IN THE COVID-19 PUBLIC INQUIRY

BEFORE THE RT. HON. BARONESS HALLET

DEPARTMENT OF HEALTH AND SOCIAL CARE

MODULE 7 CLOSING SUBMISSIONs

Introduction

1. At the outset of these submissions, the Department of Health and Social Care ("the Department") reiterates its deepest sympathies to all those who lost relatives and friends during the pandemic and to those who continue to deal with the long-term consequences of the pandemic. We would also like to take this opportunity to express gratitude to the staff who assisted with the response to the pandemic and who worked on testing, contact tracing and support for self-isolation, and all staff who so selflessly cared for others risking their own lives and health.

2. The Department wishes to thank the public as a whole for their engagement in testing, contact tracing and self-isolation. Self-isolation could have significant practical, financial, social and emotional impacts for individuals and their families. It is important to learn lessons to ensure that, for future pandemics, the public feels motivated and confident to undertake tests, to engage in contact tracing and to self-isolate where necessