 of world experts at procurement who were able to be  
 15 deployed during the pandemic, we should have a similar  
 16 small team of experts for programme management,  
 17 a similar small team of experts for digital product  
 18 design, a similar small team of experts for diagnostic  
 19 quality assurance, et cetera.

20 You could build that sort of capability that could  
 21 be deployed from existing organisations. And I think  
 22 that's at the heart of how you have a system that can  
 23 stand up faster.

24 **LADY HALLETT:** Can I just go back. First of all, you  
 25 mentioned the reserve force local public health

26

1 reducing the number of pathology labs in the NHS from  
 2 120-odd to 29, I think, in 2008 but, as we went into the  
 3 pandemic, that still hadn't happened.

4 So if you had a more scalable pathology service,  
 5 which would actually give better diagnostic capability  
 6 for the NHS today, that helps with your labs. If you  
 7 follow the evidence of Lord Bethell on more focus on  
 8 public health, more focus on prevention, more community  
 9 services in our approach to health and care, what that  
 10 will give you, my Lady, is a larger team of people who  
 11 won't be public health experts but who could do half  
 12 a day, a year's training in contact tracing, so that  
 13 when their local public health experts need them,  
 14 they're able to be deployed.

15 **LADY HALLETT:** Thank you.

16 **MS CARTWRIGHT:** Thank you.

17 Can we display your paragraph 4.31, please, at  
 18 page 19. You detail that:

19 "There were occasions on which [NHS Test and Trace]  
 20 was instructed by HMT and/or the [Cabinet Office] to  
 21 reduce operational capacity ..."

22 I'm going to move to paragraph 5.11 in a moment.

23 "... in testing and contact tracing only for  
 24 infection rates to rise rapidly with the consequence  
 25 that resourcing needed to quickly scale up existing

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services to meet demand. Further to that, [NHS Test and Trace] was frequently tasked with building new services within short time frames (such as testing the whole population of Liverpool and standing up education testing over the Christmas holidays in 2020/2021), which required consultants to be brought on and retained. As such, despite sustained efforts to reduce the use of consultants, [NHS Test and Trace] continued to use substantial numbers of temporary labour and resourcing throughout the pandemic."

Can I ask you, you've identified rising infection rates. Could you just give some clarity to the Inquiry about the role of the JBC as a resource that you had from May onwards that helped identify infection rises or things on the horizon, please.

**A.** So the Joint Biosecurity Centre was conceived as the data analysis engine for the testing and tracing service. So they provided -- they took all of the data that came from our test results and contact tracing, and used that to provide analysis to the CMO and to ministers to enable them to make decisions on implementing other non-pharmaceutical measures like local lockdowns. So the JBC was a core part of my team, because they relied on the wiring, if you like, the data flowing from test and trace, and they played a role in

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the Bronze Committee, weekly readouts for Silver and Gold, and in the early -- we'd seen in Scotland, when -- schools go back earlier, in the middle of August in Scotland -- when the schools went back earlier, Scottish infection rates had risen and, as schools came back in that first week in September, you started to see the infection rates rise and the JBC did highlight that to me and also through me to the CMO and Secretary of State and I think -- I know others have commented on this that -- through September, October and November, it was clear that infection rates were rising and, you know, it's so easy with the benefit of hindsight but, with the benefit of hindsight, I suspect we all see that should have locked down earlier.

**Q.** Thank you.

**LADY HALLETT:** Thank you. You've linked the rise or may have appeared to some to have linked the rise in infections to the schools going back but, of course, the schools are going back at a time when restrictions were being eased.

**A.** Yes, and I'm not an epidemiologist, so I need to be very careful, my lawyers keep telling me to stay in lane, and the CMO would be far better placed to give you the full answer. What I can say is that it was the JBC's role to give you the present that data and the head of the JBC,

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thinking through what questions do you ask someone to fill in when they order their test, so that you get, you know, demographic information, for example, to help you understand who might have the disease and whether there are particular pockets.

So they needed to be integrated into it. They were the data providers and analysers in the Local Action Committee, the bronze, silver and gold meetings, the silver chaired by the CMO, the gold chaired by the Secretary of State for Health and Social Care. So they were using what Test and Trace -- and they used other data from the NHS and other publicly available data sources to provide advice on where and how to combat the disease at a local level.

**Q.** Thank you.

Can I ask you, informed by that resource and expertise, you reference rising infection rates. Are you able to assist as to whether the JBC provided intelligence before as to the increase in infections in the community again, prior to us going into the second lockdown on 5 November 2020?

**A.** Yes, they did. So I think -- I wasn't obviously there during the first lockdown and the decision where there wasn't the data. But by August 2020 it wasn't perfect but the JBC were producing sort of daily readouts from

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with me sitting beside her, did do exactly that in those early couple of weeks in September to both the Secretary of State and to the Prime Minister.

**MS CARTWRIGHT:** Thank you.

Can I ask you, then, perhaps looking earlier in the chronology as well, as to what impact decision making may have had upon capacity or demand on NHS Test and Trace. Obviously, restrictions were eased and the original coming out of lockdown was around the June period of time. Was there any feeling, equally, that that had been too soon in terms of then the impact that was having around the demand being placed for tests on NHS Test and Trace?

**A.** I mean, as I say, I'm not the expert, so I need to be careful, but I think that through that summer, as a country, we were running hot in terms of the infection rates, compared to some other countries that had taken longer to come out of lockdown, and a testing and tracing service is going to be operationally more effective with lower infection rates. So there's no doubt that it made it harder, but that's a political judgement. Not one for me.

**Q.** Now, I promised that we'd go to your 5.11 but can we move first of all to 5.10 on page 20, please. You detailed that:

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"For example, [NHS Test and Trace] faced various difficulties in obtaining HMT and [Cabinet Office] approval for Lighthouse Laboratories in the summer of 2020, and this meant that the approvals process for the expansion of the Lighthouse network took far longer than it should have in the circumstances. Had [NHS Test and Trace] had greater delegated procurement authority during this time, this would likely have reduced the capacity issues we experienced in the autumn. It was these frustrations which led to the substantial delegated authority to directly approve spending on PCR and [lateral flow device] tests and award contracts up to £150 million that was agreed with the Prime Minister and HMT from 22 September 2020."

Now, I think there's some underpinning material that details the problems around the continuation of the scaling of the Lighthouse laboratories.

But can I ask you, can we display, please, just briefly to capture the state of play in May, INQ000587456. Thank you.

We've looked at this map on a number of occasions with individuals and we can see that the first four Lighthouse laboratories were established in April but then it was not until October 2020 that the Newport Lighthouse laboratory was operational, November for

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and PHE labs to expand and other labs too.

The business case for all of that expansion took far too long to get approved through June and July. Some of that may well have been due to inexperience in my own teams. You know, it was the first time we'd done something of that scale but it's really stark when you look at the map here how quickly the first set of Lighthouse laboratories went from concept to operation and how much longer it took.

And I have some empathy for why colleagues in the Cabinet Office felt they needed to scrutinise, for fear of sitting in an inquiry such as this and explaining why they'd approved things out of process, but that's why, through August, we'd discussed with the Secretary of State and with the Chancellor and the Prime Minister how we'd changed the way procurement worked because, otherwise, we were cutting off our nose to spite our face. We were slowing down when it was clear the country needed that testing and tracing capacity for the autumn and every day really mattered.

**Q.** Thank you.

Then to inform the "everyday really mattered", did the data and information you were receiving from the JBC further support that every day mattered to get greater laboratory facilities for tests?

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Charnwood, and then it took until March 2021 for the further laboratories at Plymouth, Brants Bridge and Baltic Park to then come on line, before finally the Rosalind Franklin Laboratory in June 2021.

So, April to then October before Newport, and so can you assist: did the procurement issues that you've identified result in what seems to be a big gap and a slowing down of the scaling up of the Lighthouse laboratory network?

**A.** Yes, I think it did and, just to give a bit of context, if you go back to how we all felt as we came out of that first lockdown, it was very tempting to believe that Covid was beaten, the world was getting back to normal, and I think that's what we experienced in government procurement decision making. There were, you know, substantial voices wanting it to return to pre-pandemic normal procurement processes, which would have been, you know, months if not years before you would procure at this scale, and that definitely slowed down the next phase of the building of Lighthouse laboratories.

It also slowed down the scaling of the existing Lighthouse laboratories, so the path to 500,000 tests a day for the end of October, that we were tasked with, required us to expand capacity in the existing labs as well, not just the Lighthouse labs, it required the NHS

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**A.** Absolutely. And I think you can see in the emails, in the evidence, you know, this is senior people sending emails at midnight saying, you know, basically "I'm scared, I can't deliver what I know I need to because we're stuck in the bureaucracy and we need to find a different way of doing this."

So, as you look forward, having crisis-appropriate procurement processes -- I'm not suggesting that scrutiny isn't appropriate, of course it is, but the risk of not building the labs was so much greater than the risk of spending 10% more on the procurement. And that wasn't being recognised in that summer.

**Q.** And can I ask you, then, because we know that until December of 2020 you had a reporting line to the Prime Minister, and so, particularly with the frustrations you've expressed from the summer of 2020, would it be a fair assumption to say you would have been raising these frustrations in meetings that you were having with the Prime Minister?

**A.** Yes.

**Q.** What assistance did the Prime Minister give to you to essentially get a solution as quickly as possible?

**A.** Well, in the end it was through the Prime Minister and colleagues such as Ollie Munn in the Cabinet Office that we negotiated a different process with the Treasury and

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with the Cabinet Office, but, as I know in Module 2, my Lady, you've been exploring, government decision making is complex, and one of the things that you learn, taking on the role that I did, is that actually that politicians still need to find a point of consensus amongst their cabinet, and it took a while to get that consensus through the summer, and I do think that there were a lot of us as citizens who wanted to believe that it was all over and we didn't need to do it. And that was what was playing out amongst the politicians who needed to make these decisions.

**Q.** Thank you.

Now, Baroness Harding, last week we looked at some of Lord Vallance's evening notes, and caveating that they are not anything other than handwritten notes of an evening, but one of those entries was from 6 August 2020, which described:

[As read] "People changing all the time, no one knows who's actually in charge of Lighthouse labs."

Can I ask, did the Lighthouse laboratories suffer from a high turnover and unclear leadership in the summer of 2020?

**A.** Um, I think everything is context dependent. So at that point, at the beginning of August, we must have been just at the point at which Chris Molloy, who I know has

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you then go on to say:

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

So it seems that that is a tension throughout the year that you were the Chief Executive of NHS Test and Trace; is that accurate?

**A.** I think the tensions were particularly evident at the point where very, very difficult political decisions needed to be taken. I don't think it's a coincidence that we're looking at this correspondence in December 2020, or that the previous point that we were talking about was August, September. In both cases that was where -- you know, for a lot of us, we all wanted to

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given evidence, was standing down as the head of the Lighthouse laboratories, and Dame Anna Dominiczak was taking over. So I can understand why Lord Vallance would have been observing quite a cast of characters changing.

It was also at the time where, if you think of the senior leaders that I'd brought in had done their three months, and we were changing.

But I think it's a mischaracterisation to say that it was all unstable. It was a crisis situation where people were doing a tour of duty, and then the next team was coming in. And, you know, Dame Anna had been leading the set up of the Glasgow Lighthouse laboratory. So she wasn't new; she'd been the dean of the Glasgow Medical School, she's now the Chief Scientist for Scotland for health matters. So Anna was deeply involved in the programme, and was transitioning I think at that point. So I think yes, in part. You know, crisis are chaotic, and there were a lot of changing and moving parts, but I don't think it was more than you'd expect given the rate of growth of the organisation.

**Q.** Thank you.

Can we then go back to paragraph 5.11, please. We've dealt with 5.10, which identified the ability from 22 September to award contracts up to 150 million, but

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believe that it was over, but actually the data and the disease had got a different plan, and the data was pointing to infections on the rise.

So, in December 2020, there were, you know, perfectly reasonable, very smart people wanting to believe that Christmas would be normal. But what the JBC was telling me and the Secretary of State for Health and the Prime Minister was that actually, we urgently needed to scale, and there was a real risk of needing to have another lockdown, and my instructions were: do everything you possibly can to mitigate the risk of that.

And hence getting those very conflicting instructions.

When there was a clear political path -- so, as we came out of the third lockdown, the path out of lockdown was very clearly documented, with clear rules and guidelines for how government would make its decisions. Then government was completely aligned.

Now, I'm not naive, I don't expect that in a crisis the government can be completely aligned and rely on a publicly published document, but in those particular points in 2020, NHS Test and Trace was being given directly contradictory instructions by different parts of the machinery of government. And I've no doubt in my

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1 mind that if there was a more structured process in  
2 place -- it would still have led to changing  
3 instructions, but not entirely directly opposite ones at  
4 the same time, if there'd been closer -- and I know  
5 that's more the subject of Module 2, my Lady, so I'm  
6 sorry if I'm erring where I shouldn't.

7 **Q.** Thank you.

8 Can we then continue with the questions on  
9 Lighthouse laboratories, please, and move to your  
10 paragraph 5.19, please, on page 24.

11 Thank you.

12 Now you detail within paragraph 5.19 and 5.20 the  
13 expansion of the Lighthouse laboratory network in the  
14 summer of 2020. Can I ask you, on 23 July 2020,  
15 Vaughan Gething announced a new Lighthouse laboratory in  
16 Newport, that we've looked at together didn't come  
17 online until the October of 2020. The expectation had  
18 been that that laboratory would be up and running by  
19 August but it didn't open until 5 October.

20 Can you assist, please, Baroness Harding, as to how  
21 the location of the laboratories was identified and  
22 selected?

23 **A.** I'm sorry, I can't really give you an awful lot more  
24 detail on that. I'm sure that we can go back through  
25 the records and write to you if that would be helpful,

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1 ten times faster than you would ever sensibly set up  
2 a laboratory.

3 **Q.** Thank you.

4 Now, if we look at paragraph 5.21, you deal with the  
5 response of NHS Test and Trace to the demand for  
6 increased testing. And can I ask you in particular  
7 about paragraph (b), which included procuring short-term  
8 PCR processing capacity from private surge providers.

9 Can I ask you therefore, are you able to assist as  
10 to the -- was the reason and frequency for that linked  
11 to the fact that the Lighthouse laboratories hadn't  
12 progressed as quickly as they could or should have done?

13 **A.** It was all forms of testing, weren't proceeding as fast  
14 as we would want. So I think there are a number of  
15 exhibits attached to mine and to the UKHSA corporate  
16 statement that show you the complexity of going from  
17 200,000 test capacity at the end of May to 500,000 test  
18 capacity at the end of October, and then 800,000 by  
19 Christmas. We were pushing every type of laboratory to  
20 expand as fast as they possibly could.

21 So existing Lighthouse laboratories, whether that  
22 was Milton Keynes or Randox or Alderley Park, pushing  
23 them to expand their capacity, that was about procuring  
24 more robotic automation. So automating more and more of  
25 the end-to-end factory, if you like. We were also

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1 but I wouldn't have been personally involved in the  
2 specific site selections, that would have been Chris and  
3 then Anna's team working through what they thought was  
4 the right sort of geographic location for the very  
5 complex end-to-end logistics, and to ensure wherever  
6 possible that all four nations were being appropriately  
7 supported.

8 **Q.** Thank you.

9 Can I ask you then specifically with the Newport  
10 example, what was the -- are you able to give the  
11 specifics as to why there were such serious delays in  
12 setting up the laboratory in Newport? Is it under the  
13 context of the discussion we've already had about the  
14 problems with getting the procurement for the  
15 continuation of the Lighthouse laboratories?

16 **A.** I think all of these things are multifactorial, and it's  
17 tempting to make it one. I think we've talked about  
18 procurement as being one. The sheer complexity of  
19 sourcing the equipment -- remember there was a global  
20 race for all these PCR machines, recruiting the teams,  
21 making sure that they're clinically -- the processes are  
22 clinically validated. This is a non-trivial exercise.  
23 I can't, I'm afraid, speak to the detail of exactly why  
24 that took what, in Covid time, feels like a very long  
25 time, but in normal time would still be probably about

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1 pushing NHS labs across the country to expand theirs.  
2 Less full automation there because they had less space  
3 but they were still doing some of it. And then pushing  
4 for the new labs to get set up.

5 And as it was approaching through September, that  
6 target of 500,000 tests by the end of October was  
7 looking at risk, so we were looking for any laboratories  
8 that were clinically valid to add into the network if we  
9 possibly could.

10 So it was all of the above, my Lady, not just one.

11 **Q.** Thank you.

12 Can I ask you then, you identify in that paragraph  
13 obviously that using those, short-term PCR capacity, was  
14 more expensive --

15 **A.** Yes.

16 **Q.** -- and difficult to oversee. So was there actually  
17 value for money in going to this resource?

18 **A.** Making that value for money judgement, one of the things  
19 that the team were always doing was looking at the  
20 average cost per test and looking to drive that cost  
21 down as we got more scale.

22 So, as soon as you could, you would want to remove  
23 the most expensive tests on a cost-per-test basis and  
24 also the ones that were hardest to manage and ensure  
25 quality and performance. So these were our -- you know,

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1 they were called surge labs for a reason. You didn't  
2 want to use them unless you absolutely had to. And so  
3 if we'd had more Lighthouse capacity come on earlier,  
4 then logically you wouldn't have needed to use them as  
5 much and logically you would have delivered more testing  
6 at a lower cost.

7 Q. Thank you. Can I ask you then, you identified that you  
8 were essentially utilising every possible resource for  
9 sources of testing. The Inquiry has heard some evidence  
10 from Professor McNally, for example, about what could  
11 have been offered through the university network, their  
12 ability to scale up PCR testing and with their  
13 connection to existing hospitals through the framework  
14 of medical schools, and also from the Crick in respect  
15 of their facilities and their offer of testing.

16 So can you assist, in terms of going to every  
17 available resource, were you aware of the offers that  
18 had been made by a number of academic institutions and  
19 research laboratories like the Crick?

20 A. Yes, and I can completely understand why anyone, who  
21 felt they could, really wanted to contribute and help.  
22 I think that the laboratories in London were connected  
23 in to the NHS Test and Trace Pillar 2 system in the  
24 autumn of November/December time, doing sort of single  
25 digit thousands tests per day. Now, I wasn't involved

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1 be accessed if you had a car.

2 If you were doing this again, you'd set up your  
3 first set of testing sites in local community halls in  
4 Tower Hamlets, not in Chessington World of Adventures.  
5 So I think it's a bit of a false dichotomy. I totally  
6 understand why the university leaders really wanted to  
7 help and, you know, I wish -- I think Lord Bethell said  
8 in a perfect world we would have been able to context  
9 them faster, but you had to make choices and you needed  
10 the -- it sounds very mundane but imagine 30,000  
11 boxes -- we all filled in and did tests and put them in  
12 the boxes and sent them back. Imagine 30,000 boxes  
13 arriving in this room, my Lady. They have to be  
14 unpacked safely because they might contain obvious  
15 virus; they've all then got -- all of the waste from  
16 those boxes has got to be dealt with; all of the  
17 machinery, the robots need to be working 24 hours a day  
18 to work through what is a production line. And so to  
19 get to the scale you needed in the summer 2020 you  
20 needed that.

21 Now, I do think -- if I may, I do think there is  
22 another way you could, looking forward, tackle this,  
23 which is why the Germany example is so important. If we  
24 had a slightly more regionally-scaled pathology network  
25 in the UK, along the lines that Lord Carter recommended

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1 when the original decision was taken to set out the --  
2 set up the first sets of Lighthouse laboratories, but  
3 I think -- and I've thought about this quite a lot,  
4 having listened to a lot of the evidence in this  
5 module -- I suspect that there was no other choice in  
6 March/April 2020 but to take those Thermo Fisher  
7 machines out of the universities in order to get them  
8 working 24 hours a day, seven days a week, not because  
9 the machines themselves couldn't work like that in the  
10 universities but because the logistics that you needed  
11 to have them working 24 hours a day, seven days a week,  
12 were of a scale that needed to be centralised.

13 And I am obviously a retailer by background, I think  
14 of the laboratories as the warehouses. The piece that  
15 really needed to be local in testing was the testing  
16 sites: the shops. You needed to get the testing sites  
17 as close as possible to people who most needed testing.

18 So, actually, with the benefit of hindsight,  
19 I wouldn't change the decision on setting up the  
20 Lighthouse labs, but I would change which of the testing  
21 sites that you opened first because the same scale,  
22 national approach, went into the testing sites. So  
23 I think the first testing site was at -- was in the car  
24 park of Boots' head office in Nottingham and the second  
25 was at Chessington World of Adventures. Both could only

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1 in 2008, so you had high throughput pathology services  
2 for the regular diagnostic tests that we all received  
3 from the NHS -- in this modern world of data moving,  
4 that's perfectly doable because other countries do it --  
5 you would then have laboratories within our NHS  
6 ecosystem that would be more suited for scaling than the  
7 laboratories that we had in academia and the NHS  
8 in 2020.

9 Q. Thank you.

10 Can I just explore with you your paragraph 5.24,  
11 where essentially you deal with the analysis we've just  
12 looked at together around existing laboratory capacity.  
13 But if we go over the page, please, you essentially  
14 detail that it was not possible to scale at the speed  
15 required via existing NHS, PHE or university  
16 laboratories:

17 "A university or hospital laboratory that in  
18 peacetime may conduct a few hundred PCR tests a day, did  
19 not have the space, systems or processes to conduct  
20 30,000 tests per day within a couple of months and this  
21 was the brief that was given to and urgently implemented  
22 by each Lighthouse Laboratory ..."

23 The evidence the Inquiry has heard is that certainly  
24 Professor McNally thought they could get to 3,000 to  
25 4,000 tests a day and, obviously, if you multiply that

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across the 40 universities that are linked to medical schools, there's that connectivity, as well as other institutions, other universities, that have the relevant PCR testing.

Similarly, the Crick, Sir Paul Nurse gave evidence that they, with support, believed he could scale to 10,000 tests a day and obviously gave the example that you only needed then ten places that could do that to get to the 100,000.

So can I ask you, in providing your statement and giving the answers you've just given, have you had the appropriate regard to what those that operated these laboratories believe was possible if they had been utilised, rather than moving to the Lighthouse system?

**A.** I mean, I've thought about this quite a lot over the last couple of weeks, and I think that there is a -- the thing to realise is the challenge -- the exponential complexity of having multiple laboratories. So I've no doubt that Professor McNally and Sir Paul Nurse are right that they could have scaled, themselves, to a few thousand or 10,000 but we needed hundreds of thousands, and every time you added a new laboratory, keeping them working, all the machines, all the people, working 24 hours a day, seven days a week, requires you to balance the load of tests that are arising to them. So

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apply when you were using private surge providers about how you could get the results and data across, or was there a contingency for that?

**A.** I wasn't aware of any data issues while I was there, recognising that obviously after I left there were. But I think there is a sort of higher-level point to this which the issues with the Immensa lab do show you, which is the added risk of having multiple small laboratories: that the quality assurance becomes exponentially more complex.

And this isn't a static world. So, during the year I was running Test and Trace, we learnt about the different genomic variations of Covid. We started implementing a genomic assay in the laboratories to be able to identify faster than full genomic screening whether or not you had new variants. That had to be -- those new processes had to be rolled out to every single laboratory.

So the complexity of doing that and the risk of making mistakes grows exponentially, and so I think you do have to be mindful of that when you're scaling: that you want to have fewer of these high-quality -- high-risk environments, if you possibly can.

**Q.** Thank you.

Now can I ask you about the Rosalind Franklin

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you're creating an ever more complex system. So what we had to do was make priority judgements, and the judgement was to prioritise the biggest laboratories first, in order to scale quickly because, as I've said, my Lady, that doesn't affect your ability to deliver a localised service.

And I do think, when you look at the testing capacity for the UK, compared to all other countries, there's only one country that had more testing capacity than we did by the end of 2020, and that was Denmark. Every other country including Germany was substantially less than we were. So it wasn't perfect. I'm sure that, you know, again, with the benefit of hindsight, if you'd started all of this in January 2020, could you have got more of the university labs onstream a bit earlier? Maybe you could, but you needed to have those big scale factories and, because of the lack of machines, you had to take the machines we had in the UK, which wasn't a decision I took; it was a decision Sir Jeremy Farrar and Sir John Bell advised on before test and trace was started but, with the benefit of hindsight, I suspect that we'd all do the same thing again.

**Q.** Thank you. Can I ask you, in terms of when we looked at the private surge providers, did the data issue not

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Laboratory that we've already seen came online in June of 2021, so a month after you had ceased in the role; is that correct?

**A.** Yes, it was running pilot testing just while I was leaving.

**Q.** But can I ask you, just broadly speaking, in respect of that Lighthouse laboratory, which I think was the only one owned and operated by NHS Test and Trace itself, we know that, I think, by 2023 it was fully decommissioned.

Professor McNally, for example, has described the Rosalind Franklin testing laboratory as an example of an investment waste, and that the Leamington Spa lab never really made a significant contribution to the UK testing capacity or infrastructure.

Can I ask, do you have any views as to that particular laboratory?

**A.** Yes. So the Rosalind Franklin Laboratory was very much the brainchild of Dame Anna Dominiczak. We were all mindful of how much public money was being spent on this programme and how important if it was to have an eye to the future and leaving a positive legacy, and Dame Anna's vision was to create a reconfigurable, high throughput diagnostic laboratory, that then could be used for public health screening going forward.

At the same time that -- her vision included the

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high throughput nature of the Rosalind Franklin Laboratory, it used a particular form of PCR testing called ePCR that came from the agricultural sector, actually, from testing of seeds, that was very, very large scale and would have enabled the cost per test to be substantially lower than the original Lighthouse laboratories.

So I can understand why Professor McNally might not have seen the strategy, because it wasn't available publicly, but the strategy that we were working to was, as the Rosalind Franklin Laboratory was being commissioned, if you remember at that stage the vaccination programme was rolling out, but we didn't know how much testing capacity would be needed for 2021 and 2022, and the vision was that you would close down the higher-cost Lighthouse laboratories and use the Rosalind Franklin ePCR factory flows to deliver large-scale, lower-cost-per-test PCR testing through the rest of the pandemic.

I can't speak directly for the decision making that happened after that, but I do think it is a real shame that Anna's vision for a public health legacy of high throughput testing that could be part of this government's vision for more focus on public health proactive screening -- it could have played a role. And

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letter he sent on 10 December covering a number of matters. If we could just move to page 2., we can see in particular, he was questioning the long-term strategy for testing and under "Value for money" raised the query, in particular around the costings of consultants at £3 million per day.

Can I ask, given the persisting problems with staffing, resourcing and equipment, what your view is on consultancy costs of £3 million per day and whether that did in fact reflect value for money?

**A.** So I think you've also got in evidence Lord Bethell's response to Lord Agnew's --

**Q.** Sorry, Mr Hancock's. We do.

**A.** Yes, I think --

**Q.** From the January, I think --

**A.** Yes.

**Q.** Yes, we do.

**A.** And set this all out. So you ask a much bigger question, which is about value for money, and I think to answer a question on value for money, you have to first step back and say what are you trying to achieve? So the brief that I was given, that the Prime Minister and the Chancellor gave me was to build a testing and tracing service that would reduce the risks of much more painful lockdowns and other non-pharmaceutical

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that was very much what was envisaged at the time that I was there.

**Q.** Baroness Harding, you express that as a "real shame".

Bearing in mind the costs of the establishment of the Rosalind Franklin Laboratory, would you agree that it's something far more than a "real shame" that, essentially, that whole laboratory has been completely dismantled and no longer exists?

**A.** I think the biggest shame is not taking seriously the importance of public health, that actually we -- and I believe Lord Bethell said this as well -- one of the most important learnings for me, working on this, is that prevention is so much better than cure and yet we spend so much more money so much more willingly on the cure, and so I do think it's a great shame and maybe it was an idea ahead of its time but that vision that high throughput diagnostic capability, coupled with a highly local, you know, targeted public health system that really looks after the people who most would benefit from that support, ought to be one of the legacies from Covid.

**Q.** Very briefly on cost before we break for 15 minutes, can we please just have displayed INQ000528313. You've already referenced, I think, correspondence that passed between you and Lord Agnew. This is obviously the

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interventions, and so you judge the effectiveness and the value for money of the spend on whether or not Test and Trace succeeded in reducing infection rates, reducing hospitalisation, reducing the amount of time that, as a country, we needed to spend in lockdown.

There are a number of independent assessments of that. It's quite a complex thing to determine, so it's not an easy question to ask, is it value for money or not. But the evidence that I've seen, whether it is the Rùm or the CARNA models that were commissioned by UKHSA, or the Ernst & Young Oxford work that looked at the cost per test and concluded that the cost per test was value for money in terms of QALYs, so Quality Adjusted Life Years, which is the way that in healthcare we assess the cost of pharmaceutical interventions. Both Rùm and CARNA models concluded that the Test and Trace programme meant that we spent less time in lockdown, and that was worth considerably more than £3 million a day. But, as I say, it is a complex judgement on whether or not -- and I appreciate when you look at this, this looks like an enormous amount of money because it was an enormous amount of money.

But as we went through earlier, the reason you had to use consultants was because we'd exhausted the pool of military and civil servants who could be deployed,

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1 and the team were working, as this letter was written,  
 2 flat out to recruit civil servants while, at the same  
 3 time, the disease had a different plan for us, had  
 4 mutated, and we were about to be asked to scale up even  
 5 further, which meant, actually, that consulting costs  
 6 had to go up again because we needed more people to make  
 7 sure that lateral flow tests were delivered to secondary  
 8 schools for testing in the first week of January.

9 **MS CARTWRIGHT:** Thank you.

10 My Lady, is that a convenient moment?

11 **LADY HALLETT:** Certainly. I shall return at 11.35.

12 I hope you were warned that we take breaks but

13 I promise you that we shall finish you before we break  
 14 for lunch.

15 **THE WITNESS:** Thank you.

16 (11.19 am)

(A short break)

18 (11.35 am)

19 **LADY HALLETT:** Ms Cartwright.

20 **MS CARTWRIGHT:** Thank you, my Lady.

21 Baroness Harding, in the remaining 20 minutes that  
 22 we have together I want to deal with, please -- just to  
 23 identify -- hopefully briefly, Operation Moonshot, then  
 24 contact tracing, a little more around support for  
 25 isolation, and then, finally, issues that linked to

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1 wanted the service to do. But there's no doubt that  
 2 pushing to try to test the whole population twice in  
 3 a two-week period was, I think in my view, a bit of  
 4 a distraction.

5 There is a counter to that, which is that it drove  
 6 tremendous innovation in the team scouring the world for  
 7 tests that were cheap enough, fast enough, easy enough  
 8 to deploy. In August 2020 no one knew that it would be  
 9 possible for lateral flow devices to work so  
 10 effectively. And so you could make an argument that  
 11 without the Prime Minister's desire to do Moonshot, that  
 12 might not have happened so quickly. And certainly, one  
 13 of the things I'm proud of is that the team found tests  
 14 that worked, developed a means of validating them,  
 15 procured them, scaled them, far faster than many other  
 16 countries in the world. And it's not absolutely certain  
 17 you would have had that without the Prime Minister's  
 18 push for Moonshot.

19 That said, I was deeply sceptical that it was  
 20 practically possible to test everyone within a two-week  
 21 period. It would have involved having roughly 10,000  
 22 testing sites, and we'd been going absolutely flat out  
 23 to get 1,000 testing sites. And what I learnt from the  
 24 public health experts was that, you know, you could test  
 25 99% of the population, but if only 1% of the population

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1 recommendations.

2 So I set that out bearing in mind that we've got  
 3 those topics to cover, but I think Operation Moonshot we  
 4 can cover fairly briefly because you detail in your  
 5 witness statement obviously the announcement by the  
 6 Prime Minister in September of 2020 that he had the plan  
 7 for a whole-population testing, and you therefore detail  
 8 at your paragraph 5.15 that you were among those who  
 9 expressed concerns about adopting a whole-population  
 10 testing model.

11 Then you go on at paragraph 5.17 to then say you  
 12 were relieved that a more targeted testing proposal was  
 13 then adopted.

14 But can I ask you, when you had the responsibility  
 15 for Test and Trace, and then the Prime Minister had his  
 16 own pilot or plan for this mass testing, to what extent  
 17 did that add to your burden or detract resources?  
 18 I know ultimately those lateral flows were used as part  
 19 of the full Community Testing Programme, but can you  
 20 help as to whether that was an added complexity on the  
 21 timeline we've looked at from the September time till  
 22 essentially those tests forming part of the Community  
 23 Testing Programme?

24 **A.** So, you know, obviously my role was to try to build and  
 25 deliver whatever it was that our political leaders

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1 had the disease, you could actually fail to test anybody  
 2 positively, especially if you were running a sort of  
 3 command and control operation that scared away the very  
 4 people most likely to have the disease.

5 So I was sceptical about it, I do think it was  
 6 a distraction, but it wasn't all bad.

7 **Q.** Thank you. And you detail in this run of paragraphs  
 8 essentially that it was not just you but the Chief  
 9 Medical Officer also had their concerns.

10 You say it was not all bad, but would you agree that  
 11 the Operation Moonshot was an example of poor decision  
 12 making by the government, set in the wider context of  
 13 what you were doing on NHS Test and Trace?

14 **A.** Well, I was trying to steer, all the way through that  
 15 autumn, towards multiple-use cases to reach the people  
 16 most likely to have the disease.

17 I think that looking forward, my Lady, one of the  
 18 principles for building a future mass testing and  
 19 tracing service is that you should design for the  
 20 disadvantaged, that you should in every element -- we've  
 21 proven that you can have scale testing and tracing, and  
 22 Moonshot actually led to a very wide range of different  
 23 use cases, testing in schools, testing in all vulnerable  
 24 communities, it made a huge difference, but if you  
 25 designed with the principle of designing for the most

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1 disadvantaged first, you wouldn't have Moonshot, you  
 2 would have had community testing first.  
 3 And I tried, through that autumn, to keep presenting  
 4 all the different options that weren't just testing the  
 5 whole population twice in a fortnight.  
 6 **Q.** Thank you. And so, in giving that answer, so would it  
 7 be fair to say that you were equally, then, pushing,  
 8 having identified the issue for community testing of  
 9 those most vulnerable?  
 10 **A.** Yes, I absolutely was. And we learnt a huge amount in  
 11 Leicester in the summer of 2020, working really closely  
 12 with the director of public health in Leicester and the  
 13 regional public health teams with PHE about how  
 14 important it was to design differently for the most  
 15 vulnerable.  
 16 So testing sites populated by, brilliant though they  
 17 are, the military in military fatigues scare people  
 18 away. Testing sites with your local pharmacist and  
 19 a friendly translator at the front of the queue welcome  
 20 people in. Testing people on the right side of the road  
 21 for each respective community in their community centre,  
 22 all of that makes a huge difference. And unless you  
 23 design in that way, actually the risk is you conduct  
 24 lots and lots of tests but you don't have the impact of  
 25 a test, trace and isolate system that actually addresses  
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1 we go into lockdown, we and NHS Test and Trace weren't  
 2 allowed to communicate publicly.  
 3 There was a slight quirk to the system, which is  
 4 there's the Number 10 comms team didn't block  
 5 communication on regional and local channels, so we did  
 6 a lot of -- which actually is a very effective way of  
 7 reaching vulnerable communities, using community radio,  
 8 so we tried to do a lot of communication with regional  
 9 radio, because that was a way out of the system.  
 10 But I felt quite strongly that, going forward, there  
 11 will be a need for a mass testing and tracing service in  
 12 a future pandemic, and whoever is leading that at that  
 13 time, I think, my Lady, you should think more like, for  
 14 example, the National Cyber Security Centre, who have  
 15 deep expertise but also permission to speak. And  
 16 I think it's quite important that a future health  
 17 protection agency is able to do that, because trust in  
 18 a system like this is our most important quality. And  
 19 I would have been the first to say that we could have  
 20 been done better at building society's trust in this  
 21 system.  
 22 **Q.** I think you make that point, we don't need to display  
 23 it, but on the basis that trust was so important,  
 24 I think you detail that requests for you to essentially  
 25 directly communicate on those issues was refused and  
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1 the disease and supports most vulnerable.  
 2 **Q.** Thank you.  
 3 Can I ask you, you've just identified a number of  
 4 further examples of learning that you've -- you  
 5 identified in your year in office. Was there a handover  
 6 of all these key pointers that you sort of committed to  
 7 writing or passed on before you left, as to what you  
 8 identify as the most important thing for a future test,  
 9 trace and isolate system?  
 10 **A.** Yes. All of us who worked on the programme knew that we  
 11 were coming for a period of time and leaving, and worked  
 12 very hard at doing lessons learned exercises all the way  
 13 through. So, you know, there are very detailed lessons  
 14 learned exercises on each element of the Test and Trace  
 15 programme, and I'm sure that continued after I left.  
 16 **Q.** Thank you.  
 17 Can I ask you briefly as we move to contact tracing,  
 18 one of the novel things you identified in the statement  
 19 was that all communications relating to NHS Test and  
 20 Trace had to be approved by a Number 10 communications  
 21 team. Briefly, was that a problem, that essentially it  
 22 all had to be approved by Number 10?  
 23 **A.** Yes. It meant that particularly at times where it was  
 24 very tempting for the performance of NHS Test and Trace  
 25 to be the subject of debate rather than whether or not  
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1 essentially you ended up feeling like NHS Test and Trace  
 2 became the whipping boy?  
 3 **A.** Yes.  
 4 **Q.** Can we then move, please, to contact tracing please.  
 5 It's dealt with in your witness statement, so I'll just  
 6 be picking out particular paragraphs, but could we  
 7 display, please, paragraph 6.7 at page 34 and I think  
 8 this is an issue of preparedness that perhaps created  
 9 the scale of the problem for you that you've identified.  
 10 You say:  
 11 "Prior to the COVID-19 pandemic, the UK did not have  
 12 a scalable contact tracing contingency plan. However,  
 13 the balance between data privacy and public health for  
 14 the purposes of contact tracing had been extensively  
 15 debated upon in many Asian countries post SARS and MERS,  
 16 with plans and legislation subsequently put in place.  
 17 For example, public health authorities in South Korea  
 18 were able to access individual credit card data to track  
 19 potential contacts. On the other hand, the UK had not  
 20 conceived the need for a national scale contact tracing  
 21 service and therefore all discussions about the use of  
 22 personal data in contact tracing started from scratches  
 23 during the pandemic."  
 24 Can I ask you, do you agree that this was a major  
 25 problem, with substantial adverse impacts, and one which  
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1 could not be fully rectified during the pandemic, of  
 2 really failing to not establish the necessary systems  
 3 informed by SARS and MERS?

4 **A.** Yes, I do.

5 **Q.** Then can I ask you, because obviously one of the  
 6 reflections you have is around future systems, and  
 7 particularly data, and one of the complexities, I think,  
 8 of data that we've encountered in this Inquiry is  
 9 blockages said on the basis of the complexities that go  
 10 with health data.

11 Do you have any reflections, informed by your time,  
 12 about how that problem or issue can be engaged with to  
 13 ensure that those don't become problems in future  
 14 pandemics?

15 **A.** Yes. I think you have to think about three different  
 16 things. You need to think about the data architecture,  
 17 you need to think about the data policies, and you also  
 18 need to think about the culture around data. All of  
 19 which you can do the pre-work before a pandemic, rather  
 20 than after.

21 So the data architecture, you need a local to  
 22 national architecture for contact tracing. Countries  
 23 that relied solely on local contact tracing had to  
 24 suspend contact tracing in waves 2 and 3 because they  
 25 couldn't surge capacity around the geography. So you

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1 but also the culture of this being a national asset and,  
 2 with that, bringing with you the trust of individuals,  
 3 but also recognising that you can't be selfish about  
 4 this, that we all -- we're only as safe as the most  
 5 vulnerable person in a pandemic, and so you have to find  
 6 a way of enabling that data sharing.

7 I do think there's hope because we need to digitise  
 8 our health and care system anyway. You know, last week  
 9 the government announced what in other sectors would be  
 10 completely normal: the ability to track your  
 11 prescription through the system through to a pharmacy.  
 12 You know, if you go into a future pandemic with  
 13 a properly digitally enabled health system, actually  
 14 this becomes substantially easier, which is why,  
 15 my Lady, I think you have to think about leveraging the  
 16 150 billion spent on the NHS and social care not just  
 17 the money spent on UK Health Security Agency in order to  
 18 drive change.

19 **Q.** Thank you.

20 Can I then briefly ask you, paragraph 6.5, you deal  
 21 with the SAGE advice for it to be effective, needing the  
 22 80 per cent figure, but we know that SAGE also advised  
 23 on the need for there to be backward contact tracing.  
 24 Can you assist as to why that wasn't incorporated,  
 25 namely backward contact tracing as a sort of across the

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1 need a national system, of data architecture. There's  
 2 no reason you can't have that in place and know how to  
 3 scale it.

4 You need to have a debate, a national debate, about  
 5 the data policies. So you couldn't, in the height of  
 6 the pandemic, start a debate about how do we as citizens  
 7 feel about the state having access to our credit card  
 8 statements? But you could have that debate in  
 9 preparation, as other countries. And, you know, I'm not  
 10 pre-judging the answer, but it's really important that  
 11 as a country we have that debate for our culture.

12 Which takes me to the third point, which is culture.  
 13 Health data is the data we all hold most dear to  
 14 ourselves, that we are most concerned about, and that  
 15 makes the incentives for sharing data really hard to  
 16 navigate, because there are lots of negative incentives  
 17 not to share, personally, as individuals, but also  
 18 within the health and care ecosystem. You know,  
 19 academic research is founded on your data. There's lots  
 20 of incentives not to share data with other bodies.

21 And so I think there's a real -- and we see this for  
 22 20-odd years in our National Health Service, we've  
 23 encouraged different hospital trusts to compete with  
 24 each other rather than collaborate and share data.

25 So you've got to address not just the architecture,  
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1 board part of the tracing system implemented, please.  
 2 **A.** I think you had evidence, I think it was from Ben Dyson,  
 3 saying that we did integrate backward contact tracing  
 4 into the system as fast as we possibly could. By the  
 5 time I arrived, it was already acknowledged that it  
 6 needed to be, but you had to build the system step by  
 7 step. So step one was asking people to give contact  
 8 details of people they'd been in close contact with for  
 9 the previous two days. In order to backward contact  
 10 trace you have to go back much further, so that's  
 11 a whole tranche more data.

12 So we did build, it was undoubtedly too slow and,  
 13 again, if you were doing that from scratch again, you  
 14 would have that system all set up and ready to go.

15 **Q.** Thank you. Would you agree that the contact tracing  
 16 system rolled out in May 2020 did not reflect the  
 17 diversity and needs of the United Kingdom's communities,  
 18 including the diverse language needs and barriers to  
 19 equality?

20 **A.** I think that as we built the system, we looked and  
 21 worked really hard to try to make the very best  
 22 accommodations possible for all diverse communities.  
 23 But as I've said earlier, my Lady, I think that the  
 24 principle upon which we were instructed to build the  
 25 system was one of scale and looking forward. I would

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1 start with a slightly different principle, which is  
 2 start by designing for the most disadvantaged, and  
 3 there's no doubt that that wasn't the principle that we  
 4 were given. We were given design for scale and I think  
 5 you'd need to reverse those two round, and then the  
 6 things that were done in terms of multiple language  
 7 provision, ease of access for partially sighted or  
 8 blind, or deaf, all of those things would have been the  
 9 first things you did rather than the things we did  
 10 through June, July, August, September and onwards.

11 Q. Thank you.

12 Can we then move, please, to support to those  
 13 self-isolating at paragraph 7.3, please. I think, with  
 14 what you've said at the outset, you've already made your  
 15 views fairly clear about the importance and necessity of  
 16 funding to assist those two of the most vulnerable to  
 17 self-isolate. But can I ask you briefly, at  
 18 paragraph 7.3, you specifically identify that you were  
 19 championing for an equivalent process to that provided  
 20 to those who do jury service, namely a £64.95 per day  
 21 type rate to be an appropriate way of looking at how you  
 22 support to isolate; is that correct?

23 A. Yes, that was, yes.

24 Q. Thank you. I think it's right, if we perhaps move  
 25 forward, please, to your paragraph 7.8, please, and

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1 Q. Now, again, my summary of a lot of material and  
 2 documentation, I think even when the support system came  
 3 into place at the end of September, it was clear that  
 4 there was identified low take-up and I think you  
 5 continued to champion for more to be done and we can  
 6 see, on occasions, describing it like banging your head  
 7 against a brick wall. Would that be the best way to  
 8 summarise the whole process and efforts you made to seek  
 9 to get appropriate financial support for those to  
 10 isolate?

11 A. I think the more I learnt from the data, as I said  
 12 earlier, the modelling showed that the best way to get  
 13 an operationally effective test and trace system that  
 14 would reduce the rate of infection and enable us to get  
 15 back to a more normal life was to encourage more people  
 16 to come forward for testing, and that the data told us  
 17 that people weren't coming forward for testing because  
 18 they were scared of the consequences of isolation. The  
 19 more I spent time with people from disadvantaged groups,  
 20 that was -- I had the qualitative evidence. They would  
 21 tell me that personally as well.

22 And yes, to be honest, it was intensely frustrating,  
 23 and what you see through the paper trail, I found it  
 24 quite distressing reading it, to be honest, because we  
 25 did try really hard to persuade ministers that this

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1 obviously the detail of the exchanges but also the  
 2 underpinning material that we have, you say this at  
 3 paragraph 7.8:

4 "The UK spent proportionately much less than other  
 5 developed countries enabling disadvantaged people to  
 6 self-isolate. If we had allocated more of the [NHS Test  
 7 and Trace] budget to isolation support, I strongly  
 8 suspect that fewer would have died, and infection rates  
 9 would have been lower with all of the benefits that  
 10 would have brought."

11 Do you stand by that statement?

12 A. I do.

13 Q. Can I ask: do you hold any responsibility here for the  
 14 way the NHS Test and Trace budgeting unfolded,  
 15 particularly efforts to identify or get the isolation  
 16 support in place?

17 A. Well, it's certainly the thing that I wish I had  
 18 succeeded in persuading ministers to do. We had the  
 19 money in the budget, you know, we didn't spend all of  
 20 our budget, and I also think that spending more on  
 21 self-isolation would have reduced the need for testing.  
 22 But I wasn't the decision maker. The decision maker in  
 23 this was the Chancellor and, at every opportunity from  
 24 June onwards, the Chancellor rejected the proposals and,  
 25 in the end, that was not in my control.

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1 would be a good thing, not just for the individual  
 2 wellbeing of those disadvantaged people but also  
 3 economically. This was one of the ways you could have  
 4 had less economic harm for the country as a whole.

5 And I think the Chancellor particularly, this was  
 6 a point of principle for him, it wasn't a -- I don't  
 7 think there was any amount of data and analysis that  
 8 I could have put that would have changed his mind. It  
 9 was a point of principle that he didn't want to create  
 10 an additional welfare benefit.

11 Now I do appreciate that this is a complex thing  
 12 and, you know, before we had certainty that you could  
 13 ask contacts to test themselves every day, it would have  
 14 been possible, if I'd tested positive, for me to say to  
 15 the contact tracing system, "My 500 mates were all in  
 16 the room with me yesterday", and they could all get  
 17 their non-means tested isolation payments.

18 So there is a policy conundrum there but what I was  
 19 unable to achieve was any substantive engagement in how  
 20 to mitigate that policy problem and to recognise that,  
 21 actually, the policy problem of not supporting the  
 22 vulnerable to isolate was a much bigger one. And that  
 23 was -- you can hear my frustration as I say it now.  
 24 There was an intransigence to that that I think was very  
 25 sad.

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1 Q. Thank you.

2 Finally, Baroness Harding, you have already spoken  
3 throughout your evidence about key reflections,  
4 learnings, and you detail in your witness statement from  
5 pages 44 to 48 other reflections and I hope between us  
6 we've identified the key learnings that you wish  
7 her Ladyship to have regard to.

8 But I know finally, before concluding your evidence,  
9 you wanted to publicly acknowledge and thank those from  
10 your team at NHS Test and Trace, and I don't want to  
11 take away what you want to say, Baroness Harding.

12 A. Thank you. I did, if my Lady will forgive me.

13 There were in total, at its peak, over 55,000 people  
14 who worked on this programme and I'm not for a moment  
15 suggesting that we got everything right. There is so  
16 much to learn from this but they were all people,  
17 whether they were manning testing sites in the snow, in  
18 the rain, in the winter, or sitting at home making those  
19 contact tracing calls, which are not easy calls to make,  
20 to tell someone that they've got to isolate, or whether  
21 they were civil servants or soldiers or commercial  
22 leaders, they all stepped up to serve and I think we  
23 should all thank them.

24 MS CARTWRIGHT: My Lady, there are Core Participant  
25 questions.

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1 into account how Lighthouse laboratories would need to  
2 be integrated into the NHS in Wales Test, Trace and  
3 Protect, or our wider infrastructure."

4 Then this:

5 "The lack of consistency and quality of engagement  
6 by the UK Government meant that time, resources and  
7 energy were wasted, which could have been directed  
8 meaningfully toward a four nations fully-integrated  
9 testing and contact tracing system."

10 Were you aware of problems or perceived problems  
11 with the engagement of the devolved administrations, in  
12 particular the Welsh Government, and, if so, what were  
13 those problems from your perspective?

14 A. So, clearly, it was a very complex set of relationships,  
15 at multiple levels. So, you know, I can only really  
16 speak to the operational side of Test and Trace, as  
17 opposed to some of the political engagements. So at  
18 an operational level for both the National Testing  
19 Programme, for testing and for the JBC, we had members  
20 of staff from the devolved administrations embedded in  
21 the teams in Test and Trace and, generally, I think that  
22 operational embedding worked very well.

23 Now, I -- it doesn't surprise me at all that  
24 Mr Gething felt that there were occasions when that  
25 wasn't perfect. There were so many moving parts and so

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1 Thank you, Ms Baroness Harding.

2 LADY HALLETT: There are. Ms Parsons, if you look that way,  
3 you'll see at the back.

4 THE WITNESS: Thank you.

#### 5 Questions from MS PARSONS

6 MS PARSONS: Thank you, my Lady.

7 Good afternoon, Baroness Harding, I ask questions on  
8 behalf of the Covid-19 Bereaved Families for Justice  
9 Cymru. I want to ask you about collaboration with  
10 devolved administrations, in particular the Welsh  
11 Government. This is addressed from paragraph 4.12 of  
12 your witness statement. We don't need to go to it, in  
13 fact. In short, I think you say that collaboration with  
14 the devolved administrations was crucial to the  
15 effectiveness of Test and Trace, and you give the  
16 example of the UK Government and Devolved  
17 Administrations Board being set up to ensure  
18 collaboration and shared learning.

19 Some in the Welsh Government have been critical of  
20 the levels of collaboration. I'll take you to a quote  
21 from Mr Gething, the Health Minister up until May 2021.  
22 He said this, it was in a statement prepared for this  
23 module:

24 "There was more than one occasion where the UK  
25 Government made choices without consulting us or taking

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1 much change happening as the testing service doubled in  
2 size every one to two months. I'm sure there were  
3 moments when that operational communication wasn't as  
4 smooth as it could have been, but the embedding of  
5 representatives from each of the devolved  
6 administrations into the core team, I think, worked.

7 At the clinical level, the four CMOs worked very  
8 collaboratively, as far as I could see. They were  
9 providing us with very clear direction as a united team  
10 of CMOs. And I also observed, because I attended it  
11 several teams, the four health ministers working very  
12 collaboratively.

13 I think where things got difficult is well beyond my  
14 pay grade, in the sort of big political discussions and  
15 decisions where it was beyond Covid, where certainly  
16 I experienced COBR meetings where the policy that was  
17 being debated had been announced by one or other First  
18 Minister or Prime Minister before the meeting itself,  
19 and that was so beyond the operational sort of  
20 integration and communication that I was involved in,  
21 but I imagine, and I'm only imagining, for Mr Gething,  
22 those are all intertwined.

23 Q. Thank you. Then taking into account what you say about  
24 being involved only on the operation side of things,  
25 how, if at all, would you ensure better engagement with

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1 the Welsh Government next time round?

2 **A.** I think, step one, don't break what isn't broken. So

3 embed representatives from each of the devolved teams in

4 any national service. I think the thing we didn't do,

5 that you might want to consider in the future, is doing

6 the reverse as well, so having national representatives

7 in the devolved teams. So actually the data flow wasn't

8 as good as it probably should have been from devolved

9 activities back. So I give an example, would be the

10 Merthyr Tydfil mass testing trial. Actually, I was

11 quite blind to some of that because, rightly, the Welsh

12 Government were leading on it. But I think we could

13 have improved the operational integration still further

14 by having sort of mirrored embedding in both sides.

15 **MS PARSONS:** Thank you, Baroness Harding.

16 Thank you, my Lady.

17 **LADY HALLETT:** Thank you, Ms Parsons.

18 Professor Thomas, who is that way.

19 **Questions from PROFESSOR THOMAS KC**

20 **PROFESSOR THOMAS:** Good afternoon, Baroness Harding. My

21 name is Leslie Thomas and I'm representing FEMHO, that's

22 the Federation of Ethnic Minority Healthcare

23 [Organisations].

24 Baroness Harding, you say the following at

25 paragraph 5.29 of your statement:

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1 self-isolate?

2 **A.** I think I've already said yes to that in many ways.

3 I think that it's not that scale doesn't matter; you've

4 definitely got to build very quickly in a future

5 pandemic a large-scale testing and tracing service. But

6 if you start by designing for the disadvantaged, you

7 will -- as I said earlier, you'll have testing sites in

8 the places that are most needed at the beginning rather

9 than a few months later. You'll have the services

10 easily accessible for the communities that are most

11 likely to be the ones that will be ravaged by the

12 disease. So I do think it requires a different mindset

13 to building a scale system than the one that was had

14 in 2020.

15 **Q.** Thank you.

16 In an email to Shona Dunn, dated 2 December 2020 you

17 said:

18 [As read] "The biggest concern is the very low-paid

19 workers not being willing to come forward for testing

20 because of the fear of the cost of the self-isolation."

21 And Helen Whately, whose constituency is in Kent,

22 raised it and asked you:

23 [As read] "If you and I could support these two

24 areas [that was Medway and North Kent and Boston Lincs]

25 to work up what might make a meaningful difference, both

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1 "If the National Testing Programme had been started

2 in January 2020 when the NHS began planning to expand

3 critical care capacity and ventilator beds, the

4 government might not have had to ration access to

5 testing for as long as was necessary during the summer

6 of 2020."

7 Question: can you say what impact on setting up the

8 National Testing Programme in January 2020 would have

9 had to have to protect ethnic minorities and other

10 marginalised communities early on?

11 **A.** I mean, it's hard to give you a quantitative answer to

12 that question but qualitatively it has to have -- it

13 would have had to have meant that those communities

14 would have seen lower infection rates, fewer

15 hospitalisations and fewer deaths.

16 **Q.** Yes.

17 **A.** So I think, you know, looking forward, it's really

18 important that we recognise that you need to stand up

19 a scale mass testing and tracing service immediately

20 upon declaring that you're in a pandemic situation and

21 not waiting six months.

22 **Q.** Thank you.

23 Do you consider it was a failing by government to

24 have more attention on testing capacities than catering

25 to vulnerable groups who needed more support to

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1 financial and non-financial, in terms of support. Both

2 communities have large migrant workforces, living in

3 dense housing, where I doubt our positive incentives

4 will make a difference, but support for isolation just

5 might."

6 Question: seeing as you clearly understood the

7 concerns being raised amongst these ethnic minority

8 communities, did you ever communicate these views to

9 cabinet?

10 **A.** Oh yes, many times, and I wasn't alone. I don't want to

11 give the impression that this was just me. This was

12 very much, as I think Ben Dyson said yesterday,

13 a considered view of all of us working on Test and Trace

14 and of ministers in the Department of Health and Social

15 Care, not that I should speak for them. And I -- as

16 I said earlier, I feel like I'm still campaigning on

17 this topic.

18 **Q.** Can I move on to another topic, which is public

19 communications. The evidence has shown that some

20 communities, particularly ethnic minorities, experience

21 barriers to trust due to a lack of cultural confidence

22 in public health communications. You seem to agree with

23 this sentiment in your statement.

24 So the question is, I suppose, from your

25 perspective, how can we ensure more effective public

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1 health messaging around testing, tracing and isolating  
 2 for a future pandemic, especially for communities with  
 3 historically low trust in government and state-run  
 4 services?  
 5 **A.** I think that's such an important question, and I know  
 6 that Dame Jenny Harries cares deeply about this topic as  
 7 well. What I -- if I may, I can tell you what I learnt  
 8 in Leicester is that there is no substitute for talking  
 9 directly to those communities themselves. There's  
 10 a danger that you have an argument about is it national  
 11 or local government who should lead on this, and the  
 12 reality that I discovered is that most of these  
 13 communities don't trust any government. It's their own  
 14 local community leaders that they will trust. And so  
 15 building in listening, access to those community  
 16 leaders, you can only do it locally on the ground. But  
 17 just because you're on the ground doesn't mean that you  
 18 will necessarily hear them.

19 So you have to create a culture where local  
 20 community leaders feel there are safe spaces for them to  
 21 speak up. And that's a problem for society in the  
 22 round, not just for pandemic response.

23 **Q.** Well, that leads me on to my next question, which  
 24 I suppose is tied into it a bit. To what extent do you  
 25 believe that institutional bias or a lack of

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1 those serving minority communities, in the development  
 2 and deployment of communication strategies regarding  
 3 testing and contact tracing?  
 4 **A.** There's probably never adequate. You could always do  
 5 more in this space. We worked really hard from the very  
 6 beginning, when the NHS Test and Trace launched at the  
 7 end of May, to engage and listen and learn. We had  
 8 a series of sprints into different groups, that's  
 9 detailed in the UKHSA corporate statement, and we kept  
 10 learning. But I think that, as I said, probably  
 11 repeating myself, this is something that you can't do  
 12 too much of. And with the absence of preparation,  
 13 everyone was starting where you wouldn't want to be. So  
 14 this is something that you should be building into your  
 15 pandemic preparedness so it's not something people have  
 16 to think about on day 2, it's something that's been  
 17 thought of on day minus a thousand.

18 **PROFESSOR THOMAS:** Thank you, Baroness.

19 Thank you, my Lady.

20 **LADY HALLETT:** Thank you, Professor Thomas.

21 Mr Weatherby. He's just there.

22 **Questions from MR WEATHERBY KC**

23 **MR WEATHERBY:** Baroness Harding, I ask just a few questions  
 24 on behalf of the Covid Bereaved Families for Justice UK  
 25 group.

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1 consideration for ethnic and socioeconomic disparities  
 2 influence who was able to access testing early on?  
 3 **A.** I think that this is something that is much broader than  
 4 testing and tracing, and you could ask that question of  
 5 any public service. I think that one of the examples  
 6 that really struck me was in the early days, we opened  
 7 a testing site, I think it was in Birmingham, and it was  
 8 right opposite a taxi rank, and no one initially could  
 9 understand why the testing site wasn't busy. And it  
 10 wasn't busy because the predominantly ethnic minority  
 11 taxi drivers didn't want to get tested, because they  
 12 couldn't access benefits because they were making good  
 13 money as taxi drivers but they had to be able to pay the  
 14 rental on their cars. And so they just couldn't risk  
 15 getting tested. So even though the testing site was  
 16 right next door, they didn't use it.

17 So I think the premise of your question is correct:  
 18 that for no, sort of, conscious fault, the system didn't  
 19 work because we didn't have the isolation support in  
 20 place, because we hadn't really heard how challenging it  
 21 was for particular communities, professions, roles, to  
 22 comply with what was a very, very difficult system  
 23 called isolating for two weeks.

24 **Q.** Finally, do you think there was adequate consultation  
 25 with community-based health organisations, particularly

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1 You've identified recruitment as one of the key  
 2 challenges faced in the scaling of NHS Test and Trace,  
 3 and that persisted, didn't it, and, for example, you  
 4 discussed in an email exchange with Gareth Williams from  
 5 the DHSC on 20 August the problem of a large recruitment  
 6 gap of thousands of vacancies. I won't take you to that  
 7 but just for the record I'll give the reference, which  
 8 is INQ000592556.

9 But it's right, isn't it, that at the time you were  
 10 appointed, there was no emergency plan to create  
 11 a national test and trace isolate and support system,  
 12 and, in turn, that meant that not only was there not  
 13 a structure for that, but there was no recruitment  
 14 infrastructure. And that would include recruiters,  
 15 relevant IT, human resources and, perhaps crucially,  
 16 a cadre of key workers to be seconded.

17 And that was the underlying problem, not the  
 18 recruitment issue, wasn't it?

19 **A.** Yes. And I think it's actually broader than that, in  
 20 that I don't think that in any of our civil contingency  
 21 planning in any of the potential risks on the National  
 22 Risk Register had anyone thought that you might need to  
 23 build a national citizens service that would need to  
 24 employ tens of thousands of people within the course of  
 25 six months. So there wasn't any plan to pull off the

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1 shelf to say: this is how you do it.

2 **Q.** As a follow-up to -- in your recommendations you've --

3 and this morning -- or this morning you referred to

4 a public health reserve -- resource. Would you add to

5 that a resource for recruitment?

6 **A.** Yes, I would.

7 **Q.** Yes.

8 **A.** I would. And some of the other corporate services --

9 sorry to use very corporate speak -- the human

10 resources, the project management, the IT development,

11 that regardless of the nature of the emergency, if you

12 need to scale a service up of this sort of scale, how do

13 you do it, and I think --

14 **Q.** You need the infrastructure?

15 **A.** -- we should have that plan as a country.

16 **Q.** Yes. I'm going to move on quickly because I've got very

17 limited time, but next topic, different topic, specific

18 topic, about the accuracy of testing.

19 On 29 September of 2020 you reported to the Covid-O

20 Committee, chaired by Mr Gove, now Lord Gove -- and I'll

21 just give the reference again for the record,

22 INQ000090086 -- you reported to that meeting that

23 between 2 and 2.5% of all tests were being voided each

24 day, and that was mainly due to the leakage of the

25 equipment, the tubes in particular.

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1 the home testing route was about the same. But I'm

2 afraid, I'm sorry, I just can't remember whether 2.5 was

3 above normal or not but it was never going to be zero.

4 **Q.** It was significant enough for you to raise at

5 a Covid-O --

6 **A.** I think, sorry, just to correct, I think that was more

7 that one of the members of Covid-O was remarking on the

8 number and asking me a question, rather than my raising

9 it directly.

10 **Q.** Are you able to help us how this was addressed?

11 **A.** By continuous process improvement. Again, this sounds

12 very small and detailed, but getting to a uniform size

13 and shape of test tube made a very big difference to the

14 performance of the end-to-end laboratory system,

15 changing and continually improving the instructions on

16 the test kits to make it easier, improving the materials

17 in the -- of the bags. This was the sort of industrial

18 process re-engineering that the team was continually

19 doing.

20 **Q.** Yes, okay.

21 Next topic. You've referred to the business

22 approval for Lighthouse labs issue that arose in July of

23 2020. So in an email exchange with Gareth Rhys

24 Williams, between 22 and 27 July -- and again, for the

25 record only, INQ000575993 -- relating to the business

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1 Was that a persistent problem, given that here we're

2 talking about September?

3 **A.** So I think that this was taken from the standard daily

4 and weekly reporting that we shared on the performance

5 of each of the Lighthouse laboratories and all of the

6 testing channels, and the different testing routes. So

7 you would always have a percentage of voids, whether

8 that was because test tubes had got broken in transit,

9 whether or not they'd not been closed properly and

10 sealed properly, whether or not there'd been an error in

11 the processing in the laboratory, there was always, you

12 know, either human or robotic error. The percentage

13 void rate was monitored extremely closely across every

14 single lab and every single channel to try to identify

15 potential issues.

16 **Q.** Yes, but would you agree that your 2 to 2.5 per cent is

17 a significant percentage, that would have impacted the

18 efficacy of the system as whole but also confidence in

19 the system?

20 **A.** Yeah, I'm afraid I can't remember what the range of

21 voids were, and I'm sure, if my Lady needs to, we can

22 dig that out. One of the concerns in the early days was

23 that the home testing route would have a much higher

24 void rate than the supervised testing route. It turned

25 out actually we were very good at swabbing ourselves and

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1 approval that you were seeking for extension of the

2 Lighthouse labs, he raised a number of questions around

3 value for money, including whether taking

4 a cost-per-test approach was appropriate, efficiency,

5 and the requirement of improvement and turnaround times.

6 So the question is this: given the persistent issues

7 relating to staffing levels, leadership, potentially

8 equipment in Lighthouse labs which impacted testing

9 capacity into the autumn, should the contracting have

10 been linked to efficiency and output as well as cost per

11 test?

12 **A.** Well, cost per test and bringing cost per test down is

13 an efficiency measure, in some ways. All of the

14 questions in Gareth Rhys Williams' email are completely

15 legitimate questions. They were questions that his own

16 team had been working through before and so the reason

17 I was challenging it was not that it was inappropriate

18 to look at how do you drive efficiency, it was more that

19 we risked failing to open up the testing capacity while

20 we reopened the same debates that his own team had

21 reviewed in the previous few days.

22 **Q.** Yes. Now, you've been asked about Lord Agnew's letter

23 of 10 December, which was about the long-term strategy

24 for testing, and you've been asked about the particular

25 reference to previous consultancy was costing £3 million

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1 per day, and the question of what trajectory do you  
2 anticipate and what governance exists around this  
3 deployment, and you referred to Lord Bethell's response  
4 of I think 10 January 2021. We haven't got time to go  
5 specifically to that but my Lady has it.

6 But my Lady may come to the conclusion that, on this  
7 particular point of value for money, that letter doesn't  
8 in fact say very much. Are you able to help us how  
9 value for money in this emergency context, the cost to  
10 the taxpayer, was assessed during the six months between  
11 May when you were appointed and December when  
12 Lord Agnew's letter was written?

13 **A.** Yeah, I tried to set that out earlier, but maybe if  
14 I can unpack it a bit more. So we commissioned a number  
15 of independent reviews to establish the efficacy of the  
16 testing and tracing service. So the Rüm model, the  
17 CARNA model and then, after I left, UKHSA commissioned  
18 Ernst & Young and Oxford University. All of those were  
19 attempts to assess the value for money of the testing  
20 and tracing service and, as I say, I think one of the  
21 most important conclusions to draw in this module is  
22 that population scale testing and tracing can be value  
23 for money.

24 **Q.** Yes.

25 **A.** It's very dangerous and very tempting to assume that

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1 efforts, the evidence would suggest it wasn't, that it  
2 was too complex a means of delivering and, because it  
3 was different from other benefit systems, people didn't  
4 know it existed. The people who would most would  
5 benefit from it found it hard to find.

6 **Q.** Acknowledging, of course, the very important role of  
7 local authorities in test and trace response, would it  
8 be your view that the appropriate mechanism for  
9 financial support is one delivered centrally, rather  
10 than locally?

11 **A.** I think you need to have a bit of both, but yes.  
12 I think, fundamentally, the debate we need to have in  
13 peacetime, if you will, is what that sort of isolation  
14 support payment should be and I would suggest a national  
15 system delivered probably via DWP is a better thing to  
16 do than creating something completely different.

17 **Q.** In terms of eligibility for support, the Test and Trace  
18 Support Payment Scheme, in broad terms, operated along  
19 the lines of eligibility for in-work benefits. Was that  
20 too narrow, in your view, in that it excluded people who  
21 would feel the disincentive to self-isolate but were not  
22 eligible for any support under the scheme?

23 **A.** Yes.

24 **Q.** In terms of the amount of payment, in England £500, some  
25 variants elsewhere, in Wales, for example, what were

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1 scientific developments in the future will mean that we  
2 don't have to have a system of this scale in the future.  
3 I think that would be a huge mistake to make.

4 **Q.** Final point. You've been asked about Operation  
5 Moonshot. In your view, did the government support for  
6 Operation Moonshot take priority over financial support  
7 for those who were required to isolate?

8 **A.** Well, I think the facts sort of speak for themselves in  
9 that, yes.

10 **MR WEATHERBY:** Thank you very much.

11 Thank you, my Lady.

12 **LADY HALLETT:** Thank you, Mr Weatherby.

13 Mr Jacobs, who is right down the end by the clock.

#### 14 Questions from MR JACOBS

15 **MR JACOBS:** Baroness Harding, just a couple of questions on  
16 behalf of the Trades Union Congress. You have given  
17 evidence about the principle and importance of financial  
18 support for self-isolation. I'm going to ask you about  
19 the mechanisms for delivering it effectively, okay?

20 To be effective, presumably a scheme of support  
21 needs to be one that is accessible to those who need it.  
22 Did you have reflections on whether the scheme,  
23 delivered as it was by local authorities with their own  
24 approaches and criteria, was sufficiently accessible?

25 **A.** I think, despite local authorities' brilliant best

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1 your reflections on that?

2 **A.** On -- I mean, as you can see from my evidence,  
3 personally, right at the beginning, I thought that you  
4 should sort of take the benchmark of jury service,  
5 a different but similar example where we ask people to  
6 perform a public service. But I think that this is, as  
7 you look forward, exactly what the government should  
8 consult on and settle before you're in a pandemic, not  
9 during.

10 **Q.** If we look at the purpose of financial support, if the  
11 purpose is to remove the financial disincentive to  
12 self-isolate, is the simple way forward, in your view,  
13 to have a scheme which provides sufficient funds to  
14 remove it entirely?

15 **A.** Yes, but it is, as I said earlier, also quite complex,  
16 to make sure you don't have sort of unintended second or  
17 third-order consequences. So, you know, you don't want  
18 to incentivise people to get the disease either, so it's  
19 important to get that balance right. And what I would  
20 say is that other countries, I think, got that balance  
21 right, both in Europe, in Australia and in Asia, in  
22 a way that we didn't.

23 **Q.** I note that you give some examples in your statement.

24 **A.** Yeah.

25 **MR JACOBS:** Thank you very much, Baroness Harding.

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1 **LADY HALLETT:** Thank you, Mr Jacobs.  
 2 That completes the questions we have for you,  
 3 Baroness Harding. You raised some really important  
 4 issues. There are a number of themes that go on, as  
 5 I go through the Inquiry in different modules: planning,  
 6 or lack of planning. I can't tell you how many times --  
 7 well, you'll have probably gathered -- I'll have heard  
 8 that. The other is the number of unsung heroes and  
 9 heroines of the pandemic, and you've mentioned many  
 10 thousands more, and I totally agree with you that we owe  
 11 them all a huge debt of gratitude. I mean, people were  
 12 working until they were, as you say, absolutely  
 13 exhausted, making themselves ill in the process.  
 14 But I think we also owe you a great debt of  
 15 gratitude. You didn't have to take on the huge task and  
 16 put yourself in the firing line and I know that you have  
 17 put yourself in the firing line. So thank you for all  
 18 the work that you did, all that you tried to do and  
 19 thank you for your very helpful contributions to the  
 20 Inquiry.

21 **THE WITNESS:** Thank you very much, my Lady. That means  
 22 a lot.

23 **MS CARTWRIGHT:** My Lady, can I just briefly apologise to you  
 24 and Baroness Harding. When I put the letter from  
 25 Lord Agnew, I incorrectly said that the response letter  
 93

1 statement, dated 14 April 2025 and can I ask you to  
 2 confirm, is this statement true to the best of your  
 3 knowledge and belief?

4 **A.** Yes, it is.

5 **Q.** Thank you. In identifying that you are here to speak to  
 6 the corporate witness statement and appreciating also  
 7 that you talk about legacy matters, there are a number  
 8 of questions I will be dealing with this afternoon,  
 9 where it goes back to earlier statements you provided in  
 10 a personal capacity, so can I just make that clear at  
 11 the outset.

12 But can we then, please, identify together -- in  
 13 fact this is your speaking to, I think, what's the 13th  
 14 corporate witness statement on behalf of UKHSA that's  
 15 been provided across the modules, and I think that you  
 16 yourself have identified that you have given personal  
 17 witness statements across Modules 1, I think, 2, 3  
 18 and 6.

19 **A.** Everything but 5, I think.

20 **Q.** Yes, and so can we thank you once again,  
 21 Professor Harries, for the care taken to provide this  
 22 corporate witness statement on behalf of UKHSA.

23 Can we then, please, just identify your relevant  
 24 experience and expertise over the time period that we'll  
 25 be looking at together today. I think you identify that

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1 had come from Mr Hancock in January. In fact, as  
 2 Mr Weatherby has just identified, it was in fact  
 3 Lord Bethell in the statement of 15 January 2020, so  
 4 I apologise to you and Baroness Harding by misleading  
 5 you in that question.

6 **LADY HALLETT:** Thank you.

7 Thank you very much.

8 Sorry to keep you, Dame Jenny.

9 **MS CARTWRIGHT:** Thank you.

10 Can I ask for Professor Dame Jenny Harries to be  
 11 sworn, please.

12 **PROFESSOR DAME JENNY HARRIES (affirmed)**

13 **Questions from LEAD COUNSEL TO THE INQUIRY FOR MODULE 7**

14 **MS CARTWRIGHT:** Thank you.

15 Can you please give your full name to the Inquiry.

16 **A.** Jennifer Margaret Harries.

17 **Q.** Can I just check, I apologise, to ensure that I get  
 18 things correct, do I refer to you as Dame Jenny or  
 19 Professor Dame Jenny?

20 **A.** Any will do. I think it's been Professor Harries  
 21 through most of it because that's -- for other people,  
 22 so I'm happy with anything.

23 **Q.** On this occasion, Professor Harries, you've provided  
 24 a corporate witness statement on behalf of UKHSA. If we  
 25 could please turn to page 114 within that witness  
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1 during the relevant period we'll be looking at you were  
 2 the Deputy Chief Medical Officer from 15 July 2019 to  
 3 31 March 2021.

4 **A.** Yes.

5 **Q.** Then you essentially took over from Baroness Harding.  
 6 I think you tell us at your paragraph 1.6 that, from  
 7 1 April 2021, you essentially became the Executive Chair  
 8 of NHS Test and Trace, formally taking up the  
 9 operational role from 7 May 2021 when Baroness Harding  
 10 completed her one year of service?

11 **A.** Yes. So nominally from 1 April, following Baroness  
 12 Harding on the 7th, but operationally fully then for  
 13 UKHSA on 1 October.

14 **Q.** Thank you. I think we know that UKHSA, as  
 15 an organisation, I think, had been referenced in being  
 16 from April 2021 but, as you've just identified, did not  
 17 become operational --

18 **A.** Yes.

19 **Q.** -- until October 2021.

20 **A.** Yes.

21 **Q.** So are we right, then, for the period from 7 May 2021,  
 22 to essentially see you as performing a similar role as  
 23 the Executive Chair of NHS Test and Trace?

24 **A.** Broadly, yes.

25 **Q.** Thank you.

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1 Now, you plainly have detailed within your witness  
 2 statement the extensive relevant experience you have,  
 3 and so please excuse me by not going through all of  
 4 that, but perhaps of significance to what we're going to  
 5 deal with today, it's right, isn't it, that from April  
 6 2017 until July 2019 you formally held the Strategic  
 7 Incident Deputy Medical Director role at Public Health  
 8 England?  
 9 **A.** Yes.  
 10 **Q.** Also, alongside that, you were interim Deputy National  
 11 Medical Director for PHE from 2016 to 2017, providing  
 12 specific support for strategic incident response?  
 13 **A.** Yes.  
 14 **Q.** Then, even before then, you have relevant experience as  
 15 a director of public health. You tell us that you were  
 16 director of public health in Norfolk and Waveney,  
 17 Swindon and Monmouthshire, and you were also a chief  
 18 officer in Norfolk and Waveney and Swindon?  
 19 **A.** Yes.  
 20 **Q.** So you have relevant public health experience alongside  
 21 all the other qualifications that you've detailed in the  
 22 witness statement?  
 23 **A.** That's right.  
 24 **Q.** Can I ask you specifically, then, is there any other  
 25 relevant experience that you wish to particularly draw

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1 disease but also from external hazards such as chemical,  
 2 radiological, nuclear and environmental threats. It  
 3 brings together expertise from predecessor  
 4 organisations, including Public Health England, NHS Test  
 5 and Trace, the Joint Biosecurity Centre and the Vaccine  
 6 Taskforce."  
 7 **A.** Yes.  
 8 **Q.** Thank you.  
 9 Now, with the time we have together today,  
 10 Professor Harries, I'm not going to be dealing with the  
 11 whole chronology that you detail and set out in terms of  
 12 the legacy organisations, then NHS Test and Trace and  
 13 also UKHSA but please be assured that this statement  
 14 will be published. So can we then perhaps start with  
 15 the first topic, please, of preparedness, please, and if  
 16 we could turn to your paragraph 3.31, please, at  
 17 page 24. Thank you.  
 18 Now, you detail within the witness statement that:  
 19 "As of 1 March 2020, PHE was able to process up to  
 20 2,100 PCR tests per day (ie collected, delivered and  
 21 processed by laboratories). PHE laboratory capacity had  
 22 been required for the delivery of its public health  
 23 specialist functions and to support the NHS. Therefore,  
 24 the government's strategy reflected the fact that PHE  
 25 had never been resourced to undertake large-scale

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1 to the fore, by reference to what we'll be looking at  
 2 together in test, trace and isolate?  
 3 **A.** I don't think so, the point about having DPH experience  
 4 both in Wales and in England but also obviously I've  
 5 worked in hospitals and in primary care as well, so it's  
 6 a lens, I hope, that has looked through many of the  
 7 different views that the Inquiry will cover.  
 8 **Q.** Thank you. So then bringing things up to today's date,  
 9 you are the chief executive of the UK Health Security  
 10 Agency and, in fact, I think you've already formally  
 11 announced your retirement, so your position in this role  
 12 is perhaps coming to an end, is it, soon --  
 13 **A.** I have slightly postponed it in order to be here, so  
 14 I finish on Friday.  
 15 **Q.** Well, thank you. Can we then just identify UKHSA again,  
 16 her Ladyship has heard quite some evidence about UKHSA  
 17 but let's identify it as an organisation. If we could  
 18 display your paragraph 1.2. You confirm that:  
 19 "UKHSA is an executive agency of the Department of  
 20 Health and Social Care and carries out certain statutory  
 21 functions for the Secretary of State for Health and  
 22 Social Care."  
 23 **A.** Yes.  
 24 **Q.** "[It was] Fully operational from October 2021, UKHSA's  
 25 role is to protect the public not only from infectious

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1 population testing or tracing, and the need to focus  
 2 efforts on scaling capability and capacity rapidly."  
 3 So can I ask you: in that context, had the risk of  
 4 a pandemic requiring large-scale testing and tracing  
 5 been assessed by PHE and/or across the government?  
 6 **A.** So the role that Public Health England had and was  
 7 specified in its remit was providing specialist public  
 8 health laboratory services, and what that means is that  
 9 the clinical care, normal clinical testing of patients  
 10 with infections would be part of the NHS responsibility,  
 11 and the role that Public Health England did would be, if  
 12 you like, for sort of rare diseases, so things like  
 13 Ebola, things entering the country, but also, it had  
 14 specialist labs looking at things like antimicrobial  
 15 resistance or specialist reference laboratories, for  
 16 meningococcal diseases or flu viruses --  
 17 **LADY HALLETT:** Remember we have a stenographer. Thank you.  
 18 **A.** Sorry.  
 19 Then also used its services for things like  
 20 surveillance, so looking at tests for that. But routine  
 21 testing and for large patient numbers would normally be  
 22 part of the NHS's responsibility.  
 23 **MS CARTWRIGHT:** Can I ask you, then, in terms of PHE's role,  
 24 obviously there's reference to PHE laboratory capacity,  
 25 do you know whether there have been any preparedness

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1 work and particularly post-MERS and SARS, that had  
2 looked at what else existed beyond the PHE laboratories,  
3 such as the virology network and how that stood in 2020,  
4 please?

5 **A.** So I think this goes back to my first point, which is it  
6 was a -- they would tend to be specialist public health  
7 laboratories. So as I know her Ladyship has heard, the  
8 test, the assay, the diagnostic assay, was actually part  
9 of the work of that virology network. It was  
10 internationally linked in and was specialist work. So  
11 it was that sort of lab work, the initial phase of  
12 testing, that would normally be the responsibility of  
13 Public Health England.

14 It had never been funded and I don't think it had  
15 been assessed for whether it could roll out into a very  
16 large system. The role it took was to expand to its own  
17 labs, but it wasn't responsible at the time and was  
18 never funded to go beyond that level.

19 **Q.** Thank you.

20 Can I ask you, then, with the current state of  
21 affairs as of 2025, does there now exist essentially  
22 a directory that identifies what laboratory capacity  
23 there is existing across virology, pathology, that  
24 actually identifies where the laboratories are with the  
25 specialism to scale up in a future pandemic?

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1 we have mapped out precisely where those will be. We  
2 are exploring and we've done some market exploration  
3 ourselves to do that.

4 I think what you're asking is has somebody  
5 nationally done that?

6 **Q.** Yes.

7 **A.** And I think that would normally sit with the Department  
8 of Health and also with the Office for Life Sciences,  
9 who deal with many of those companies regularly.

10 **Q.** Thank you. Well, perhaps we'll look at that when we  
11 look at recommendation, because I think you do give some  
12 understanding as to what UKHSA would have available by  
13 way of testing.

14 **A.** Yes.

15 **Q.** And I think is it somewhere in the order of 3,000 tests  
16 a day that would be essentially --

17 **A.** That would be the smallest amount, because that would  
18 depend on the high containment level, which we've  
19 discussed. We could surge up to 12,000, if the  
20 containment level was lower, and we are actively working  
21 in that preparedness plan, hopefully with an update by  
22 September, and within our means, to have under our  
23 direct control up to 25,000 tests within six weeks.  
24 Because -- because of the experience, I think, of the  
25 last pandemic, we feel that it's important that we can

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1 **A.** That's quite a complex question, which I'll try to  
2 answer. So we have reviewed and we have a programme of  
3 what we call agency surge capability and preparedness  
4 across the UK Health Security Agency now, which includes  
5 our labs -- in this case the reference virology labs are  
6 mostly based at Colindale -- and across some of our  
7 regional laboratories. The rest of the laboratories are  
8 either private sector or they are owned by the NHS.

9 So I know where our capacity is and I can talk later  
10 about how we're trying to work to increase our capacity  
11 and speed of surge. I do not have control over the  
12 other parts of the laboratory systems.

13 **Q.** No, I appreciate that, but in terms of an identification  
14 of where, across public and private, the laboratories  
15 sit, is there anyone that's collating that information,  
16 so there's an understanding of infrastructure both  
17 publicly and privately owned?

18 **A.** We have quite a lot of good information, and we work  
19 very strongly, which we may come on to, with various  
20 elements of the private sector, but the overarching  
21 responsibility for pandemic preparedness sits with the  
22 Department of Health, and so what I try to do is, within  
23 a -- boundaries of finances, which we may come on to, is  
24 create our responsibility to that boundary and then seek  
25 out -- and we are working with others, but I don't think

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1 surge further than was available previously.

2 **Q.** Thank you.

3 Can we then please -- I've already highlighted that  
4 I'm taking you back to your earlier statement. Can we  
5 please go to your fourth statement, which is  
6 INQ000273807. It's page 142 but it's your  
7 paragraph 10.5 and 10.6, please.

8 So that's INQ000273807. Thank you.

9 You detail that:

10 "Testing and contact tracing does not however confer  
11 the same benefit for all diseases. In the context of  
12 seasonal influenza, the disease usually has a relatively  
13 short incubation period of one to three days. The  
14 consequence is that once exposed, people rapidly become  
15 symptomatic and infectious themselves. Contact tracing  
16 aimed at identifying these people and enabling their  
17 absence from societal interactions before they have had  
18 the opportunity to spread the disease is therefore more  
19 difficult."

20 Then you go on:

21 "10.6. Further, as the disease transmitted  
22 predominantly by the respiratory route, influenza can be  
23 spread to large numbers of people who might then be  
24 difficult to identify ..."

25 And obviously give the various examples of that.

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1 A. Yes.

2 Q. "Accordingly, the opportunity to test an individual,  
3 identify them and intervene before they have had the  
4 opportunity to spread the disease is correspondingly  
5 lower. The consequence is that testing and contact  
6 tracing are likely to be of less assistance in the  
7 control of a pandemic with pathogen characteristics  
8 similar to seasonal influenza. Accordingly, widespread  
9 testing and contact tracing has not historically been  
10 employed successfully or recommended in the management  
11 of influenza pandemics."

12 Can I ask you, did the failure to consider and/or  
13 develop contingency plans for rapid scaling of testing  
14 and tracing prior to 2020 result from excessive focus on  
15 the risk of a pandemic influenza, and lack of focus on  
16 the public health interventions which might be required  
17 to deal with a pandemic caused by a novel pathogen?

18 A. For my own perspective, I don't think it is the  
19 influenza that's the important point. But I do think  
20 you have hit upon probably what, for me, is the biggest  
21 learning from this, not just for the UK but for almost  
22 all western countries, which is actually in -- nobody,  
23 I think, had really caught up with the 21st century.  
24 Nobody had really thought through can we test at the  
25 scale that we now know that we can, following the work

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1 it's 0.1% you probably wouldn't set up a system designed  
2 around asymptomatic transmission. But the consideration  
3 of it in pandemic planning, or indeed in any infectious  
4 disease outbreak, is really important. And I think that  
5 is one of the big learnings from this pandemic.

6 It is a general point which says each time we look  
7 at a potential pathogen, its characteristics and what it  
8 could do, we need to think: what would the differential  
9 response be if a large or a small portion of this --  
10 proportion -- was asymptomatic transmission?

11 I mean, we are trying to do some of this work, we  
12 may come on to, in looking at priority pathogen  
13 families, setting that framework, looking at the testing  
14 that we can develop ahead of any potential outbreak or  
15 pandemic.

16 Q. Thank you.

17 Can I ask you, in terms of the approach that was  
18 adopted for Covid-19, are you able to assist us as to  
19 why the UK Government did not follow the approach of  
20 South Asian countries in creating a rapidly scalable TTI  
21 infrastructure following the response of SARS and MERS,  
22 or even contingency TTI plans?

23 A. I think it goes back to the points which I've just said.  
24 In the environment -- and it wasn't just the UK.  
25 I mean, I think it's very important that all systems,

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1 which NHS Test and Trace had done.

2 And so -- and probably, in a resource-constrained  
3 environment as well, it was very unlikely any public  
4 health person would have thought that resource would  
5 come forward to do that sort of scale of testing.

6 So I think there is a point, which is -- both on  
7 moving into the 21st century and what was possible, in  
8 the way of testing and digital infrastructure, but also  
9 considering asymptomatic transmission as well.

10 And those two combined, if put at the front of this,  
11 so almost forget the pathogen but put those two at the  
12 front, and then the scenarios of what -- of the art of  
13 the possible in pandemic preparedness changes  
14 considerably.

15 Q. Thank you. And then can I ask you in particular, you'll  
16 have -- you'll know that a lot of the questions of  
17 a number of witnesses have related to asymptomatic  
18 transmission, and you seem to be saying that needs to be  
19 considered at the start of the process now as an  
20 assumption. Is that --

21 A. So asymptomatic transmission, and I think the Inquiry  
22 has heard evidence frequently, it is always considered,  
23 I think, by individuals who understand infectious  
24 diseases. The issue is the proportion of cases which  
25 are asymptomatic is a really important one, because if

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1 more or less I think, are outside Southeast Asia, where  
2 they had had direct experience. So maybe that is  
3 significant. I don't think there was a belief, perhaps,  
4 that you can stop a pandemic or curtail it in such  
5 a way. You can see from the historic teaching, almost,  
6 for infectious disease management in large outbreaks  
7 like this, is that you will change your definition of  
8 a case as the outbreak progresses.

9 And that's exactly what happened through Covid: we  
10 changed, you know, the first case's definitions -- the  
11 first definitions were travellers coming back from  
12 Wuhan, then it changed to people in a wider geography,  
13 then it changed to those who needed -- for whom you need  
14 tests for clinical care, and then when we had a wider  
15 system, it changed then to those -- you know, universal  
16 testing.

17 But that's probably all I can say at this point.

18 Q. Thank you. Can we move, still in this statement,  
19 please, your fourth witness statement, to paragraph 5.21  
20 on page 24, please.

21 Now, you highlight in paragraph 5.21:

22 "I was aware from my previous roles however of the  
23 excellent scientists and very committed teams within PHE  
24 who regularly provided internationally recognised health  
25 protection expertise as well as direct contributions to

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1 local, national and international infectious disease  
2 control and scientific understanding. I was also aware  
3 of the resource constraints of that organisation. These  
4 included sustained reductions in funding over the life  
5 cycle of the organisation, with a 40% reduction in the  
6 overall PHE budget between 2013/14 and 2019/20."

7 So, are you able to offer any views as to whether  
8 resource constraints inhibited effective pandemic  
9 preparedness as far as test, trace and isolate  
10 infrastructure or planning was concerned?

11 **A.** So I can speak with some personal experience of this,  
12 because at the time of much of this I was the regional  
13 director for the South of England for Public Health  
14 England, and even our front line what I would call  
15 routine health protection teams, which would have  
16 been -- which have been very active during Covid, were  
17 at a bare minimum when I left the organisation.

18 I think it's had two impacts. Number 1, there was  
19 no flexibility. It was continuing to do vast amounts of  
20 work, including international surveillance, on what --  
21 the budget of one small -- well, medium-sized hospital.  
22 I mean, it's quite -- so an extensive emergency response  
23 system across the country for more than just infectious  
24 disease, and international work.

25 But I think also what's happened is, and

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1 systems, despite the fact that we are now running  
2 a whole load -- we are a new organisation, we do  
3 genomics, we do data analysis, a whole load of new  
4 things.

5 So it's difficult to say because I absolutely  
6 recognise the resource constraints of the current  
7 system, and that is important. And therefore, I do my  
8 role and work within the budget.

9 I do raise issues where I think that is difficult  
10 for health protection, and where they are important for  
11 the protection of the public. But nevertheless, the  
12 decision finally on the resource and the surge  
13 capability and expandability of the service relies on  
14 risk appetite and ministerial decisions, and quite  
15 rightly, those are political decisions.

16 The one thing would say is I will fight very  
17 strongly to maintain baseline capabilities, so losing  
18 scientific skills in an area where you can -- where you  
19 stand no chance of surging them again or reducing to  
20 a certain level where they are not operable is an area  
21 where I call a red line.

22 And we are not there. We have a very good service  
23 in this country. And I'm very aware that actually some  
24 of our really important areas, things like our  
25 high-containment labs, have been noted publicly to be

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1 I referenced it earlier, it probably resulted in a bit  
2 of a minimalist mindset, in the sense that if every time  
3 the budget cycle came round it was cut, the idea that  
4 you might start thinking through -- I mean, this is my  
5 own reflection and not evidence -- but it wasn't in the  
6 psyche to start thinking through: if somebody  
7 injected £1 billion here, could we set up a new testing  
8 system for a potential -- for a pandemic? Because it  
9 was effectively a breadline health protection public  
10 health service.

11 **Q.** Thank you.

12 Can I ask then as to how things currently operate  
13 with UKHSA with a health protection service,  
14 essentially. Is that appropriately funded now? So not  
15 operating on the breadline that you've just identified  
16 that PHE England was -- or Public Health England.

17 **A.** So I think I have shown the efficiency of myself and the  
18 management in the reduction of our budget. So we, I  
19 think, I'm advised, have delivered the largest single  
20 downsize in the budget post-war, from 15 billion to  
21 3 billion in one year, and my overall budget now --  
22 there are slightly different figures, I know, have been  
23 presented, because we have vaccines budgets running  
24 through the organisation, if you like, but we are back  
25 to effectively a one medium-size hospital for our

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1 under immediate consideration in the spending review.

2 But we are in a very different place. I think the  
3 vision for the organisation when I came in is probably  
4 not achievable on the budget that we have at the moment.

5 **LADY HALLETT:** Sorry, under immediate consideration for  
6 a decrease or an increase?

7 **A.** No, so there is a particular issue -- and I say it here  
8 because it is in the public domain and has been the  
9 review for National Audit Office and Public Accounts  
10 Committee -- for replacement of the countries, so --  
11 which UKHSA oversees, high-containment laboratories. So  
12 these are the CL4, above CL3 pathogen level. So there  
13 has been a significant amount of urgent consideration.  
14 The runway into building these is actually about  
15 15 years, and so there's been a delayed programme in the  
16 country that should be -- I know is under active  
17 consideration for the spending review this year.

18 **LADY HALLETT:** Thank you.

19 **MS CARTWRIGHT:** Thank you.

20 Can I pick up on the red lines and what is  
21 appropriate and necessary, just deal with at this stage.  
22 Obviously the roles you've had at UKHSA have involved  
23 essentially the mothballing or dismantling of the  
24 UK Lighthouse laboratories, and perhaps the most  
25 significant example of that being the Rosalind Franklin

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Laboratory, NHS Test and Trace owned, that had a vision for a long-term role, we've heard, when created, that it would exist beyond a pandemic.

Are you able to assist whether you're a party to or any of the discussions around that decision to essentially dismantle the whole laboratory -- Lighthouse laboratory network that had had so much public funding into it, invested into it, but specifically where Rosalind Franklin was wholly owned by NHS Test and Trace?

**A.** So actually, important objective, I think the Rosalind Franklin Laboratory, it was actually leased, so we need to be quite careful about who owned it and whether it was sold or not. I think the key point you make is it has ceased to function and I do have some insight into that. I mean, clearly, all of these decisions are ministerial decisions, they're not ones I make on my own and, each time a decision is made, it will be a balance between highlighting what I've been asked to do, with a budgetary constraint, for example, and making sure ministers understand what the impact of that might be.

I think, for the two different areas, Rosalind Franklin Laboratory was not -- I didn't conceive the idea, I wasn't part of the original business case, and there is a reflection on that, which I think comes back

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I wouldn't personally necessarily say that was the crown jewel, if you like. I think we need to be really, really good, systematic, over the long term at looking at what we're building and how we build into it, the functionality to turn it into a country operational use, if you like, in the event of a pandemic.

And if I may, I mean, I've been -- we worked closely with my equivalent agency, KDCA in South Korea, and I've looked with them, with Dr Jee, the director, quite carefully, at how they used their laboratories, and a lot of this is about turning facilities that are there and having them available directly for government for intervention.

**Q.** Thank you, and thank you for that additional insight around the decision making to the closure of the Rosalind Franklin.

Can I then, finally before lunch, just deal with another topic under the heading of preparedness, please. Can I ask to be displayed please INQ000535912. Thank you. This is an Independent SAGE paper. I hope you've had an opportunity to consider this as part of the material, Professor Harries.

Can we move into the fourth page, please. Thank you.

We can see under the heading "The UK experience", it

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to perhaps nearer the end about looking forward, on making sure that where we are investing as a country and where government invests in different building structures and programmes, they are aligned, and there is a case for them to be running in peacetime.

That was not the position with the Rosalind Franklin Laboratory and, in fact, my own organisation put in a very, very significant amount of work, almost retrospectively, to try to work with academia, with local universities, with the private sector, to see what could be made of it, so that it could continue to everyone and then, in the future, turn back to being something that we might be able to use in the event of a pandemic.

That was not possible, and, I mean, I think the costs for maintaining these are quite staggering. I think, if I remember correctly -- and I might need to confirm after -- it's about 500,000 a month for it not to be working, if you see what I mean, just sitting there. There are also, another key point, issues to do with maintaining staffing of these establishments, as well, which was always a problem.

So I think, on the face of it, it looks like a huge loss. It actually, in fact, only, I think, at the peak delivered 125,000 tests a day of the 850,000. So

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expressed the view that the UK could have:

"... broken transmission chains if we had mobilised local test and trace capacity during February and early March, with proper incentives for isolating households, and community facilities provided for less severe cases."

Can I ask, do you agree with the conclusions of Independent SAGE that TTI could have been effectively mobilised at this stage, despite the barriers including lack of infrastructure and speed of widespread seeding of infection?

**A.** I think it's important to realise that local testing and tracing systems were mobilised and, in fact, they never paused. I think we've had their statements, I've seen in different documents, saying, you know, why was community testing stopped? Why was something stopped? In actual fact, where it was possible to keep going, it was. It tended to be focused. So Public Health England teams then would, for example, look at backward contact tracing on, you know, different outbreaks.

So I think that's an important point. I think I broadly -- it goes back to my comment I've just made, which is, whilst I don't agree with the detail here, I do think there is an issue which the UK, plus many, many other countries, did not have a capacity sitting

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1 ready for the eventualities and the mindset that said,  
 2 "We can stop this", and for me in my current role, that  
 3 is actually the really important element to go forward  
 4 because, in doing that, it encourages us all, I think,  
 5 to look at all of the opportunities and set out on  
 6 a long term basis how we can manage these in the future.

7 There are some particular issues here around, for  
 8 example, isolating households, that we may come on to,  
 9 and, I'm sure, about how we support households. And  
 10 I think there is a much wider issue, which is really  
 11 important, around where were those local hotspots, why  
 12 were they the hotspots and who was most affected, that  
 13 again, we need to address in peacetime, in a much more  
 14 transparent way, than perhaps normally occurs for our  
 15 health service. We need resilient communities, as well  
 16 as all of the things that we're discussing.

17 **Q.** So can I ask you, in terms of that we need to identify  
 18 the hotspots, why they're there, and do that work in  
 19 peacetime: has that reflective work happened in UKHSA?

20 **A.** Yes, definitely. So I mean, those are -- identifying  
 21 hotspots can be a surveillance issue, which I'm happy to  
 22 pick up separately, but what I'm referring to is there  
 23 are two things that I did when I first came in and this  
 24 does pick up my background as a director of public  
 25 health. One thing was about starting the "Future of

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1 much of this is vaccine preventable disease, that we  
 2 could -- we can amend.

3 But we need to work with communities on the longer  
 4 term, not just when a pandemic hits.

5 **MS CARTWRIGHT:** Thank you, my Lady, is that a convenient  
 6 moment?

7 **LADY HALLETT:** Certainly.

8 I'm sorry we couldn't finish you before lunch,  
 9 I know busy you must be, if anything else, tidying your  
 10 desk.

11 I'll return at 2.00.

12 **(1.00 pm)**

13 **(The Short Adjournment)**

14 **(2.00 pm)**

15 **LADY HALLETT:** Ms Cartwright.

16 **MS CARTWRIGHT:** Thank you, my Lady.

17 Professor Harries, before lunch I think you made the  
 18 point that testing didn't stop at any point completely,  
 19 or contact tracing, and perhaps that's referable to  
 20 clarifying what happened after 12 March, and the  
 21 movement from the 'contain' to the 'delay' phase.

22 Building on that, can I ask you a question, please,  
 23 by reference to the quote attributed to yourself linked  
 24 to the "test, test, test". I'm going to first take you  
 25 to an Irish Times report but then I will give the full

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1 Health Protection" work programme, which has actually  
 2 yielded some really positive results recently. It was  
 3 the first thing I kicked off, and it has taken  
 4 three years to get to the answers, but it is co-produced  
 5 with local authorities, with ADPH, with environmental  
 6 health officers. So that's a really important piece of  
 7 work.

8 But what I'm really referring to, is actually we  
 9 know where the communities are who are going to be least  
 10 confident to come forward, who are least going to trust  
 11 us, who are also going to have the worst underlying  
 12 health conditions, and those underlying health  
 13 conditions and the disparities in them are there now.

14 So the real question is, why are we not addressing  
 15 them now so that when the next pandemic starts off,  
 16 we're at least on an equal platform? And the work  
 17 I have done there and probably as I'm leaving -- I'm  
 18 doing my legacy point -- which is actually to -- I think  
 19 we are the first Health Protection Agency in the world  
 20 to have a health -- equity in health protection  
 21 strategy, so that's an overarching strategic to really  
 22 push this out into the domain of routine work, and then  
 23 we've just done our first report, which highlights the  
 24 different rates of infectious diseases, admissions to  
 25 hospitals. And you can see this by deprivation. And

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1 context from within your statement, your fourth  
 2 statement.

3 So can we look, first of all, please, at The Irish  
 4 Times article, which is INQ000474852, and if we move to  
 5 page 2, please, we can see you were referenced there by  
 6 reference to "test, test, test", linked to what had been  
 7 said by Tedros Ghebreyesus, and then you were suggested  
 8 as saying:

9 "... 'test, test, test' was intended for countries  
 10 less developed than Britain."

11 And over the page, please, to page 3. Thank you.

12 We can again see, again, selective quotes from you  
 13 relating to:

14 "So the point there is that they are addressing  
 15 every country, including low and middle-income  
 16 countries, so encouraging all countries to test of some  
 17 type."

18 So I think this is the foundation for a question I'm  
 19 going to ask you about, but I know in particular that  
 20 the context to this quote you're anxious to be  
 21 considered, and so, please, can we then move to the full  
 22 context that you've provided linked to the comments made  
 23 on 26 March 2020.

24 Can we move to INQ000273807, at page 145.  
 25 Paragraph 10.18. Thank you.

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1 And so we've looked at aspects of what you said  
2 within The Irish Times article, but we can see that you  
3 address this within your fourth witness statement,  
4 giving the full context, I think, to what was said.

5 And if we go over the page, please, we can see in  
6 particular at page, paragraph -- yes, at the end of  
7 paragraph 10.18, again further context that you've  
8 highlighted in bold:

9 "So obviously if there was infinite testing  
10 facilities, and we were growing them at pace and we will  
11 have them, then it moves to the public, but we need to  
12 be very careful about focusing where it's clinically  
13 most valuable."

14 If we go and just expand out again, we can see  
15 further you give context to this conversation at  
16 paragraphs 10.19 and 10.20. So that -- there's wider  
17 context there, but can I ask you, do you agree that  
18 essentially what was said by you around these quotes  
19 linked to the 26 March ignores the fact that other  
20 countries with at least as well developed public health  
21 system as the UK were at this time testing extensively  
22 at a rate many times that in the UK?

23 A. So thank you for showing the complete section there,  
24 which I think The Irish Times does not pick up fully,  
25 and I would encourage the Inquiry to look back at the

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1 And if I remember, this data actually goes on to  
2 flag that if you -- whatever testing you have, you need  
3 to use it effectively. If you're using it in community  
4 testing, where most people are likely to do well, and  
5 not using that for those who need the test for clinical  
6 benefit, you will disadvantage the people who need it.

7 Q. Thank you.

8 Can we next move, please, to the topic of capacity,  
9 please. And I asked you before lunch around experience,  
10 international experiences, but can I ask you, did the UK  
11 fail to mobilise TTI resources at an early stage and  
12 emulate the approach adopted by countries such as  
13 Taiwan, Singapore and South Korea? First of all, do you  
14 accept that as a proposition?

15 A. So I think international comparisons generally are  
16 extremely difficult, and I know many people who have  
17 commented here and put in statements and in other  
18 modules have flagged the differences. It's not simply  
19 what testing capacity you have or how you might use it;  
20 it's actually the context in which you're using it as  
21 well.

22 So, for a country like Taiwan or South Korea, which  
23 I've visited myself, there were some very, very -- how  
24 shall I put this? -- non-Libertarian interventions for  
25 individuals. So for things like the use of credit card

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1 detail of what I've said. I think that's important.  
2 What I actually said, and I think you showed it, was it  
3 was encouraging all countries to test of some type, that  
4 included the UK. The reason that I flagged the  
5 lower/middle-income countries was actually because, at  
6 the time, 80 out of 194 of the WHO countries had not  
7 reported any cases at all, and WHO was including and  
8 exhorting all countries to do so, regardless of what  
9 their -- you know, constraints. Some of them were  
10 political, I think, and many of them were the lack of  
11 capacity, and in fact the UK had been supporting them.  
12 And that was exactly my point. So I felt that perhaps  
13 that had been misconstrued and I was actually  
14 encouraging countries and other countries to support  
15 those without testing capacity.

16 The point -- the other point I think that you've  
17 flagged there is, and I mentioned this just before  
18 lunch, was that back around -- as we were moving from  
19 'contain' to 'delay', there had been a change in advice  
20 Public Health England had published, that changed back  
21 on 14 March, and I think my comments there were made on  
22 26 March, so they were following effectively that  
23 movement in the case definition and targeting the  
24 testing that was there towards those cases where it was  
25 most appropriate.

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1 details to know where individuals were travelling, so --  
2 as well as a very, very highly developed digital  
3 infrastructure.

4 So, on top of the points I've made earlier, which is  
5 actually I don't think -- it's not just the UK. I mean,  
6 Germany is flagged as a country which had a lot of  
7 testing, but the testing fell over I think in the second  
8 wave, as well. I don't think many countries outside the  
9 ones that you have mentioned, which are predominantly  
10 around Southeast Asia, and I think probably had learnt  
11 from MERS more effectively, and had very highly  
12 developed infrastructure systems, did very well in this  
13 space.

14 So I wouldn't necessarily pull the UK out as  
15 different to other countries but obviously what you see  
16 in the development of the activity and the start-up of  
17 test, trace and isolate is a decision, and I think it  
18 came on 17 March at a roundtable from Number 10 I wasn't  
19 at, where there was clearly a ministerial decision to  
20 move to building a testing capacity for the country  
21 which had not been envisaged before.

22 Q. Thank you. And so can I seek your views. Would you  
23 agree that there was a failure to take proper account of  
24 international experience and expertise in establishing  
25 the TTI system?

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1 **A.** I think that's a different question, if I've understood  
 2 it correctly, which is: did people look to see what  
 3 systems had been developed elsewhere as they developed  
 4 TTI? Is that the question? I don't think that is the  
 5 case, because there were a number of different strands  
 6 of -- you know, there are automatically a lot of links  
 7 that we have for different countries. I've just  
 8 mentioned we have MoUs for different countries so we can  
 9 ring different colleagues up and ask what they're doing,  
 10 but I think more importantly Cabinet Office right  
 11 through the pandemic actually ran a comparator,  
 12 international comparator. So I think people were  
 13 looking for international experience to help and support  
 14 them in how they developed a service.

15 **Q.** Can I then ask to take it back a step in terms of you  
 16 identifying that South Asian countries had learned from  
 17 MERS and SARS.

18 Do you think there's an identified failure to not  
 19 respond effectively in preparedness to look to what  
 20 South Asian countries were doing, informed by the  
 21 experience of SARS and MERS?

22 **A.** I think in retrospect -- and I say, I'm not singling out  
 23 the UK from this -- given my points earlier about  
 24 planning through for a different -- for example,  
 25 a disease with asymptomatic transmission -- or more  
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1 the pandemic to support testing policy development and  
 2 changes including for individuals being discharged from  
 3 acute care settings to care homes. However, despite  
 4 clinical support for discharge testing to be undertaken  
 5 as soon as possible, testing was not initially available  
 6 at the scale necessary to achieve the objective."

7 You go on:

8 "Any system of testing prior to discharge from  
 9 hospital into care home settings would have been  
 10 dependent on there being sufficient tests available, as  
 11 well as ensuring the appropriate process parameters --  
 12 such as time of test, time period over which a test  
 13 remained valued, turnaround time of the test result --  
 14 were agreed and evidence based. These were fundamental  
 15 considerations for the [Social Care Working Group] work  
 16 programme."

17 Can I ask you then, are you aware of any analysis,  
 18 in March 2020, of the testing capacity that would have  
 19 been required to implement mandatory testing prior to  
 20 discharge to care homes?

21 **A.** Not specifically at that point but, given that we know  
 22 what the testing was, capacity, and I think it was --  
 23 from memory, it was somewhere between 5,000 and 10,000  
 24 in mid-March, and on 17 March there was a roundtable  
 25 where the country was -- where ministers agreed to start  
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1 importantly, I think, is this mindset which says we can  
 2 actually stop a pandemic. And that, I think, is the  
 3 critical learning point for the future.

4 I think for those countries who were very nearby --  
 5 I mean we have had MERS cases and we have managed them  
 6 perfectly effectively. So that in itself is slightly  
 7 problematic, because if you manage an infection  
 8 effectively, perhaps it reinforces the idea that this  
 9 is -- you know, you have systems that work. And  
 10 evidentially, we have done that. We haven't had  
 11 epidemics emerging.

12 **Q.** Thank you. Can I then, please, take you back into your  
 13 fourth witness statement, please, to paragraph 9.41 at  
 14 page 135 which is INQ000273807, and this is on the  
 15 question of discharge to care homes, please. You say  
 16 this:

17 "I am aware that in an email of 14 April 2020 the  
 18 [Chief Medical Officer's] advice was that testing within  
 19 care home settings was a priority following concern  
 20 highlighted by a recent study of 39 care homes  
 21 indicating potential high rates of nosocomial  
 22 transmission. The issue of ingress into residential  
 23 settings was one of significant clinical consideration,  
 24 including at the [Social Care Working Group], where  
 25 workstreams were delivered on an ongoing basis through  
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1 developing a testing system. I mean, that would not be  
 2 a difficult test -- number. That wasn't the planning  
 3 issue, I think the issue was that the country was  
 4 starting to develop a large testing system, it would be  
 5 very easy to calculate the numbers that were needed at  
 6 that point.

7 **Q.** Thank you. Then following on from that, then, are you  
 8 aware whether there's any consideration given to  
 9 implementing alternative measures in the event of  
 10 anticipated shortfall in testing capacity, such as  
 11 deferral of transfers into care homes until testing  
 12 could be implemented and/or mandatory isolation of  
 13 patients to mitigate the risks of transmission?

14 **A.** So this is going to quite a long space outside testing.  
 15 So if I go back to the previous question, I seem to  
 16 remember, and I can't remember who said it, listening to  
 17 some of the previous representatives, that there was  
 18 an email from Ros Roughton, it may have been Mr Hancock,  
 19 actually, who -- there was a series of hearing  
 20 information presented where it was made very clear that  
 21 she had calculated -- so she was the Director General  
 22 for care at the time and, on the afternoon that the  
 23 decision was made, they had actually calculated how many  
 24 tests were required. So, I mean, I think that is, and  
 25 it was going to be difficult, both in practical terms to  
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do, as well as the delivery of the tests because, clearly, you need to ensure that staff on the front line in hospitals are able to do that and process the results and what have you.

Just going back to that one, I think it was calculated. That was not the issue.

The second point is a very, very different one because, actually, and probably a point I should have made right at the start -- on all of these issues, the test is not the intervention; the test is -- the intervention, for safety, is the isolation. The test is an adjunct to all of this and, even if you have a test, if somebody doesn't act on it and self-isolate, then it is not really of any validity. It might give you surveillance information but it won't protect anyone.

So when we come up on then to care homes, actually the critical intervention here was about keeping the patient safe and the safest thing for these -- and I can reference back, I'm sure, to a number of other Inquiry documents -- is staying in hospital, if you're usually elderly and frail, is a very dangerous place to be, so that is not a helpful thing to be retained there. And importantly, even if you have had a test and it is negative, it doesn't mean you won't develop -- it's only negative at the point the test is taken. So the really

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essentially it details about symptoms but then, if we go over the page -- and particularly to paragraph 22, please, it again details essentially the predicted autumn second wave.

Thank you.

If we can then go to Professor Pagel please, which is the -- sorry, I do apologise. Sorry, I'm going to start this questioning again.

If we can start, first of all, with Professor Pagel, thank you.

INQ000575988 -- thank you -- which is paragraph 36 on page 14, please. Thank you.

We can see here reference to the tests, but also increasing prevalence from September onwards, and then, please, if we can separately, then, deal with Professor Fulop, which is INQ000587244, paragraph 19, please. Thank you.

If we can go to paragraph 19 to 21, essentially the same point identifying the failure to prepare for the second wave, if we move over to paragraph 21, please. Thank you.

So can I ask you, do you agree with Professor Fulop and Professor Pagel that the United Kingdom had failed to prepare adequately for the predicted autumn second wave, including by failing to improve testing, tracing

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critical intervention for the individual and for the care homes who were receiving them was for the individual to go into isolation after they moved.

So testing at this point is an adjunct but it is not the main intervention for keeping an individual safe.

**Q.** Can we then, please, look briefly at your paragraph 4.33 in the UKHSA corporate statement, please, which is at INQ000587365, at page 46, please. Thank you.

You say this:

"In September 2020, after schools reopened, the UK experienced a second wave of infection resulting in further lockdowns across the [United Kingdom]. It was anticipated that the winter would create a dual challenge of managing flu and Covid-19, and the UK Government wanted to avoid a second lockdown. [NHS Test and Trace] was therefore asked to expand PCR testing capacity with a target to meet processing of 500,000 tests per day by the end of October 2020 already part of the July 2020 [NHS Test and Trace public plan]."

So, can I then ask you, you have had provided to you statements from Professor Fulop and Professor Pagel, around the second wave, and so can we briefly look at Professor Fulop's statement, please -- sorry, I think this is actually Professor Pagel's then, I do apologise.

But, in any event, if we look at paragraph 8,

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and isolation, despite calls for such improvement from bodies such as the Academy of Medical Sciences, SAGE and Independent SAGE?

**A.** So I obviously was nothing to do with test, trace and isolate at this time, so it's difficult for me to be absolutely clear beyond what I've put in the statement about what preparations were made. I know there was a winter plan and that, actually, it took a lot of those into account. I did notice in reading through that specific Pagel had said much of this was predictable and, of course, all the bits that one would think about, people going inside more because it's cold, and mixing, as far as I can see from the evidence, was actually considered.

The only thing I would say is that I don't think it was actually predictable because these were some of the least predictable winters that we had. If we looked, actually, flu didn't go up in the way we thought it would, it went down, and children's illnesses changed because they weren't mixing, so it varied quite a lot.

So I think it really is -- just highlights that planning throughout this phase was incredibly difficult for all sorts of people, for the health services and particularly, I think, for which I experienced later, trying to predict, for example, the number of LFDs and

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1 then actually moving that through a procurement system  
2 and sign-off.

3 So as I said, beyond that, I don't think I can  
4 really add more to what's in the statement.

5 **LADY HALLETT:** Wasn't a second wave predictable? Putting to  
6 one side winter, I thought the evidence I'd heard was  
7 people like Sir Patrick now Lord Vallance and Professor  
8 Whitty were advising of the possibility of a second wave  
9 or the likelihood of a second wave quite early on.

10 **A.** So waves are definitely predictable and I think one  
11 would anticipate this, that there would be other waves.  
12 So that's absolutely the case. The precise point and  
13 severity of a wave is not and, actually, what this  
14 highlights -- and I agree with Professor Pagel in the  
15 sense of, you know, we know what the normal in  
16 infectious disease patterns are during the winter and so  
17 what you had then is not being precisely sure of when it  
18 is going to come and knowing that, if they hit together,  
19 you would have one impact; if they hit in close  
20 succession, it might have another.

21 So for example, if you did have a wave of flu and  
22 then you had a wave of Covid, you would have them  
23 building on each other. You'd have people remaining in  
24 hospital from previously. If you have Covid, and  
25 everybody locks down, you won't have the flu,

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1 certainly endorse if that's the case, that was  
2 particularly different because the flexibility to turn  
3 on additional resource for procurement and then actually  
4 get the products in, bearing in mind that much of it was  
5 in high demand globally and was being produced overseas,  
6 was incredibly difficult. So whether or not the  
7 planning was there, it may not have resulted in, you  
8 know, all of the capacity that you may have wished for.

9 **Q.** Thank you. Now, we looked, before going to Professor  
10 Pagel and Professor Fulop's statement, at your statement  
11 which had identified the second wave after schools  
12 reopened, and can I ask you now some questions, please,  
13 about testing in schools.

14 Could we please display paragraph 4.117, at page 68  
15 of your statement, please. Thank you. In fact, if we  
16 go back a page again, please, I think we can see the  
17 section where you dealt with testing in schools. Thank  
18 you. We can move up a page, thank you.

19 You tell us in the witness statement that:

20 "Mass asymptomatic testing was implemented after  
21 schools and further education colleges reopened [we're  
22 now in March 2021] following the national lockdown.  
23 Asymptomatic pupils initially tested at ATSS within  
24 their educational settings supervised by staff. Tests  
25 were repeated onsite for pupils ideally at

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1 potentially, and so it goes on.

2 The point, I think, is there are predictabilities  
3 around winter normally but this was not a normal winter,  
4 and you can predict new waves but you can't predict  
5 precisely when they come, which is why the surveillance  
6 is so important because you can start to see where those  
7 peaks and troughs are happening.

8 **MS CARTWRIGHT:** Now, obviously, you've identified winter but  
9 I particularly want your views, please, before September  
10 2020, what preparatory steps should have been taken by  
11 NHS Test and Trace before September 2020 and, in  
12 particular, during the period of low prevalence over the  
13 summer of 2020?

14 **A.** I mean, I'm happy to make some general comments but  
15 I think those are probably questions that were better  
16 addressed to Baroness Harding because it's difficult for  
17 me to be precisely sure what measures were taken.  
18 I wasn't involved in that. I would have seen plans,  
19 general plans come forward.

20 Obviously, at any point during the pandemic  
21 preparedness you will want to have a reasonable amount  
22 of tests, but you will have to vary that with the  
23 controls, which I think we've heard from ministers, on  
24 deciding about costs and expenditure, and I think, as  
25 I suspect Baroness Harding has said, but I would

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1 a three-to-five-day interval, and for staff, twice  
2 weekly through self-tests at home."

3 Then, as we see at 4.117:

4 "After two weeks, pupils move to home-based  
5 self-testing when the levels of self-test stock  
6 available allowed."

7 I think you've also had provided to you the paper  
8 from the Secretary of State for education, titled  
9 Asymptomatic Testing in Schools and, if we can briefly  
10 display that, please, which is INQ000075484. Thank you.

11 If we move in particular to page 6 of this paper,  
12 paragraph 13. Sorry, we'll go back a page, please.  
13 Again, it details:

14 "... core proposition will require asymptomatic test  
15 sites to be set up in every secondary school and college  
16 ..."

17 You've also, I think, had a chance to review the  
18 statement of Kate Bell where she specifically deals with  
19 the fact that schools were informed of plans to  
20 implement asymptomatic testing in schools on the last  
21 day of term in December 2020 and the reference for all  
22 that, although I don't think it needs to be displayed,  
23 I think you've had an opportunity to read it, is  
24 INQ000587569, paragraph 96.

25 Can I then ask you, please, Professor Harries, do

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1 you consider that sufficient plans were in place to  
 2 enable asymptomatic testing in schools to be effective?  
 3 **A.** So first of all, the tests need to be effective and  
 4 I think you've highlighted there I'm very familiar with  
 5 the fact that many of the tests, actually, could not be  
 6 used, although we've all got used to that now -- were  
 7 not able to be used for self-tests because they weren't  
 8 accredited that way through MHRA at that time. So  
 9 I think there is a practical issue there. I'm afraid  
 10 the rest of it not my domain. It's clearly a decision  
 11 made by the Department for Education, I'm sure they're  
 12 much more familiar with what schools are able to do or  
 13 not. My experience of teachers during the pandemic was  
 14 they were absolutely wonderful and delivered a huge  
 15 amount but whether or not that was practical for  
 16 an average school, I think is for the teachers and for  
 17 the Department for Education to answer.  
 18 **Q.** Then can I ask you, from your public health expertise  
 19 perspective, would you agree that testing regimes in  
 20 schools should have had greater involvement from persons  
 21 with specialist expertise, from local public health, and  
 22 those administering/supervising the tests should have  
 23 been provided with better training?  
 24 **LADY HALLETT:** You'd need to know what the baseline was,  
 25 before you could say they should have had better?

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1 was under-reporting of negative self-tests conducted at  
 2 home."  
 3 In light of those statistics that you have been able  
 4 to provide, are you able to assist as to what are the  
 5 lessons to be learned from asymptomatic mass testing in  
 6 schools?  
 7 **A.** So I'm just trying to look at the point above this,  
 8 again, this is not a piece of work I was directly  
 9 involved with at all, and I'm just reading very quickly,  
 10 and I think it says focusing on a five-week period from  
 11 1 March '21 to 4 April '21 and, obviously, how effective  
 12 something will be will depend on a whole load of other  
 13 contextual areas. So one of the things about testing,  
 14 which I am aware of, in schools is that at different  
 15 points, actually, it was very -- the pupils and staff  
 16 found it very supportive. They found -- and I think one  
 17 of the general endeavours -- this is standing back from  
 18 this particular element -- was we all recognised how  
 19 important it was for children to be in school. That was  
 20 an absolute priority. So for -- to support and  
 21 encouraging individuals back to school, testing can  
 22 actually be quite a supportive -- it gives them  
 23 confidence to be there.

24 The timing here, to me, suggests that you can also  
 25 find that people -- their engagement diminishes and so

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1 **A.** I would also add a comment about -- for the reasons  
 2 which I flagged at the start, which is, you know, local  
 3 public health, I have worked in local public health, if  
 4 I had been part of this team centrally, would that have  
 5 been adequate input or not? I mean, there is a general  
 6 point here and it's one that UKHSA tries to work toward,  
 7 which is around co-production of all of this guidance,  
 8 and I suspect that Baroness Harding will have flagged  
 9 that -- which I know is the case, that as NHSTT  
 10 developed, they tried to move more of their services in  
 11 the way that they did things to the community and work  
 12 with community and absolutely recognise that.

13 But I think that, you know, these are different  
 14 demands in a very fast-moving space but I wasn't  
 15 directly involved so I don't think I can add more.

16 **MS CARTWRIGHT:** Finally, can we go back to your statement  
 17 INQ000587365, at page 68, please, and if we could just  
 18 look at the statistics you have helpfully provided in  
 19 the corporate statement, which is at paragraph 4.117.1.  
 20 That's INQ000587365 at page 68. Thank you.

21 You've helpfully provided these statistics:

22 "Reported participation varied between secondary  
 23 school pupils (27%), college pupils (8%), primary school  
 24 staff (43%), secondary school staff (34%) and college  
 25 staff (15%), although it's considered likely that there

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1 I'd be interested, on this one, just it would perhaps be  
 2 helpful to compare what happened in January and February  
 3 with March and April, because I know, from my own  
 4 experience from some of the care home testing, was that,  
 5 actually depending on the regimens and whether you were  
 6 a PCR or LFD and at which point in the pandemic cycle it  
 7 was, people were more or less engaged with it.

8 So I think that's probably more -- all that I can  
 9 say. I don't think we should assume that those  
 10 apparently low numbers, that, you know, necessarily mean  
 11 it was not effective and we need to define what we mean  
 12 by effective at the end of it, if more children were in  
 13 school and they were healthy, that probably has  
 14 extremely long-lasting positive effect.

15 **Q.** Thank you. Can we then, please, move backwards to your  
 16 paragraph 3.40, please, at page 27 within this statement  
 17 and I want to see, please, Professor Harries, if you can  
 18 assist us a little bit more on asymptomatic transmission  
 19 and testing and prioritisation.

20 We can see there, from 15 April 2020:

21 "... PCR testing will be offered to 'everyone who  
 22 needs one' in social care settings. The press release  
 23 stated that all symptomatic care home residents would be  
 24 tested; all patients discharged from hospital were to be  
 25 tested before going into care homes 'as a matter of

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course', and that all social care staff in need of a test would 'now have access to one'."

Obviously, the caveat:

"Of course, this depended on the availability of tests."

Now, the Inquiry has heard evidence that, by March 2020, it was established that there was credible evidence of asymptomatic transmission, and that PCR tests could pick up asymptomatic cases, meaning that there was value in testing people with and without symptoms, even if those tests were not 100 per cent sensitive.

Now, you reference there the announcement of 15 April 2020 about testing in social care settings, including the commitment that all patients discharged from hospital would be tested as a matter of course.

Therefore, can I ask you, in light of this, do you agree that the measure should have been adopted earlier, and particularly, when the Covid-19 hospital discharge service requirements were published on 19 March 2020, to promote discharge in order to free up hospital beds.

A. I think I'm probably going to repeat myself slightly because we established, I think, on -- when the prioritisation of testing note was established, on 8 March by PHE and then was put out on 14 March, that

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wasn't there; and, secondly, I think, as far as I can see, it was put in as soon as the evidence base was clear for the country.

Q. Thank you. Can I just pick up about -- with what you've just said about the prioritisation list.

A. Yeah.

Q. Can we briefly look at, I think, the 11 March prioritisation list, which is INQ000270014. I hope that's the correct reference. Thank you.

Now, we can see the prioritisation list devised, I think, by Public Health England on 11 March 2020, so just building on the question I asked a moment ago, should that have been amended to include all patients being discharged into care homes at that time?

A. So the basis -- I mean, this is an evidence-based clinically agreed proposal that I think was put forward by Public Health England and considered by the UK CMOs and a number of other senior clinicians so this is an agreed position. It predominantly runs with those individuals for whom, at this stage, testing was required for the management of their clinical care, and you can see that running all the way through.

So this feels the right prioritisation. I can't -- I don't think anybody that I've spoken to since has looked back and felt this was wrong for all the test

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there couldn't have been testing on 19 March, so I mean the basic point is you would need a test to implement this. So I think that would not have been a possibility, notwithstanding whether it was desirable, there is a second point, which is we start with the premise that asymptomatic testing and the risks were completely understood, I think, in March.

In fact -- and I think again, Mr Hancock made these points in his evidence -- at the start of April -- and I've made it -- you've actually pulled up my own evidence here -- there was a particular study in the US, in the Seattle care home, which gave a lot of strong evidence with very good data and denominator factors of asymptomatic transmission, and then PHE actually did what's known as an Easter 6 study, in the Easter weekend, which gave us, if you like, homegrown UK figures for the first time, which were really robust and then went on to do some more detailed evidence.

So I think it was generally around April time, which is when the reality of the proportion of cases, if you like, of asymptomatic transmission was recognised, and that is exactly why the DoH moved quickly for their 14 April announcement, and this one, actually.

So I think, on the one hand you need a supply of tests, so it's -- they can't have put something in if it

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capacity and clinical care requirements at the time, and also bearing in mind, of course, we're still quite early on it pandemic to understand what the different outcomes might be for different groups.

Q. Can we then next move to a new topic, please, on symptoms. Can we display, please, INQ000151498. Thank you.

Now, you tell us in your fourth witness statement -- so rather than going to the statement, I thought it better to look at the email itself. You refer to the not of advice you gave to the DHSC on 20 February 2020 listing symptoms associated with Covid-19 infection, saying:

"Top ones ... are, in order, history of fever/chills, cough, sore throat, general weakness, runny nose, headache, muscular pain, diarrhoea, shortness of breath."

Can I ask you, please, what involvement did you have in identifying the symptoms which were communicated to the public as sufficient to require or trigger symptomatic testing for Covid-19?

A. Just for clarity, this is an email responding to Miriam Wraight, who actually headed up the visual aids and communication sides. So this is not clinical advice to the Department of Health or anyone else. Usually

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what would happen is they would be crafting pictures and/or posters and they would pass them through myself and Professor Van-Tam to see if we could spot obvious issues.

Second point is all of those symptoms you've just listed, as it says in the email, are the ones which have come from a release from WHO, so these were not my advice; these were the ones which WHO had put forward. So this is not advice to the clinicians or the Department of Health, it's what the WHO had said.

Notwithstanding that, your question is, usually it wasn't my responsibility. I would perhaps see end results or that came into Senior Clinicians Group for observation for, you know, recognition and discussion, but all of the symptoms which arose would routinely be looked at and reviewed, because the importance of symptoms is that you have a very high positive predictive value, if you're going to use them, and you can't put 99 things out in a list to the public because, actually, the whole of the public would come forward with something.

So I wasn't directly involved. Often, it would be colleagues in NERVTAG, for example. So Professor Van-Tam, Sir Peter Horby, Andrew Hayward, and it would be those in Public Health England who were looking at

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using the app until around the 23rd, I think, of the next month.

**Q.** That's correct and certainly by 1 April he had identified and indicated loss of taste and smell was a strong indicator?

**A.** Yes, but he wasn't the only one, obviously. There was -- and all of the new symptoms that arose, and there were numerous symptoms, would be considered, and by -- through an evidence base.

And, in fact, there were three different groupings for symptoms that were recognised reasonably early on. One was what you might call the respiratory ones, which were predominant, probably, there were a group of neurological symptoms and there were a group of gastrointestinal symptoms, the important thing is that you can't go out to the public with every symptom. What you actually have to do is get the highest sensitivity and specificity in those listings that will give the greatest care to the population. Otherwise, you'll over-flood -- you'll flood the symptoms.

I mean, the other issue is, I think, that when Professor Spector raised those points -- I think we were in lockdown about then anyway, so I think we need to think through the practical implications. Key point is, those are symptoms -- and in fact Professor Spector's

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the evidence base.

**Q.** Thank you, I appreciate the clarification you've given to this email. Perhaps if I just summarise how you've referenced it in your fourth witness statement please, you say this, it's your paragraph 7.23, I don't think it needs to be displayed:

"On 20 February 2020, I emailed DHSC advising them of the symptoms associated with Covid-19 infection in order to respond to questions on material to be included and social marketing health promotion messages."

So can I then ask you, please, given the range of symptoms that we see identified in the email, and particularly you identify the source of that being the WHO, do you share the concerns expressed by Professor Spector about the impact of relying solely on testing and the two to three symptoms of Covid-19 -- fever, cough, shortness of breath -- that essentially remained as the list until loss of taste and smell was added on 18 May 2020.

**A.** These were two separate things, for the reasons which I've just said, so I don't think we should consider this as advice. As I said, it was for social media, and I think I note somewhere it's very early on, this is around the -- when is it -- 20 February. So I think Professor Spector, from memory, didn't actually start

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work was actually funded by the Department of Health between 2020 and 2022, and I know that colleagues in NERVTAG were in continuous communication with him. So I did listen to his evidence, but I think he may have been slightly mistaken about some of the communications.

**Q.** Can I ask you, as a proposition, certainly using 1 April and the loss of taste and smell, would you agree that those symptoms should have been added much sooner than 18 May 2020 as indicators of infection for Covid?

**A.** So regardless of whether it was anosmia, ageusia, or any of the other symptoms, only if they were going to deliver the greatest benefit for the population in getting them the right care at the right time.

My point is, and I think and I'm fairly sure it has been disclosed to the Inquiry, if you look at the conversations between colleagues in NERVTAG, particularly Sir Jonathan Van-Tam, they were asking, from Professor Spector, for the data in order to make the appropriate comparisons and to get the right grouping. And once that moved to -- and it did change, actually, through the pandemic, as well -- then those symptoms were included.

So this was all symptoms, including anosmia, were under consideration right the anyway through, and it is the grouping of those to give the right sensitivity and

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1 specificity that were the ones that were utilised for  
 2 the public.  
 3 **Q.** Thank you.  
 4 Can we then, please, move in your witness statement,  
 5 please, to INQ000587365, please, to paragraph 3.77. So  
 6 it's page 36 of INQ000587365, please.  
 7 Now this falls under a run where you deal with  
 8 contact tracing -- sorry, the statement deals with  
 9 contact tracing and the development of the Covid-19 app,  
 10 and if we can then -- sorry -- you give update figures,  
 11 and they are, please -- sorry, if we can move now  
 12 to 4.144 -- sorry, page 74, please. Thank you.  
 13 Can I ask you then just generally on the app and  
 14 Wales, can you assist as to what consideration was given  
 15 to the population in Wales who did not have smartphones  
 16 or may have had challenges due to technological  
 17 illiteracy?  
 18 **A.** I don't think I can -- apart from the fact I am a Welsh  
 19 resident, so I could make comments about the signals in  
 20 Wales, but I don't think I can because I wasn't involved  
 21 with the development of either the first app or the  
 22 second and, whilst we did work very closely with Wales,  
 23 I wasn't involved in this particular bit, so I don't  
 24 think I can help any further with that.  
 25 **Q.** Thank you. Can we then just complete the questions on  
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1 Can you cast any light on that?  
 2 **A.** I'm afraid I can't. I mean, obviously I felt, as an  
 3 agency preparing for pandemics, I should understand  
 4 whether the apps have been useful or not, and I think  
 5 there's universal agreement that they are. They're not  
 6 the only thing but they have been very successful in  
 7 saving lives and preventing cases. But the distribution  
 8 across Wales, I'm afraid I can't.  
 9 **Q.** Can you assist, bearing in mind the positive things  
 10 about the app that have been quoted by way of the data,  
 11 as to whose task it would have been to look at that,  
 12 what appears to be a trend of very low uptake across  
 13 Wales?  
 14 **A.** Well, I think if I was sitting in Public Health Wales at  
 15 the moment, which I have done previously, I would be  
 16 very interested to understand that. And I do think it  
 17 is important to understand the technology sitting behind  
 18 it as well, because obviously you -- there is a gadget  
 19 and an app to use, but you have very -- you know, the  
 20 area of central Wales, for example, I know from my own  
 21 past experience of being a director of public health  
 22 there, is very sparsely populated, so you would not  
 23 expect to have significant high uptake, and actually  
 24 signals are very poor. I was joking before, but this is  
 25 a fact. So people may not have found it as useful to do  
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1 the app then, please. Can we move forward to page 74  
 2 and paragraph -- in fact, sorry, it's 75, 4.146.  
 3 I think you give details within the statement about  
 4 the priority was ensuring it was broadly accessible, the  
 5 languages. And can I ask you, was the data obtained  
 6 about the number of users of the app in languages other  
 7 than English obtained?  
 8 **A.** I don't think I would be able to answer that. I can --  
 9 I mean, it would probably be a good question for people  
 10 like Professor Fraser, who I think you've spoken to.  
 11 **Q.** Thank you.  
 12 And then can we move forward to your  
 13 paragraph 4.151, and again, we have specifically asked  
 14 Professor Fraser about this.  
 15 You reference at 4.151 and 4.152 essentially the  
 16 success stories of the app when it was available after  
 17 24 September, including downloads, uptake and prevention  
 18 of hospitalisations and the like, including deaths  
 19 averted.  
 20 For time, I'm not going to display it but I think  
 21 you've had an opportunity today, because you reference  
 22 the Nature article as the foundation for these  
 23 statistics. We've asked number of witnesses who have  
 24 relied upon the data whether or not they can assist with  
 25 the map that shows almost universal low uptake in Wales.  
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1 that.  
 2 I think this is one that -- we talked about local  
 3 understanding, and this is exactly the sort of area  
 4 where you would need local insight both to the digital  
 5 infrastructure, the telephony infrastructure, and  
 6 actually utilisation by people in communities.  
 7 **Q.** Thank you.  
 8 Can I next move then, please, to support for  
 9 self-isolation. And can we move to paragraph 6.32 of  
 10 the INQ000587365 statement at page 100.  
 11 INQ000587365. Thank you.  
 12 We can see at paragraph 6.32 you detail that -- the  
 13 financial support provided under the Test and Trace  
 14 support scheme, and you say this:  
 15 "Finances can act as a brake on the ability of those  
 16 who are otherwise willing to self-isolate. That can be  
 17 because they are in precarious employment or have been  
 18 told that they do not have recourse to public funds.  
 19 While this is not a matter that falls directly within  
 20 UKHSA gift, it is an important point which was  
 21 highlighted during the pandemic and continues to be so  
 22 because it has the relevance to the ability to control  
 23 the spread of an infectious disease. From historic  
 24 experience, this is both for population and individual  
 25 disease transmission risks."  
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1 So can I ask you, do you consider that the TTSPS and  
2 the discretionary support scheme adequately address the  
3 issue which you identify that finances can act as  
4 a brake on the ability to self-isolate?

5 **A.** So I think "adequately" is a challenging word, but the  
6 point about, for example, precarious employment, I think  
7 it's precarious lives. I think Professor McKee  
8 mentioned this. It is very obvious that if you live  
9 hand to mouth day by day, you need to know that you have  
10 an income. And if you don't have that and you have  
11 demands on your finances, you're very unlikely to engage  
12 in these sorts of settings. And I think that is  
13 evidently obvious.

14 I know that NHS Test and Trace -- so I know that the  
15 Secretary of State -- I was in personal meetings -- was  
16 really trying to promote this and make sure it was  
17 understood across government that this was -- it may be  
18 a financial burden on the country but actually it would  
19 have financial implications in terms of the economics of  
20 the country as well, in terms of extending potentially  
21 the length of the pandemic.

22 The issue I've put at the bottom there, and this  
23 was -- actually, it reminded me particularly of  
24 a meeting that I was in with the Secretary of State on  
25 this topic at the time, which was he -- this is

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1 for this have made this point recurrently. I think it's  
2 become -- it was perhaps hidden for routine health  
3 protection cases, but it's well known amongst those, as  
4 I say, working -- whether in local authorities or  
5 actually whether in UK Health Security Agency and  
6 predecessor organisations, I -- I am trying to think,  
7 I don't think -- well, I think we have formally raised  
8 it in many of the products that we have published.  
9 We've looked at inequalities. We did a review of the  
10 interventions, so those are available and will be  
11 available to other government departments. We've put  
12 everything into the public domain.

13 **Q.** Thank you. And can I ask, that included any  
14 consideration about whether the £500 support payment  
15 that was introduced in England was sufficient?

16 **A.** So I think we -- you can see through the evidence that  
17 people suggest it's not. It feels -- logically, it  
18 feels relatively little to encourage somebody with  
19 family, for example, responsibilities to be immediately  
20 staying out of employment. Clearly, there is a demand  
21 on the public purse for that, and that's why I think it  
22 is entirely appropriate and reasonable that the Treasury  
23 is the centre point for consideration of that  
24 alongside DWP.

25 But the precise amount and how it's administered

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1 Matt Hancock, he was trying to understand how we could  
2 do this, what the challenges might be, and also how  
3 important it was. And I had flagged that through my  
4 time working with communities on infectious disease,  
5 this is a recurrent problem: if you have a case of  
6 something and somebody needs to be -- you would advise  
7 them to be off school or off work but they are not ill  
8 themselves, this is actually a major block to their  
9 engaging with that intervention.

10 And he actually asked us to go away and see if we  
11 could come up with something which we could utilise both  
12 for Covid and for this. And because -- it was actually  
13 extremely difficult, and so my recommendation at the end  
14 of this is that, actually, it does need looking at,  
15 not -- I mean, obviously with the UKHSA support, but  
16 it's a DWP Treasury, I think, opportunity, because it  
17 affects the economy, and we do not want infectious  
18 people going in and out of work on a routine basis as  
19 well as during pandemics.

20 **Q.** Now, with giving that answer and also the identification  
21 that it's not within UKHSA's gift, has that view been  
22 fed back as to the -- those relevant departments that  
23 really need to grip this issue in peacetime?

24 **A.** I think it's very well recognised. I mean, I think most  
25 people who have been working certainly on the front line

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1 I think needs some wider thought. I don't think -- we  
2 can help but I don't think it's (unclear).

3 **Q.** Thank you. Can we then go back to paragraph 6.5,  
4 please, on page 92. You detail that:

5 "The pandemic highlighted the need for more agile,  
6 responsive, and comprehensive approaches to health  
7 inequalities. Pre-pandemic planning did not fully  
8 account for the scale of inequality revealed by the  
9 COVID-19 pandemic, particularly in emergency response  
10 scenarios."

11 Given that extent of health inequality was known,  
12 can you assist as to why pre-pandemic planning did not  
13 really engage with this issue fully?

14 **A.** So I think anybody working in health protection knows  
15 that a pandemic and infectious disease generally will  
16 follow in the wake of inequalities. That's nothing new.  
17 The inequalities agenda is -- I don't think is  
18 recognised enough routinely. It was the point I was  
19 making before the break. And it's one of the reasons  
20 while I have, right from the start of UKHSA, had  
21 a strategy which highlights inequalities and the need to  
22 reduce them.

23 We have an inequalities strategy but, most  
24 importantly now, we are increasing the data that we are  
25 putting out to effectively ensure that other parts of

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1 the system, so, for example, trusts and ICBs, are able  
2 to look at the data and understand it for their areas,  
3 and actually take action. Because that action will  
4 allow the health of the population to improve and the  
5 economy to improve but it will mean that we are much  
6 more resilient in all of our communities the next time  
7 a pandemic hits.

8 **Q.** And can I ask you, does that analysis of data now also  
9 include disaggregated data?

10 **A.** So wherever we can we are working to do that, and in  
11 fact I think -- I made some comment, there was a Public  
12 Health England heat tool before, but we have built in  
13 a number of what I would call automatic checkpoints. So  
14 if we are doing emergency response, inequalities  
15 immediately gets flagged up for our emergency response.  
16 It's inescapable, if you like. If we're looking at  
17 data, we're asking the questions.

18 We don't always have the data and I think this is an  
19 important point. If it's not disaggregated when it is  
20 collected, so if a survey is not done with data which  
21 can be disaggregated, then clearly we can't then analyse  
22 it and look at what the impacts and the outcomes are  
23 likely to be. But wherever it is, we do, and if we find  
24 areas where we want to know more, we will be pushing  
25 back on those data streams.

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1 of groups that were hard to reach and engage?

2 **A.** Do you mean the Targeted Community Testing?

3 **Q.** Yes.

4 **A.** I mean, that's -- obviously that was very much  
5 introduced -- the start of that was the Community  
6 Testing Programme, which again predated UKHSA.  
7 I think -- I go back to the comments I made earlier on,  
8 and I know from having come in behind Baroness Harding,  
9 there was a growing recognition of the importance of  
10 community engagement, but I think a growing evidence  
11 base as well about underserved communities who do not  
12 necessarily engage through the same routes, do not feel  
13 comfortable, we don't make the easy for access. But  
14 I think I am probably picking up my director of public  
15 health experience and know that those communities are  
16 very well known in local authorities and that's probably  
17 where the starting point should be.

18 **Q.** Thank you.

19 Now, finally for my purposes, under lessons learned  
20 and recommendations, can we thank you and UKHSA for the  
21 14 pages of reflections which are contained within the  
22 witness statement but can I pick up on a couple of  
23 issues, please.

24 Can I ask you first of all, we've heard from  
25 Professor Fraser, linked to apps, that it was his

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1 **Q.** Thank you.

2 Can we just go to the next paragraph, 6.6 and over  
3 the page, you've just referenced the heat tool.

4 **A.** Mm.

5 **Q.** Are you able to assist as to when that was actually  
6 brought in?

7 **A.** So this was actually a Public Health England  
8 introduction, so again I wasn't directly involved with  
9 it, but I was aware of it, and I think it's an example  
10 of ensuring that everybody who was working in health  
11 protection emergency response, but actually routinely as  
12 well, when you're planning services or looking at any  
13 intervention, consistently looks at the inequalities  
14 lens.

15 Now, I would say most public health trained  
16 individuals do that routinely, but it also doesn't hurt  
17 to be reminded to do it absolutely systematically, not  
18 as a tick-box exercise but actually to say, "We have  
19 this data, we don't have this data", and have a feedback  
20 cycle to go back so we know if it's not there this time,  
21 that we can improve it the next.

22 **Q.** Thank you.

23 And just on a further topic, we know that latterly,  
24 targeted testing came in. Can you assist as to why that  
25 wasn't introduced sooner to essentially assist with sort

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1 evidence and understanding that it would take  
2 three months to deploy a new version of Exposure  
3 Notification in a pandemic.

4 First of all, is that accurate and is that the  
5 current position?

6 **A.** Well, Professor Fraser would probably be better informed  
7 to give a precise timeline on that than I personally  
8 would, but I think two things: one is we did consider  
9 this very carefully. There was a ministerial decision  
10 to decommission the app. But along with many other  
11 things, we've had passage-in-specific -- so  
12 Covid-specific interventions where we actually are  
13 trying to grow systems routinely which can surge for  
14 anything and are pathogen agnostic. So this didn't fit  
15 that, and I think we would like -- we recognise how  
16 valuable an app can be. We have explored to a degree,  
17 again within our budget, what would be possible. We do  
18 not have that in active consideration at the moment,  
19 partly because we actually do need to understand what  
20 our budget settlement will be going forward and how many  
21 of these different interventions and programmes we have  
22 running we'll be able to take forward.

23 Final point is, I think, that, as we've seen during  
24 the pandemic, the three to four months with -- you know,  
25 could well come down with the right budgetary input and

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1 the right ministerial direction at the time, and we  
2 would obviously respond to that very quickly.  
3 Most importantly, you know, we have good connections  
4 with people like Professor Fraser and so we can  
5 automatically link with them now, in perhaps a way that  
6 was not there at the start of the pandemic.

7 **Q.** Thank you.

8 Professor Harries, you will have heard no doubt  
9 Lord Bethell's evidence essentially about how we have  
10 gone backwards in the last three years, not forwards,  
11 the diagnostic infrastructure is dismantled, data spine  
12 closed down.

13 Obviously you deal with aspects of UKHSA's  
14 preparedness for a future pandemic, and appreciating it  
15 could be any pathogen, but can you assist: is UKHSA  
16 currently in a position to effectively fulfil its role  
17 to provide the UK's standing capacity to prepare for,  
18 prevent, and respond to, infectious diseases and other  
19 threats to health?

20 **A.** So I think the short answer is: within the budget  
21 envelope that we have, but we have programmes in  
22 progress. Lord Bethell's comments I agree with in some  
23 ways, which is many systems have been decommissioned.  
24 But I think it's important to realise, as I've just  
25 mentioned with the app, that the majority of those were

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1 of the community PCR testing. So we have set up  
2 a diagnostics accelerator but it's not linked in right  
3 across Government to investments which would allow  
4 spin-off companies to build those up, for production  
5 lines, and some of the digital infrastructure.

6 And I think my sadness, as I leave my post, let's  
7 put it that way, we've done lots of work with the  
8 private industries because we need to do that to be  
9 better prepared. We're working on the 100 Days Mission  
10 for -- and we've described the priority pathogens and  
11 worked out which tests we don't have and which vaccines  
12 we don't have. So we have a roadmap, if you like, for  
13 the UK to build on.

14 But actually the Civil Service is quite a clunky  
15 system to get to unite. In a way, there will be a new  
16 life sciences plan, life sciences sector plan, which  
17 will be helpful and so I think the Government is very  
18 much in this way. But actually, the Civil Service  
19 itself does not enable some of these logical  
20 investments, interventions and connections which  
21 otherwise, I think, could be win, win, win, so we don't  
22 have empty factories and we don't have empty buildings.  
23 We're using them for developing life sciences routinely,  
24 and then we can turn them more logically together at the  
25 event of a pandemic.

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1 built very quickly, quite expensively, for one pathogen,  
2 during the pandemic. And what we are trying to do is go  
3 back -- so they will have been decommissioned, and we're  
4 trying to rebuild a system, which we are partly doing to  
5 get to a point where the country can surge, so -- to our  
6 boundary envelope.

7 So we have got a new, for example, equivalent of the  
8 CTAS system, the community tracing system, in  
9 development. We've got a prototype, we're working on an  
10 NH5N1, so avian flu, PCR model, so that -- but something  
11 that in the future can be used for any pathogen. So  
12 even on a daily basis, if we have an outbreak in  
13 a region, we could use this, but we can extend it out to  
14 national levels.

15 And I think I've outlined a lot of these issues  
16 there.

17 The bit that I think -- and perhaps if I could  
18 indulge a few minutes -- that I think where we are  
19 missing out, is we do not have, and this was one of Lord  
20 Bethell's points, the production capacity, if you like,  
21 to, for example, deliver to make our own LFDs, and yet,  
22 we in UKHSA are developing techniques which might mean  
23 that we don't need large quantities of the PCR testing  
24 capacity. If you can take from an LFD the viral RNA and  
25 find that out, you actually avoid the need to have any

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1 **Q.** Thank you. Can I just ask then finally, for my  
2 purposes, to get to that joined-up system and with the  
3 identified issue linked to the clunkiness of Civil  
4 Service, who has to be part of that collaboration to get  
5 that joined-up system?

6 **A.** So nominally it is there. I'm being very realistic as  
7 I leave post because it is one of my frustrations.  
8 We've done a lot of -- as I've outlined, a lot of what  
9 I would call front end work, we're working very closely  
10 with industry but if I go and ask some of the industry  
11 colleagues I've been working with, they will tell you  
12 there are five or six different front doors to come  
13 through. And I know the Government is currently working  
14 on that, and so the ambition and the vision is exactly  
15 as I think it should be. I actually think the culture,  
16 if I'm being entirely honest -- and I'm critiquing  
17 myself, because I'm part of it -- needs to move into the  
18 21st century in the same way we need to move forward in  
19 our thinking about actually stopping a pandemic, and  
20 that's -- my term about scientific pre-emption is yes,  
21 we need big testing capacity but most of the time we  
22 shouldn't need to get there. We should have done a lot  
23 of upstream work, we should have tests more or less  
24 available, we should know who we're linking with and we  
25 should have colleagues in production, in private sector,

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1 who are working with us routinely, all with appropriate  
 2 governance frameworks, that we can just turn on and go.  
 3 And it's those same connections which, out of  
 4 a pandemic, could be supporting life science growth.  
 5 **MS CARTWRIGHT:** Thank you. Professor Harries, those are my  
 6 questions.

7 My Lady, there are Core Participant questions.  
 8 **LADY HALLETT:** Ms Parsons I think is going first -- who is,  
 9 if you look that way, to your right.

10 **MS PARSONS:** In fact, my Lady, in light of evidence given  
 11 already, we don't need to ask our question of  
 12 Professor Harries, but thank you very much, my Lady.

13 **LADY HALLETT:** Thank you very much, Ms Parsons.  
 14 Right, Professor Thomas.

#### 15 Questions from PROFESSOR THOMAS KC

16 **PROFESSOR THOMAS:** Good afternoon, Professor. I'm  
 17 Leslie Thomas, representing FEMHO, the Federation of  
 18 Ethnic Minority Healthcare Organisations. I only have  
 19 a small handful of questions for you.

20 FEMHO members found it nearly impossible to feed  
 21 back to those in charge about the practical issues  
 22 associated with the TTI policies. Help us with this:  
 23 why was it not possible for expert healthcare workers to  
 24 provide feedback from the front line with the aim of  
 25 improving the services for ethnic minority individuals?

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1 set the TTI agenda at the start, so I'm not really very  
 2 able to be helpful with that, with the early phase of  
 3 development.

4 **PROFESSOR THOMAS:** But, my Lady, there was one other small  
 5 question that arose out of Ms Cartwright KC's question.  
 6 May I ask it? It's very short.

7 **LADY HALLETT:** You may, Professor Thomas.

8 **PROFESSOR THOMAS:** I'm most grateful.  
 9 Professor, just one question that arose in relation  
 10 to the questions that you were asked about whether  
 11 the UK should have taken more heedance from what was  
 12 happening in Asia. Can I just follow up on that, just  
 13 in this way: do you believe there were missed  
 14 opportunities for the UK to learn from countries that  
 15 successful managed their Covid testing and tracing and  
 16 isolation response, particularly not just from Asia but  
 17 also from Africa as well; do you think more lessons  
 18 could have been learnt?

19 **A.** There's a general point here I think: you're inviting me  
 20 to say should we learn from other countries? We  
 21 absolutely always should and we do. And, in fact,  
 22 actually, UKHSA works very closely with Africa CDC, we  
 23 actually have somebody embedded in that country and we  
 24 actually have two teams -- so I myself have been out to  
 25 Nigeria, for example -- and would liaise very carefully.

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1 **A.** I think this probably relates to NHS Test and Trace and,  
 2 obviously, I was only responsible for that for the last  
 3 part of the journey. So I can only say really what  
 4 we're doing in UK's Health Security Agency now. I think  
 5 there are two points: one is I would hope and expect  
 6 that the early comment on that for the future would go  
 7 through your -- for the different health organisations,  
 8 and, actually, we have means of picking that up both at  
 9 national level and local, particularly we work through  
 10 directors of public health, as well, very closely, so  
 11 each of our local health protection teams usually has  
 12 a nominated, actually, consultant, who will link with  
 13 the director of public health for a patch. So that's  
 14 one very good route.

15 I think the other one is we now have -- work --  
 16 manage with the Department of Health and NHS England,  
 17 a voluntary organisation oversight group, which should  
 18 allow for information to feed back in but I think the  
 19 obvious practical answer is, we hope -- I hope we are  
 20 very responsive to any routine requests that come in and  
 21 we have a routine system for doing that.

22 **Q.** So you would agree that there should be such a pathway?

23 **A.** Well, I think there should be a pathway for anybody to  
 24 feed back on services. We should have strong customer  
 25 services. I think my problem is I wasn't -- I didn't

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1 We support surveillance systems in other parts of the  
 2 world. So my experience from it always is, it is  
 3 two-way learning. It's never one way. There are lots  
 4 of things. And actually, importantly, as we go  
 5 forward -- and we haven't mentioned vector borne  
 6 disease, will come to the UK, and colleagues in Africa  
 7 are experts, and we have to learn from other countries  
 8 in our preparation.

9 **PROFESSOR THOMAS:** My Lady, thank you very much. Those are  
 10 all my questions.

11 **LADY HALLETT:** Thank you very much, Professor Thomas.  
 12 Mr Jacobs, right down the end.

13 **MR JACOBS:** My Lady, my question was on financial support.  
 14 In fact, I don't think I can take it further than the  
 15 questions and answers given.

16 **LADY HALLETT:** I'm very grateful to you and Ms Parsons for  
 17 curtailing the questions you need to ask.

18 Thank you very much.

19 That completes the questions for today. I'm afraid  
 20 you may have retired but you can't escape my clutches.  
 21 So I'm going to have to ask you, I think, to come back  
 22 for the next module, I think, isn't it?

23 **THE WITNESS:** Yes. One more, I hope.

24 **LADY HALLETT:** But I do appreciate the burden on you, as  
 25 I've said many times, and of course on the UKHSA, so

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1 thank you very much for your help to the Inquiry so far.  
 2 I hope the next time I'll be able to say good bye.  
 3 Thank you.  
 4 **THE WITNESS:** I would like that.  
 5 **LADY HALLETT:** Very well. I shall break now and return  
 6 at 3.25.  
 7 **MS CARTWRIGHT:** Thank you, my Lady.  
 8 **(3.08 pm)**  
 9 **(A short break)**  
 10 **(3.25 pm)**  
 11 **LADY HALLETT:** Ms Islam.  
 12 **MS ISLAM:** My Lady, the next witness is Mr Fell.  
 13 **MR GREG FELL (affirmed)**  
 14 **Questions from COUNSEL TO THE INQUIRY**  
 15 **LADY HALLETT:** Sorry you're the last witness of the day,  
 16 Mr Fell.  
 17 **A.** That's okay. Someone has to be.  
 18 **LADY HALLETT:** They do, I'm afraid.  
 19 **MS ISLAM:** Good afternoon.  
 20 Please could you tell the Inquiry your full name.  
 21 **A.** Thank you. I'm Greg Fell.  
 22 **Q.** Mr Fell, you've provided the Inquiry with one witness  
 23 statement, dated 30 April 2025. It's Inquiry reference  
 24 INQ000587434, which should be coming up in front of you  
 25 just now.

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1 **A.** Correct. I still am a director of public health as  
 2 well. I have to balance the two jobs.  
 3 **Q.** Thank you very much. So it's right to say that you held  
 4 that role during the pandemic?  
 5 **A.** Yes, absolutely.  
 6 **Q.** Thank you. And in terms of the ADPH itself, it's  
 7 a representative organisation of the directors of public  
 8 health across the UK?  
 9 **A.** Yes, correct.  
 10 **Q.** And you work in partnership with other organisations,  
 11 including a range of government departments, the NHS,  
 12 local authorities, and the like?  
 13 **A.** Entirely correct, yes.  
 14 **Q.** And the ADPH represents the views of directors of public  
 15 health on public health policy?  
 16 **A.** Yes.  
 17 **Q.** And you advise on public health policy and legislation?  
 18 **A.** Yes.  
 19 **Q.** And in respect of the Covid-19 pandemic specifically,  
 20 the ADPH collated and present the views of the directors  
 21 of public health to help inform the government's  
 22 response; is that right?  
 23 **A.** Entirely correct.  
 24 **Q.** And is it also right to say that the ADPH had a good  
 25 working relationship with the Local Government

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1 At page 50 it's signed and dated with a declaration  
 2 of truth. Can you confirm that you've read your  
 3 statement recently and that the contents are true to the  
 4 best of your knowledge and belief?  
 5 **A.** Yes, correct. Read it this morning.  
 6 **Q.** Thank you very much.  
 7 We're going to deal with the following topics in  
 8 your evidence, firstly touching on your background and  
 9 professional experience. Secondly, looking at an  
 10 overview of ADPH and the role of directors of public  
 11 health, then moving on to the centralised approach, the  
 12 TTI system, some data challenges, the directors  
 13 of public health's role in respect of local contact  
 14 tracing, self-isolation, inequalities, and lastly your  
 15 observations on any lessons to be learned for the  
 16 future.  
 17 So turning then, please, to your background and  
 18 professional experience, it's right that you are  
 19 currently the president of the ADPH, which stands for  
 20 the Association of Directors of Public Health.  
 21 **A.** Yes, that's correct.  
 22 **Q.** And you've been in that role since November 2023?  
 23 **A.** Correct.  
 24 **Q.** And prior to this role, you were a director of public  
 25 health yourself in Sheffield for ten years?

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1 Association?  
 2 **A.** Very good. Then and now.  
 3 **Q.** Thank you. We don't need to go into the detail of it  
 4 but it's outlined in your statement between  
 5 paragraphs 21 and 39. In summary, the ADPH is governed  
 6 by a board?  
 7 **A.** Yes.  
 8 **Q.** There are four membership types?  
 9 **A.** Yes.  
 10 **Q.** And as of October 2024, there are a total of  
 11 448 members; is that correct?  
 12 **A.** Yes. I can't remember the exact number --  
 13 **Q.** Approximately?  
 14 **A.** -- but approximately.  
 15 **Q.** Thank you very much.  
 16 So the Inquiry has heard quite a lot of evidence  
 17 about directors of public health, and I'd like to ask  
 18 you some more detail about their specific role and  
 19 function.  
 20 So can we go to your statement, please, pages 10-11  
 21 looking at paragraphs 47 and 49. Starting, please,  
 22 with 47. You say that:  
 23 "The core purpose of the DPH is as an independent  
 24 advocate for the health of the population and to give  
 25 system leadership for its improvement and protection."

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1 Is that right?

2 **A.** Entirely correct. I could unpack that more if needs be.

3 **Q.** Thank you.

4 And you go on to say that it's a high-level

5 statutory role which sort of bridges local authorities,

6 the NHS and other appropriate sectors; is that right?

7 **A.** Still correct, yes.

8 **Q.** Thank you.

9 And then briefly, please, paragraph 48. You say:

10 "It is important to note that the ... purpose [of

11 the director of public health] and core role is the same

12 whatever the structures within which they sit across the

13 UK."

14 **A.** Yes, in Scotland, Wales and Northern Ireland, the DPH is

15 based in the health board or equivalent. In England,

16 it's based in local government.

17 **Q.** Thank you. And we'll come on to the devolved

18 administrations in just a moment and I'll ask you a bit

19 more about that.

20 Before we do that, can we look at paragraph 49

21 please. Here you set out more about the

22 responsibilities of directors of public health.

23 Just looking at the first four bullet points, you

24 talk about being responsible for: measurable health

25 improvement?

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1 I think what you say is that in England the directors

2 sit within the local government, and in Scotland and

3 Wales they sit within the NHS on the boards; is that

4 right?

5 **A.** And the same in Northern Ireland.

6 **Q.** Thank you very much.

7 And just in terms of the numbers of directors of

8 public health, are you able to assist us with how many

9 there are in total?

10 **A.** 175. I can do the proper count later and get back to

11 you. It's in that order.

12 **Q.** Thank you very much. I think you told us there's one in

13 Northern Ireland.

14 **A.** Yes.

15 **Q.** Are you able to assist us with how many, approximately,

16 are in Scotland?

17 **A.** One in every health board. I am slightly guessing now,

18 I'd say it's about ten, twelve. And one in every health

19 board in Wales, which I think is eight or nine.

20 **Q.** Thank you very much.

21 **A.** But if precise numbers are needed I can get those to

22 you.

23 **Q.** No problem at all, thank you very much.

24 And then in England I assume the remaining

25 numbers --

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1 **A.** Yes.

2 **Q.** Health protection including emergency response; public

3 health input to health and care service planning and

4 commissioning; and also the reduction of health

5 inequalities?

6 **A.** Yes, that's entirely correct.

7 Just one thing to clarify. Emergency response would

8 be with respect of a public health emergency, perhaps

9 not a major fire. That would be a different part of

10 local authority and obviously the fire service. So it's

11 the emergency response but it's particularly pertaining

12 to things that are classed as public health.

13 **Q.** Thank you very much indeed.

14 And also the next two bullet points, you talk about

15 being an independent advocate for the health of the

16 population, and also to be the person who elected

17 members and senior officials look to for expertise on

18 a range of public health issues such as outbreaks of

19 disease and emergency preparedness; is that correct?

20 **A.** Entirely true.

21 **Q.** Turning then to the devolved administrations, and you

22 began to touch on this just a moment ago and we don't

23 need to go to it but you deal with it at paragraph 52 of

24 your statement, and you talk about there being

25 a distinction between how the arrangements operate, and

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1 **A.** Yes, correct.

2 **Q.** -- would be in England? Thank you.

3 I wonder if you can help us with this, please: the

4 Inquiry heard evidence last week from Mr Hancock who was

5 asked about the capacity of directors of public health

6 to perform the role of contact tracing, and he said that

7 the capacity was wholly inadequate because, in the

8 context of England, there was one person in each of the

9 upper tier local authorities and therefore around

10 100 people. And my question is -- we'll come back to

11 capacity shortly, but in practical terms, is it just one

12 director of public health as the individual officeholder

13 or do they in fact work in bigger teams with shared

14 expertise?

15 **A.** So we have a team. I have about 30 or 40 people in my

16 team, and in the period of the pandemic they were fully

17 deployed on the pandemic and nothing else.

18 So it's not true to say DsPH were one-man bands or

19 one-woman bands. We have a team.

20 It's probably also true to say that we drew on the

21 capacity and capability of the whole of the local

22 authority, and we deployed them in contact tracing and

23 a range of other activities with regard to managing the

24 Covid pandemic.

25 **Q.** Thank you.

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1 And would that be the same across all of the  
 2 devolved administrations, that they would work within  
 3 teams as such?  
 4 **A.** Oh yes, yes. I don't know the detailed arrangements for  
 5 the Covid response at local government level in  
 6 Scotland, Wales and Northern Ireland, but in England  
 7 that's actually categoric -- categorically the case.  
 8 For the public health teams, ie, my direct team, yet all  
 9 of my oppos in Wales, Scotland and Northern Ireland will  
 10 have a them of people.  
 11 **Q.** Thank you. And turning then just exploring specifically  
 12 the relevant expertise that directors of public health  
 13 have in relation to a TTI system, can we go to  
 14 paragraph 84 of your statement, please.  
 15 It's page 19 over to 20.  
 16 You talk about:  
 17 "[Directors of public health] and their teams have  
 18 extensive knowledge of their communities and the wider  
 19 health and social care system. They have a critical  
 20 contribution to make in developing approaches that work  
 21 on the ground and in ensuring solutions are tailored to  
 22 the diversity of communities and the range of needs that  
 23 exist (from language to inequalities)."  
 24 How was this particular expertise relevant in the  
 25 context of a test, trace and isolate system, please?

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1 interventions."  
 2 Can you expand, please, on this particular paragraph  
 3 in the context of developing and operating a TTI system.  
 4 **A.** So we'd expect -- or I would expect all directors  
 5 of public health to be appropriately qualified and  
 6 competent. They should be either on the GMC or the  
 7 UK Public Health Register. Most of them have undergone  
 8 a formal public health training programme that lasts  
 9 five years, which includes all of those aspects of  
 10 training and competency development and more.  
 11 We'd expect all qualified public health specialists,  
 12 some of whom are directors of public health, some of  
 13 whom are consultants in public health, to meet the  
 14 faculties' public health training requirements, which is  
 15 set out in a very detailed curriculum which includes all  
 16 of those factors and more. Some of our teams will then  
 17 have further specialisms and have deep knowledge in  
 18 behaviour change. But we'd expect DsPH and their  
 19 immediate consultant team to be fairly competent  
 20 generalists across all of those -- all of those aspects.  
 21 **LADY HALLETT:** I couldn't ask you to slow down, Mr Fell,  
 22 could I? The poor stenographer has had quite a day.  
 23 **THE WITNESS:** Sorry, I had been warned, my Lady. Yes,  
 24 I will. Apologies.  
 25 **LADY HALLETT:** I share the same failings. I understand.

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1 **A.** So if we need to get testing rates high in response to  
 2 an outbreak in a particular part of a certain town, and  
 3 that happens to be multi-ethnic, deprived part of town,  
 4 there's no -- to be overly blunt, don't give me  
 5 a megaphone and tell me to stand on the steps of the  
 6 town hall, because I'm a middle-aged white bloke.  
 7 Work with and through community faith leaders, which --  
 8 you know, all of us will know who they are in our towns.  
 9 And that's how we get reach and trust in the message to  
 10 the places where it's needed.  
 11 That definitely can't be done adequately from  
 12 national perspective; it has to rely on local contacts,  
 13 local expertise and, importantly, trust.  
 14 That's in addition to all of the technical  
 15 competencies that you'd expect directors of public  
 16 health, importantly, and their teams to have.  
 17 **Q.** Thank you.  
 18 We're just coming on to the more technical  
 19 expertise. If we could look at paragraph 92, please, of  
 20 your statement. You talk in this paragraph about  
 21 directors being:  
 22 "... trained in containing infectious diseases, both  
 23 understanding and interpreting data, recognising risk  
 24 factors, understanding the evidence base and what  
 25 motivates behaviour change, and helping develop policy

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1 **MS ISLAM:** Thank you, my Lady.  
 2 Can we go to paragraph 93, please, where you talk  
 3 about another aspect of expertise, and it's in relation  
 4 to contact tracing and you say:  
 5 "Contact tracing is a tried and tested public health  
 6 intervention. [Directors of public health] -- and their  
 7 teams -- have experience and knowledge of contact  
 8 tracing, their local communities and the wider health  
 9 and social care system."  
 10 You talk about:  
 11 "Within local government, there [being] numerous  
 12 people with the skills -- from environmental health  
 13 officers to public health specialists and sexual health  
 14 staff -- to support the contact tracing efforts in  
 15 response to the coronavirus. However, the involvement  
 16 of local councils and DsPH in the Test and Trace service  
 17 was, in the beginning of the pandemic, fairly limited."  
 18 So would it be right to say -- we've looked at the  
 19 three elements, we've looked at the local community  
 20 expertise, we've looked at the containing infectious  
 21 disease and all those training requirements you've told  
 22 us about, and we've looked at contact tracing. It's  
 23 right to say that directors of public health had clearly  
 24 relevant and applicable expertise to TTI matters, would  
 25 you agree?

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1 A. My view is that's entirely fair. The important -- there  
2 is an important point, at the beginning of the pandemic  
3 was fairly limited. That did improve over the course of  
4 the pandemic. Our environmental health teams, that's  
5 what they do with regard to food-borne outbreaks. Our  
6 sexual health services, that's what they do with regard  
7 to containing sexually-transmitted infection outbreaks.  
8 And they're very, very, very good at it.

9 Q. Thank you. And we'll come on to that, we'll talk about  
10 the improvement and the timeline of that in due course.

11 I wanted just to ask you some questions, please,  
12 about the centralised approach, which is a topic you  
13 touch on quite a lot in your statement. And I'm going  
14 to invite you to offer observations on that approach and  
15 the extent to which directors of public health were  
16 engaged sort of initially and later on.

17 So we don't need to turn to it, but at paragraph 141  
18 of your statement you describe the structure of the test  
19 and trace system as opaque, and say it was unclear where  
20 responsibility lay for different functions.

21 Are you able to just expand on that, please?

22 A. Certainly earlier on the impression -- you know, my  
23 impression and the impression of lots of the directors  
24 of public health, as they've said to me, was that there  
25 was a predilection towards a central -- a centralised

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1 been more efficient to use existing local systems and  
2 support them with surge capacity as needed. This  
3 national centralised system didn't work optimally for  
4 these reasons and required local systems to mend the  
5 service and ensure the public was protected."

6 So I just want to ask you specifically, you talk  
7 about consultants having to spend time with public  
8 health officials and wider LA teams; can you just tell  
9 us a bit more about that specifically, please.

10 A. So my recollection, recollection of my colleagues, is  
11 that we all spent quite a lot of time explaining to the  
12 contractors of the day -- who did change from time to  
13 time, and not infrequently -- the situation on the  
14 ground, for me in Sheffield or for my colleague in  
15 Derbyshire or wherever. That took time and that took  
16 time for that person or that group of people to  
17 understand the local community organisations, what would  
18 and wouldn't fly, what would reach a community in  
19 a specific part of the country. And that would be  
20 different in different parts of the country, because  
21 these things are, by necessity, local. A huge amount of  
22 energy and effort was put into developing a trust with  
23 a local communities. The pandemic largely revolved  
24 around trust, actually.

25 So later on in the pandemic, when we had had stood

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1 system that's run nationally for the whole of the  
2 country, with very limited involvement in -- of local --  
3 local authorities, not just directors of public health  
4 but local authorities, in the execution of that service.

5 Again, my recollection is I was never sure who was  
6 accountable for the totality of what became NHS Test and  
7 Trace, certainly in the early days, and there seem many  
8 people accountable for different bits of it but we  
9 weren't clear who was the person who was actually  
10 accountable and pulled it all together, and it was quite  
11 difficult to have conversations in that context.

12 It's worth remembering the context at the time was  
13 a very, very, very fast-moving situation. And that is  
14 an important caveat.

15 Q. Thank you very much.

16 Just unpicking, please, some more of your  
17 observations around centralisation. If we could go to  
18 paragraph 143 at page 34 of your statement, please, you  
19 say here that:

20 "Money spent on private sector outsourcing was  
21 wasted since local public health teams already had both  
22 the knowledge and expertise of contact tracing and their  
23 local area. Consultants had to spend time with public  
24 health and wider LA teams in order to understand the  
25 local situation. The DsPH view is that it would have

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1 up, with resourcing from government, local contact  
2 tracing teams, we found that we were able to reach  
3 people quicker and close the case, ie, trace the  
4 contracts and ensure that we'd made sure that there was  
5 isolation support available. We were consistently able  
6 to do that much quicker than the national service.  
7 Which matters for disease transmission, obviously.

8 Q. Thank you. Then if we can please look at paragraph 102  
9 of your statement, which is at page 24 and over to 25.  
10 You talk about, in the early stages, there being  
11 a significant disconnect between how policy was formed  
12 nationally and how it was implemented on the ground.  
13 You describe a top-down approach by government that  
14 meant that directors of public health were sidelined in  
15 terms of national decision making and centrally run  
16 programmes, such as testing regimes, and you say there  
17 was an assumption that decisions could be made at  
18 a national level that would be suitable for all local  
19 areas and that proved costly as a one-size-fits-all  
20 approach was not effective.

21 Can you just explain, please, more about the  
22 one-size-fits-all approach and why that wasn't  
23 effective. You've touched on it but is there anything  
24 further you want to say about that?

25 A. Just to -- I mean, to elaborate for what would work in

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one part of -- I'll pick a town -- Wolverhampton, wouldn't work in another part of Wolverhampton because the conditions on the ground were different, the characteristics of the population are different and the types of networks that were needed to reach those populations with some trust and credibility would be different.

The same applies nationally. What will fly in Wolverhampton would be different to what will fly in Walsall, hence whilst it's not for directors of public health to be setting government policy, we aren't the government. That's not our job. It's not our job to be advising Government on Government policy because our responsibility is to local populations.

We consistently made the point that a one size fits all approach wouldn't be optimal by some stretch, and we will help the government execute the most effective policy on the ground, but that would need to be necessarily different in different parts of the country.

**Q.** Thank you very much.

You provide further detail throughout your statement about the practical consequences of the centralised approach. We can take that down now, thank you. I am just going to run through a few examples, we don't need to go to the statement itself but for example you say at

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if you wouldn't mind, trying to slow down a little bit, and don't worry, I suffer from the same issue but I think we're just trying to catch everything you're saying, Mr Fell, so I'd be very grateful. Thank you.

Just touching on another example that you give, at paragraph 175, you talk about, again, this top-down approach. There was an expectation that local agencies would make national decisions functional but without any consultation on those processes being developed.

What was the sort of consequences of that and what would the practical -- what difference would it have made had there have been consultation on those types of decisions?

**A.** It may not have made lots of difference to the actual implementation. It's not for local authorities or directors of public health to set national policy. Never was, never will be. But the -- it was an issue quite frequently that a change in the rules or the change in a process was made on an evening press release, evening press release or one of those evening press conferences that happen most days during the pandemic, that was when we first learnt of that. Local stakeholders would legitimately come to me to say, "Well, what does this mean, Greg?" And I would be expected to have an answer and if I'd heard at the same

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paragraph 123 that:

"DHSC, for example, did not have an up-to-date contact list for Directors of Public Health, which led to delayed or absent communication."

Is that right?

**A.** My recollection is that that is definitely true and was an issue on more than one occasion during the pandemic.

**Q.** Thank you. Another example you provide is that ambitious targets were set for testing but without a clearly communicated rationale for the programme overall, for example, there would be big testing venues such as stadiums but they would be inaccessible to certain communities, often the most vulnerable, which risked worsening pre-existing inequalities?

**A.** On a number of occasions, it wasn't clear what the strategy for a scaled-up approach to testing was and, obviously, if it happens -- if a testing site happens to be in a stadium that's some considerable distance from where a good proportion of the population live and they have low car ownership, they can't get there. So our experience is that local testing sites were much more accessible, particularly for low income populations where car ownership is much lower. If I can walk to it, I'm more likely to go to it.

**Q.** Thank you very much, I've been asked to ask you, please,

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time as everybody else, sometimes I didn't have the answer. So then we all spent some time working out the implications. That wasn't optimal.

**Q.** Thank you. Just looking at one last example at paragraph 145. Again, we don't need to go to it, but you talk about there being a concerning lack of public health expertise and advice at all levels, with a reliance on short-term secondments and consultants, and that this severely limited the opportunity to build and maintain constructive relationships, and you talk about stakeholder engagement being rushed and fragmented. What do you mean by stakeholder engagement? Who specifically are you talking about there?

**A.** An example is the one I've just given --

**Q.** Thank you.

**A.** -- is the learning of a significant change to the rules or significant change to the process on the daily press call. I learnt at the same time as everybody else but I have to be on point to explain that to councillors or the leader of the council or significant other stakeholders within Sheffield.

On the significant lack of public health expertise, it was a public health emergency. Public Health England, as was, a lot smaller than it once was, and local authorities were a lot smaller in terms of their

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public health trained capacity and capability than they once were. So we went into the pandemic with a smaller than optimal trained public health workforce to be responsible for managing what is -- what was a public health emergency.

**Q.** Thank you. I just want to touch briefly, please, on the reason for the limited engagement that you describe with directors of public health to begin with, and you touch on this at paragraph 91 of your statement. If we could turn to that, please, it's at page 21 and page 22.

What you say is this:

"The local public health system has been undervalued by successive governments, demonstrated particularly by lack of real term increases in England to the public health grant. The central Government response to the pandemic, and particularly the limited engagement with [directors of public health] in the early stages, reflects the historic lack of understanding of the importance of public health and the role of [directors of public health] in creating healthy populations and places. As [directors of public health] are responsible for their local population's health, they have information about rates of existing illness and disease, as well as a network of partnerships with individuals and organisations within communities that are ideally

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Government's austerity policy is that the public spend at local level is very, very much smaller than it once was. I think I've commented elsewhere in the brief that the spend in public health teams, both the team -- my direct team and the services I'm responsible for commissioning, is 25/26 per cent less than it was. We have less staff and there are -- there were consequences of that.

One thing that's not in there, that is a really important context in terms of the lack of engagement, which is -- let's take us back to the context of the time -- an awful lot of developments were happening very, very quickly and I have no doubt that was very difficult for the Government to coordinate and engage as well. That is in the mix there.

**Q.** Thank you. I just want to touch briefly on the historic lack of understanding point a little bit more. The Inquiry this morning heard evidence from Baroness Dido Harding and she was asked about the under-utilisation of directors of public health and she used the term "a Whitehall disease for central Government not to understand local government", and there being a local disease for local government not understanding central Government but, in her view, we needed both central Government and local government, essentially, to work

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placed to support planning and ensure that advice is delivered in the right way to the right people."

Can you tell us a bit more about what you consider to be the historic lack of understanding of the importance of public health and the role of directors of public health, please.

**A.** There's a few thoughts I'd have. I'd still stand by that. I think every DPH in the country would still stand by that. A few thoughts. It's harder to maintain an infrastructure when you can't see and count the benefits of what you do. No one can count the measles outbreak that don't happen. No one can count the meningitis outbreak that was closed down really quickly. That's the art of prevention. So it's hard to demonstrate that you've got value in that context because success is nothing happens, which quite hard when government understandably has significant resource constraints.

Also, I guess, public health workforces, soft "C", competing with the NHS, that treats people and, historically, a significant proportion of resource has given to treating people, not preventing illness in the first place, and that is a thing that's in the mix.

And third, the third thing that's worth saying in that context is that the consequences of the previous

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together and I wondered if you had any observations on that particular view?

**A.** I would concur entirely with Baroness Harding. I will talk unrelentingly about local level response, that's my job, that's what I'm responsible for, as are my colleagues. The optimal is the right balance of local and national. Local can get to places with more grip, faster and with credibility, that national simply can't. But, equally, there is a role for national -- finding the right balance is difficult. I would also agree with the Baroness Harding that there's a longstanding culture of national not understanding local, witnessed by the "directors of public health are one-person teams". We're clearly not one-person teams. So -- but that does cut both ways. And some of that improved during the course of the pandemic specifically in this context, actually, as well. That's an important lesson for the future.

**Q.** Thank you. You touched on resources in one of your most recent answers and I just wanted to ask you if you could help us with this: so given the issues with resourcing and you touch on it in your statement, in your view, were the directors of public health still best placed to be engaged in the response in the ways that you've outlined and did they have the capacity to do so in real

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1 terms?

2 **A.** No, not at the start of -- not at the start of the  
3 pandemic, and it's worth saying that we -- it's  
4 an untested question, we'll never know the answer, but  
5 many of us would contend that we could have scaled up  
6 really very quickly because remember, it's not just my  
7 team or my colleagues' team, the resources of the whole  
8 of the local authority were largely available to us.

9 So we quickly repurposed call-handling capacity that  
10 we used for handling a range of other things that come  
11 into a local authority, to be, in effect, the contact  
12 tracing team, so we could have scaled it up very, very  
13 quickly, and we'll never know whether we could because  
14 obviously that chance has gone.

15 **Q.** Thank you. Just on this same theme, please, I'd like to  
16 take you to the witness statement of Professor Deenan  
17 Pillay, who the Inquiry is going to hear from later in  
18 the week. It's Inquiry reference ending 5152,  
19 paragraph 31, please. It's quite a lengthy bit of text.  
20 I'm not going to read it all out but, in essence, it  
21 talks about it being true that local authority capacity  
22 for public health has been reduced but, nevertheless, it  
23 seemed obvious that local public health structures were  
24 ideally placed to receive further investment to grow  
25 contact tracing and isolation support for the population

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1 within diverse populations over the telephone."

2 He talks about this not being joined up with the  
3 identification of particular risk individuals or  
4 communities. The advice on isolation was generic and  
5 one-dimensional. There seemed to be little  
6 understanding of the specific pressures people were  
7 experiencing, for example supporting people in isolation  
8 from multi-generational households, high risk  
9 individuals, those without private outdoor spaces, those  
10 on zero-hour contracts and, in his view, these  
11 challenges remained unevaluated without solutions being  
12 sought.

13 His view is that delegating such tasks to local  
14 health protection teams would ensure a more sensitive  
15 and responsive and indeed effective outcome; do you  
16 agree with that analysis?

17 **A.** I can't comment on the SERCO aspects because I wasn't  
18 there.

19 **Q.** Thank you.

20 **A.** I wasn't involved with that operationally. It would be  
21 fair to say that we developed local contact tracing  
22 services within each of the local authorities,  
23 certainly. That was with call centre staff who weren't  
24 trained. We were responsible for making sure they were  
25 trained and appropriately supervised, and I'm assuming

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1 they serviced, since this would not only build on  
2 existing expertise but also be best placed to understand  
3 local drivers of the pandemic and how best to mitigate  
4 these risks.

5 So just pausing there, do you agree with that  
6 analysis?

7 **A.** Agree entirely. It's worth saying that the shift of  
8 local level capacity for public health to the Health  
9 Protection Agency in 2007 and then to PHE in 2012, in  
10 effect, that was the local-level capacity, some of the  
11 boots on the ground capacity, PHE fulfil that for us in  
12 peacetime perfectly well. That was the deal that was  
13 struck and, as I've said, we have local level capacity  
14 and capability for contact tracing in environmental  
15 health and sexual health services, all the time. That's  
16 what they do.

17 We have those key capabilities, we could have scaled  
18 up the capacity by use of furloughed and other staff  
19 within local authorities but we weren't given the chance  
20 early enough.

21 **Q.** Thank you. Just continuing with this paragraph, please.  
22 Professor Pillay says:

23 "By contrast, SERCO were contracted to undertake the  
24 Covid contact tracing function ... with underskilled  
25 staff tasked with dealing with the heterogeneous risk

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1 that some of that happen with SERCO, I can't comment on  
2 the quality of that because I wasn't there. It's mine  
3 and my colleagues' recollection that there was perhaps  
4 an overemphasis on the process of identifying the  
5 individual with the positive test, phoning her or him up  
6 and chasing down their contacts but not understanding  
7 the context and life circumstances that people were in,  
8 which clearly mattered to his or her ability to isolate.

9 Again, local trust in local stakeholders mattered.  
10 We had lots and lots of anecdotal experience that local  
11 accents really mattered in terms of developing that  
12 trust.

13 **Q.** Thank you very much, I'm going to move on to a new topic  
14 now and it's the topic of data and, again, the Inquiry  
15 has heard quite a lot of evidence about data and  
16 challenges around data flows from the sort of central  
17 level to the local level. You touch on this in your  
18 statement and, essentially, what you say, for example,  
19 at paragraph 152 -- we don't need to go to it -- is that  
20 national bodies were slow to provide local authorities  
21 with data, this caused significant problems, for example  
22 directors of public health struggled to get information  
23 on positive cases in their area, which meant that  
24 sometimes you were learning about cases via the media  
25 and left on the back foot.

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1 Is there anything further you want to say about  
 2 that?  
 3 **A.** It was unusual that we'd have learnt about cases from  
 4 the media, except in the very, very, very, very early  
 5 days, where there were a handful of cases. But it is  
 6 fair to say that it did take too long for directors of  
 7 public health and their teams -- let's be clear -- to  
 8 have executable identifiable data that we could then  
 9 direct to local operational response and that's  
 10 a critical piece of learning for the next pandemic. It  
 11 was four/five months into the pandemic. It was the  
 12 worst public health emergency ever, the worst national  
 13 emergency since World War II, that I had executable  
 14 identifiable data that I could direct an operational  
 15 response. We can do better; it's a key piece of  
 16 learning for me.  
 17 **Q.** Thank you. We'll come back to the timeline on when the  
 18 data improved in just a moment but I just want to touch  
 19 on something you say in paragraph 153, which is:  
 20 "In general, data sharing from PHE to local  
 21 authorities worked better when existing systems and  
 22 processes were used, as opposed to new arrangements  
 23 which would often create data flow issues."  
 24 Just on that, and this idea of using existing  
 25 systems versus new systems, the Inquiry heard evidence

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1 **A.** I think I remember that table, however.  
 2 **Q.** Yeah, that one's the care home. We want the one before.  
 3 Yes, "Test and Trace", thank you very much.  
 4 So I think you've seen this, Mr Fell, so just so we  
 5 can see what we're looking at, on the left-hand side,  
 6 the first column is "Who is asking?" We can see the  
 7 directors of public health are listed in every row.  
 8 The next column is "What do they need?" We can see  
 9 the different types of data categories that are being  
 10 requested here, for example tests and positive cases,  
 11 testing performance, demographic breakdown, contact  
 12 tracing information, and so on.  
 13 The third column is "Why do they need it?" We'll  
 14 come back to that.  
 15 Then the last column deals with "Does it exist?" We  
 16 can see that in three of those rows it does exist,  
 17 subject to some of those caveats and in two of those  
 18 rose it didn't currently exist at the time of this  
 19 document.  
 20 So I just want to look at, please, in further detail  
 21 the "Why do they need it?" column, so by way of example,  
 22 if we could look at the one dealing with demographic  
 23 breakdown, please, it's the one just from the bottom,  
 24 you can see it in front of you.  
 25 **A.** Yes.

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1 from Mr Cook on behalf of Deloitte and, in his evidence,  
 2 he talked about the development of a new system called  
 3 OMIP, which was designed to be a single source of truth,  
 4 he said, of data with testing activity, results by  
 5 locations and regions, and he said that the DHSC was  
 6 provided that and some local authorities that access to  
 7 that platform; were you aware of that platform?  
 8 **A.** Not unless it was also referred to by another name but  
 9 I don't recall OMIP, it sounds quite useful.  
 10 **Q.** Thank you. Turning then, please, to another document.  
 11 It's Inquiry reference INQ000104738. If we could go to  
 12 page 1 of that document and, just to contextualise what  
 13 this document is, you've had it by way of your witness  
 14 preparation?  
 15 **A.** Yes.  
 16 **Q.** It's an advice memo -- it's MHCLG document. We explored  
 17 it with Mr Garton from the MHCLG, when he gave his  
 18 evidence and, as we know, the MHCLG is a conduit between  
 19 central Government and local government. In summary,  
 20 what this document is is summarising essentially that  
 21 there are data requests from the local level and that  
 22 there are some ongoing issues.  
 23 Can I take you first to page 5 specifically of this  
 24 document. What you should see in front of you, it's  
 25 just the page before that one, sorry.

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1 **Q.** Then the one to the right of that talks about that was  
 2 needed to understand coverage of different communities  
 3 and sectors of society to target policy change and  
 4 engagement activities. We can see in the last column  
 5 that it wasn't currently available, although there were  
 6 figures provided for mortality and cases.  
 7 So, in your view, what were the implications in this  
 8 type of data not being available at this stage when it  
 9 came to trying to develop interventions for particular  
 10 communities?  
 11 **A.** To immediately spring to mind, one is inability to  
 12 direct mobile testing sites and to get people to mobile  
 13 testing sites in a specific community particularly  
 14 affect, and there were times when there were very, very  
 15 small numbers of people affected, and there were times  
 16 when obviously that was much bigger. And the second is  
 17 the ability to direct local comms, either comms via me  
 18 and my team, or often, more importantly, working with  
 19 and through voluntary and community sector stakeholders  
 20 or faith leaders who, again, can get to communities with  
 21 much more reach and grip and trust than I possibly  
 22 could.  
 23 The ability to have really granular data enables us,  
 24 or not having it doesn't enable us, to direct some of  
 25 our interventions very precisely in a targeted way.

200

1 Q. Thank you very much. Just looking at a few more of  
 2 these in this particular column in detail, "Why do they  
 3 need it?" So for example, details of tests and positive  
 4 cases in row one, "Why do they need it":  
 5 "To understand who is being tested and the specific  
 6 hotspots ..."  
 7 The next category, it's channel turnout rates are  
 8 needed to understand how well utilised testing centres  
 9 are in different locations to better direct resources.  
 10 We've looked at the demographic breakdown one but,  
 11 you know, so on and so forth, but the point is, it's  
 12 right to say that -- and can you confirm it for me,  
 13 please -- that these categories of data that you didn't  
 14 have at this point were crucial to your work on the  
 15 ground?  
 16 A. Yeah.  
 17 Q. Is that fair?  
 18 A. Not having them, we carried on doing the work we did but  
 19 with less granularity, less specificity and less ability  
 20 to precisely target. There were undoubtedly many more  
 21 iterations of the "Why we need specific data" lines that  
 22 aren't captured here. I'm sure could remember them if  
 23 needs be, but we asked, and asked, and asked many times.  
 24 I must say, credit to Public Health England teams who  
 25 eventually built the data platform to enable us to have  
 201

1 Q. Thank you. If we could look at briefly paragraph 59 of  
 2 the same statement, in this paragraph Ms Killian talks  
 3 about local authorities being excluded from the design  
 4 of a data collection form which captured the information  
 5 needed to act on a test result and, as a result, the  
 6 forms are poorly designed for operational use. Can you  
 7 help us, please, with what exactly these data collection  
 8 forms were and how they were intended to be used  
 9 locally?  
 10 A. I'm not sure I can, actually. I can't remember the  
 11 specifics of what was on the data collection forms.  
 12 My -- I've a vague recollection of being unhappy about  
 13 being excluded from that, and certainly those who were  
 14 very operationally involved were of the view that many  
 15 fields should have been collected that weren't  
 16 collected, but I can't actually remember, I'm sorry, the  
 17 specifics of what were collected on the form.  
 18 Q. That's fine, thank you very much.  
 19 And paragraph 62 -- and again, just briefly, she  
 20 talks about there being a general reluctance by  
 21 government to routinely share individual test and trace  
 22 data with local councils. And as a result, in her view,  
 23 she says:  
 24 "... valuable time and effort was expended by local  
 25 directors of public health in trying to access data that  
 203

1 the access. It did change the nature of our response  
 2 quite markedly.  
 3 Q. Just touching on that, then: in your view, when did that  
 4 become available to you?  
 5 A. I think it was May, June, July 2020-ish. I'm afraid  
 6 I can't remember the exact dates but it was four or five  
 7 months into the pandemic.  
 8 Q. Okay. I want to take you, please, to the statement of  
 9 Joanna Killian from the Local Government Association  
 10 and, again, you've had this statement in your pack and  
 11 you've already told us you had a close working  
 12 relationship with the LGA. I'm just going to take you,  
 13 please, to paragraph 52 of her statement. I'm not going  
 14 to read it all but, essentially, what she says in her  
 15 statement is that:  
 16 "The lack of individual level data on Covid-19 cases  
 17 being shared with [directors of public health] at the  
 18 outset made it impossible to support those affected and  
 19 to control outbreaks."  
 20 It goes on to say that:  
 21 "The LGA repeatedly requested this data ..."  
 22 Does that sort of accord with your experience? We  
 23 touched on it.  
 24 A. Yes, I know the LGA did, I know ADPH did, and many  
 25 others did individually, as well.  
 202

1 would enable them to respond better ..."  
 2 Do you agree that there was a general reluctance to  
 3 routinely share data?  
 4 A. Yes, for a number of reasons, one of which was a fear of  
 5 breach of confidentiality, which is -- a true fear and  
 6 should treat seriously, during the course of the  
 7 pandemic, when we eventually had access to identifiable  
 8 data about who was being tested, what test results --  
 9 what test results were, ie, the -- we could map  
 10 epidemiological trends, we doubtless -- each authority  
 11 doubtless handled many, many millions of lines of data.  
 12 I don't think there was a single data breach in the  
 13 course of the whole pandemic. We can be trusted with  
 14 this data and we know what we're doing with it.  
 15 Q. Thank you very much.  
 16 I just want to touch briefly on the sort of timeline  
 17 of when the data improved. Now, Mr Garton, from the  
 18 MHCLG, who I've mentioned, in his evidence suggested  
 19 that the issues were essentially resolved by the end of  
 20 July. But reflecting on Ms Killian's statement, and we  
 21 don't need to go to it, but she deals with it between  
 22 paragraphs 65 and 69, seems to suggest that issues  
 23 persisted well beyond July.  
 24 And I just wanted to put a series of propositions  
 25 that she talks about, and ask you whether you agree.  
 204

1 The first one is that she says, despite the LGA  
 2 requesting data on 29 July, it was not made available  
 3 until some months later. And I think you've said four,  
 4 five months onwards. So does that sound --

5 **A.** That's my recollection, yes. I can't remember the date  
 6 of the big reveal where we actually got the executable  
 7 and identifiable data, but from memory it was four to  
 8 five months at least.

9 **Q.** Thank you.

10 She talks about poor quality data even when it was  
 11 eventually shared. She says even by December 2020, data  
 12 was poor quality, missing, or incomplete, for example  
 13 lack of URPNs.

14 Does that accord with your experience?

15 **A.** Yes, but -- and it did improve over time. As is the  
 16 case with new datasets, new data collections, often it  
 17 is poor quality. In this case it was about Covid  
 18 testing, but it did improve over time.

19 **Q.** Thank you.

20 She also reflects on issues with access and sharing,  
 21 saying that when it did begin to flow -- and she says it  
 22 was about ten weeks later after the request -- and  
 23 you've touched on this -- access was hampered by  
 24 multiple data sharing agreements and access protocols?

25 **A.** I can remember them only too well. We shouldn't --  
 205

1 **A.** That was an issue in mid to late summer 2020. It did  
 2 improve. It did improve over time.

3 And again, credit to those people who made it  
 4 improve, because it didn't happen by magic, it happened  
 5 because people eventually listened to our feedback from  
 6 the front line, so to speak.

7 **Q.** Thank you very much. I'd like to move on to a different  
 8 topic now please and this is dealing with essentially  
 9 when the local level became more involved, and in  
 10 particular in relation to local contact tracing  
 11 partnerships, I believe they're referred to.

12 If we could look at paragraph 97 of your statement,  
 13 please. It's at page 23.

14 Thank you.

15 In this paragraph you talk about:

16 "Data demonstrated that local Test and Trace systems  
 17 helped increase the uptake ..."

18 You give examples of Sandwell and Blackburn as being  
 19 positive examples. Could you elaborate on those  
 20 examples and particularly why this was a more effective  
 21 model.

22 **A.** As I said earlier, this isn't about either national or  
 23 local; this is about a blend of both. And early in the  
 24 pandemic we had single -- a single national approach,  
 25 which wasn't optimal in terms of the speed by which  
 207

1 again, a hindsight and learning point: there should be  
 2 a single data sharing agreement and a single data  
 3 sharing protocol that should be generic across the whole  
 4 of the country. But there were multiple.

5 **Q.** Thank you.

6 She talks about another issue, that councils were  
 7 required to nominate a single named person?

8 **A.** Yes.

9 **Q.** And they were given access, which would delay things?

10 **A.** From memory, I think for Sheffield I was the single  
 11 named person. My team needed the data, because there's  
 12 no point it just resting with me. Again, it goes back  
 13 to the proposition that the director of public health  
 14 was a sole actor. I was acting on behalf of an  
 15 institution, the right people within the institution  
 16 needed access to the data; so a single named person  
 17 wasn't a good solution.

18 **Q.** Thank you.

19 And another issue she talks about is the fact that  
 20 data was fragmented across multiple platforms with  
 21 different rules, log-ins and access rights, and it meant  
 22 that data was on different dashboards and dashboards  
 23 didn't allow for the downloading of data which posed  
 24 problems.

25 Does that accord with your experience?  
 206

1 cases were completed, ie, the contact -- the case was  
 2 identified and called and the contacts were found, and  
 3 the case and contacts were -- the appropriate  
 4 interventions were in place.

5 Sandwell and Blackburn were typical examples of lots  
 6 of places that had local contact tracing teams that were  
 7 largely run by directors of public health or their  
 8 teams, more to the point, using local authority  
 9 employees quite often, often with close connection and  
 10 collaboration with voluntary and community sector  
 11 organisations that can really get into specific  
 12 communities.

13 Two things, the intelligence I received and lots of  
 14 people -- the directors of public health also received,  
 15 the two things really mattered: local numbers, because  
 16 people have more trust in local numbers; and secondly,  
 17 local voices. I've still never quite got underneath why  
 18 the local voices thing mattered, but that was  
 19 a consistent piece of feedback throughout the whole  
 20 course of the pandemic.

21 My experience, I think the data would back me up on  
 22 this, is that when we had properly and fully established  
 23 local contact tracing services, we could complete cases,  
 24 ie find the case, find the contacts, and do the  
 25 appropriate interventions, much more quickly, and with  
 208

1 the much more depth than a single national approach.

2 **Q.** Thank you very much indeed.

3 And just on that theme, can we turn to another  
4 document, please.

5 It's Inquiry reference ending 5177. If we could go  
6 to page 2 of that, please, it's an article by  
7 Adam Briggs, in the BMJ, talking about the role of local  
8 contact tracing.

9 And if we could highlight, please, sort of the --  
10 that section there, thank you very much indeed.

11 I'm not going to read it all but it touches on some  
12 of what you've talked about, so, for example:

13 "Some of the cases missed by the national team don't  
14 want to be reached and may never engage. Some will have  
15 incorrect contact information and some will not have  
16 noticed the call coming through. But others will be  
17 vulnerable, socially isolated, digitally deprived,  
18 transient or economically worse off ... It's here where  
19 local systems can really make a difference."

20 And it goes on to say that local teams were more  
21 successful at reaching those cases compared to the  
22 national team, because they can:

23 "... draw on local databases to update missing  
24 contact details. Having a local phone number appeared  
25 to help, as does having local call handlers ..."

209

1 your team, directors of public health, have specifically  
2 in relation to supporting self-isolation?

3 **A.** So we administered the system whereby for those cases  
4 that -- for those -- those people that were asked to  
5 self-isolate for whatever day it was, it started 14, it  
6 became 10, I think it became shorter later on in the  
7 pandemic, that we administered the isolation payment and  
8 got it into bank accounts as quickly as humanly  
9 possible, and did a broader wraparound support, food,  
10 medicine, other essential supplies.

11 **Q.** Thank you.

12 And do you, on behalf of, sort of, the ADPH, have  
13 any views about the adequacy of self-isolation payments?

14 **A.** It wasn't enough. That was broadly accepted by many  
15 people -- by many stakeholders. And many, including  
16 ADPH, drew that to the attention of government on  
17 a number of occasions.

18 It was particularly problematic if I am on  
19 a zero hours contract or am self-employed, because there  
20 isn't any sick pay at all. And from memory it was £500  
21 for the period. It may not have covered rent, food,  
22 feeding the kids, important things of that ilk. So  
23 I don't think it was not enough. And many at ADPH felt  
24 the same.

25 **Q.** Thank you.

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1 A local population can speak the right languages,  
2 et cetera. The capacity to visit people at home, and  
3 a heavy emphasis on being able to provide support around  
4 isolation.

5 In summary, do you sort of agree with that analysis  
6 as to why the local model was more effective?

7 **A.** Yes, entirely, I agree with Adam's article. I'll draw  
8 your attention to some of my earlier comments. Language  
9 mattered, obviously local dialects clearly matters, as  
10 I've said. Non-English -- non-English language  
11 speakers, we non-English language speakers in many of  
12 our contact tracing teams and drew on those.

13 And as you say, the ability to draw on the local  
14 databases, the council tax system, was an incredibly  
15 effective tool to fill missing fields that weren't  
16 available and thus enable us to reach a case or one of  
17 their contacts.

18 The other thing it's important to say is that the  
19 ability to quickly administer the isolation payment but  
20 also the wraparound welfare support, that can only be  
21 really administered locally.

22 **Q.** Thank you.

23 And that brings me on to the next topic, of  
24 self-isolation, which you've just touched on.

25 Can you just tell us briefly what role did, sort of,  
210

1 And do you have any views about whether the adequacy  
2 of what you've just described and barriers to isolation  
3 more generally have contributed to disproportionate  
4 outcomes for those from vulnerable and marginalised  
5 groups?

6 **A.** Undoubtedly. Transmission patterns followed  
7 occupational profiles. I could work from home, but folk  
8 that work in a warehouse, folk that drive taxis, folk  
9 that work in transport, can't work from home, therefore  
10 there's more occupational exposure.

11 I've got a spare bedroom. Maybe I can self-isolate  
12 in my spare bedroom. But if I'm in a very, very crowded  
13 house, I can't.

14 So all of that will have contributed to propagating  
15 chains of transmission.

16 If you add then onto that poorer baseline health,  
17 those in poorer health were much more likely to be  
18 severely affected by Covid infection, that will have  
19 made the difference to the eventual outcomes.  
20 Covid wasn't an equal opportunities disease.

21 **Q.** Thank you.

22 Touching briefly on something you describe at  
23 paragraph 85 of your statement, we don't need to go to  
24 it but you talk about a public health principle of  
25 proportionate universalism which requires that action be  
212

1 universal but with a scale and intensity that is  
2 proportionate to the level of disadvantage, and you note  
3 that universal action, if not tailored, can widen health  
4 inequality.

5 Would you mind just elaborating on that in the  
6 context of the TTI programme, please.

7 **A.** So if I'm running a universal service, it's the same  
8 service for the whole of the given population.

9 I'll pick my population in Sheffield because it's  
10 easy. There's a fair likelihood, and experience backs  
11 this up in policy area after policy area, that I would  
12 find it easier to reach those in the more affluent parts  
13 of my city, Sheffield, and that population would find it  
14 easier to self-isolate because of larger houses with  
15 spare bedrooms and less occupational exposure because of  
16 the nature of occupations people can work from home.

17 Therefore, by having a single universal service,  
18 I can almost exacerbate inequalities by rote of who does  
19 and who doesn't or are more likely to take up a single  
20 universal service, hence the proportionate nature:  
21 I need to offer a different model and a different  
22 service for those with greatest need or -- and more  
23 vulnerability. Does that help articulate?

24 **Q.** It does. Thank you very much indeed.

25 Turning then, please, to lessons learned and  
213

1 should be default setting, consistent access, providing  
2 quality, timely access, and ensuring that data is  
3 usable. So the format of data which we've talked about.

4 Was there anything further you wanted to expand upon  
5 in terms of that as a lesson to be learned, please?

6 **A.** Not much. I'd still stand by that. There are two other  
7 things that are probably worth saying at this point --  
8 three other things.

9 One, this is something that can be sorted in  
10 peacetime. There will be another pandemic, we need to  
11 sort this in peacetime because we can't go into another  
12 pandemic where it takes four, five months to get  
13 executable data.

14 My second point is, building on that, there's  
15 something about the technical capability in building the  
16 right data systems to enable that. Now, that can be  
17 done now, and I hope is being done. I don't know  
18 whether it's being done.

19 And the third point is about risk appetite. My  
20 experience is that data sharing or lack of it isn't  
21 really about the technical ability to share data; it's  
22 about risk appetite. There is a risk of a breach of  
23 confidentiality, which is a bona fide risk and needs to  
24 be managed carefully and appropriately, but equally  
25 there's a bona fide risk of not sharing data, as we  
215

1 recommendations for the future. If we can very briefly  
2 display, please, paragraph 108 of your statement  
3 page 26, again here you display statement of principles  
4 for contact tracing and you list some bullet points as  
5 to what you consider would create a framework for an  
6 effective system looking forward.

7 So you've listed: whole system approach,  
8 subsidiarity, localism, minimum viable products,  
9 avoiding duplication, integration, responsiveness, data  
10 sharing, capacity and resources, proper recognition of  
11 multiple local roles and ownership.

12 Is there anything you want to expand upon in terms  
13 of this framework for lessons to be learned?

14 **A.** I don't think so. I broadly stand by it. Sometimes  
15 there may be the devil in the detail but there's  
16 a high-level statement of principles, I think I'd still  
17 stand by that.

18 **Q.** Thank you very much indeed.

19 And can we briefly please go to paragraph 139 of  
20 your statement. Here you summarise the ADPH data  
21 explainer:

22 "... key recommendations for more effective data  
23 sharing ..."

24 And again, you've touched on this, but essentially:  
25 sharing local data with directors of public health  
214

1 learned to our cost.

2 **Q.** Thank you very much indeed.

3 If I could turn, please, to another document, ending  
4 4857, starting at page 1.

5 You've seen this as part of your evidence prep for  
6 today, it's a report from Independent SAGE titled  
7 "A blueprint to achieve an excellent Find, Test, Trace,  
8 Isolate and Support system", and the Inquiry has looked  
9 at this with other witnesses.

10 If we could turn, please, to page 2 very briefly,  
11 bullet point 1, under "Summary of blueprint":

12 "Independent SAGE [talks about calling] for the  
13 replacement of the failed, falsely named and private  
14 sector run 'NHS' Test and Trace with a system for  
15 England which is rooted in the regions of England and in  
16 local areas. It must be integrated throughout with the  
17 [NHS] and provide for the needs of people and the  
18 communities in which they live."

19 Do you agree with that sort of proposition?

20 **A.** Broadly. I wouldn't comment on the failed and falsely  
21 named private sector, that's a political call, that's  
22 and not for me to make, but we can have the basics of  
23 a scalable testing and tracing system for a future  
24 pandemic.

25 A future pandemic may have more or less of  
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1 a requirement for testing and tracing depending on the  
 2 nature of the illness, the virus or the bacteria, and  
 3 its characteristics, but it's fairly likely that we will  
 4 need some form of capability and capacity which we  
 5 already have at local level and, to a large extent,  
 6 already exists within the health protection -- sorry,  
 7 the UK Health Security Agency regional teams as well.  
 8 They are very competent in such matters, and do that for  
 9 outbreaks that have happened since the Covid pandemic as  
 10 well.

11 **LADY HALLETT:** Can I ask -- sorry to interrupt -- do you  
 12 agree it should be integrated throughout the National  
 13 Health Service?

14 **A.** The anchorage to place these matters, yeah -- I'm not  
 15 a part of the National Health Service. I'm an employee  
 16 of the local government. I'm not wedded to the fact  
 17 that it should be part of the National Health Service or  
 18 not. It should be anchored to places and, if I'm  
 19 responsible for it, preferably with some links to me and  
 20 my team and the capabilities that exist within local  
 21 government, because, again, it isn't a me and my team  
 22 thing, this a corporate responsibility or a corporate  
 23 capability.

24 **MS ISLAM:** Thank you.

25 And can be turn to bullet point 3, please, on the  
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1 We can take that down now.  
 2 In your witness statement -- we don't need to go to  
 3 it, but it's at paragraph 202 -- you talk about TTI  
 4 systems should be designed and delivered by teams that  
 5 have a thorough understanding of vulnerabilities and  
 6 inequalities, and you've talked about that in quite  
 7 a lot of detail.

8 Are there any changes that you would recommend to  
 9 ensure that those principles are implemented in future  
 10 public health responses?

11 **A.** Probably not changes. It's just, I suppose, however we  
 12 do the design, wherever we do the design, clearly there  
 13 are some process issues that need to be attended to in  
 14 running a test, trace and isolate system.

15 One of the weaknesses of the system that we had was  
 16 it tended to focus on the process, the completion,  
 17 rather than the complexity of someone's lives.

18 People weren't able to afford to isolate for  
 19 ten days because they have to feed their kids, and if  
 20 they're on a zero hours contract they've still got to  
 21 feed their kids. So the understanding of how test,  
 22 trace and isolate plays out in a context of the complex  
 23 lives people have, is -- I'm not sure how we develop  
 24 that as a design principle but it does matter.

25 **Q.** Thank you.

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1 same page. It talks about:

2 "In each top-tier local authority, the Director  
 3 of Public Health should have the leadership role and  
 4 convene the necessary management structure in  
 5 conjunction with the local NHS and local authority."

6 Do you agree that it should be the director  
 7 of public health that has that sort of leadership role?

8 **A.** If it's a public health emergency, then yes, it probably  
 9 ought to be somebody qualified and capable in public  
 10 health.

11 **Q.** Thank you. And if we can turn over the page very  
 12 briefly, please, looking at the "New organisational  
 13 principles", number 1 talks about operating at as local  
 14 a level as possible, building community solidarity,  
 15 which would encourage individuals to come forward for  
 16 testing, utilisation of local civil society  
 17 organisations, especially those from deprived and  
 18 minority ethnic populations.

19 Do you agree with that sort of proposition?

20 **A.** I 100% agree. The role of voluntary and community  
 21 sector organisations, faith organisations, was wholly  
 22 unsung during the course of the pandemic and after the  
 23 pandemic. It was absolutely critical to get to places  
 24 with credibility that, bluntly, I couldn't have got to.

25 **Q.** Thank you very much.

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1 And in your view, should directors of public health  
 2 be given a more formal role in national-level emergency  
 3 planning and testing infrastructure design to ensure  
 4 that these types of issues are accounted for from the  
 5 outset?

6 **A.** Possibly. Worth remembering that directors of public  
 7 health, they're responsible for local authority or  
 8 health board populations, not national. So a voice and  
 9 a perspective rather than a responsibility. I'll  
 10 happily accept a responsibility but I'm responsible for  
 11 the population of Sheffield. That's the day job. So  
 12 there's something about making sure the voices heard  
 13 rather than becoming -- directors of public health and  
 14 their teams becoming the national public health agency.  
 15 We aren't.

16 So there's a nuance in there that needs to be  
 17 thought through.

18 **Q.** Thank you very much. The last question from me Mr Fell:  
 19 you deal with lessons learnt and recommendations at  
 20 length in your statement between 189 and 207 and we've  
 21 covered those themes, communication and data sharing,  
 22 poor recognition of the role of directors of public  
 23 health, a disconnect between the national and local  
 24 vulnerabilities and public health capacity resources and  
 25 funding, but was there anything else that you want to

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1 say at this juncture in terms of any lessons to be  
 2 learnt for the future or any recommendations for my Lady  
 3 to consider?

4 **A.** Two. One is we mustn't neglect regional teams in this.  
 5 We've talked local and we've talked national at some  
 6 length but there was regional coordination here as well,  
 7 so we should make sure that we consider multiple levels  
 8 of geography.

9 And the second addition is scope of planning and  
 10 response. Going into the pandemic, Covid was seen as  
 11 a public health issue, therefore public health  
 12 professionals should respond. It was blatantly apparent  
 13 very, very quickly that a whole of society response was  
 14 needed and was eventually what was put into place. The  
 15 next pandemic may be the same. The previous pandemic  
 16 was a swine flu pandemic, it wasn't as severe, it didn't  
 17 require a whole of society response. The next one may  
 18 or may not but we should plan accordingly because we  
 19 learned the hard way that Covid -- this pandemic was  
 20 definitely a whole of society thing, so we should plan  
 21 an exercise accordingly.

22 **MS ISLAM:** Mr Fell, thank you very much for your assistance.  
 23 **THE WITNESS:** Thank you.

24 **MS ISLAM:** My Lady, those are my questions.

25 **LADY HALLETT:** Thank you very much indeed, Mr Fell. That  
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1 completes the questions that we have for you. Thank you  
 2 for your contribution, they've been extremely helpful  
 3 and thank you to you and to all your colleagues around  
 4 the country working -- or leading public health teams,  
 5 for all the support and attempted protection that you  
 6 gave to all your communities. So thank you very much  
 7 indeed.

8 **THE WITNESS:** Thanks, my Lady. I shall pass that on.

9 **LADY HALLETT:** Very well. 10.00 tomorrow.  
 10 **(4.29 pm)**  
 11 **(The hearing adjourned until 10.00 am the following day)**  
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85/6 85/7 85/16 86/16 87/20 88/22 89/24 90/9 91/11 91/23 92/15 95/4 95/20 96/4 96/11 96/18 96/20 96/24 97/9 97/13 97/19</p>	<p>98/23 99/7 103/6 103/14 105/1 117/20 121/6 147/6 159/3 164/20 168/23 170/5 170/21 171/5 171/9 171/13 171/16 171/18 172/7 172/9 172/12 173/7 173/14 174/1 174/6 175/14 176/1 177/4 177/4 179/23 198/15 199/3 199/25 202/24 204/4 205/5 205/15 206/8 210/7 218/8</p> <p><b>yesterday [3]</b> 11/23 72/16 80/12</p> <p><b>yet [3]</b> 54/13 162/21 177/8</p> <p><b>yielded [1]</b> 118/2</p> <p><b>you [1003]</b></p> <p><b>you'd [8]</b> 16/17 38/20 47/2 50/14 69/5 133/23 137/24 178/15</p> <p><b>you'll [9]</b> 27/4 74/3 79/7 79/9 93/7 106/15 106/16 147/19 147/20</p> <p><b>you're [19]</b> 11/13 27/11 50/1 51/21 78/20 81/17 92/8 103/4 113/4 120/20 123/3 123/20 129/20 145/18 153/11 158/12 167/19 169/15 187/3</p> <p><b>you've [74]</b> 1/11 2/25 7/8 7/10 9/19 10/18 13/14 19/14 29/11 31/16 34/6 36/16 37/2 49/11 54/23 55/11 62/3 62/4 64/9 66/25 69/14 69/14 79/3 84/1 85/2 87/21 88/22 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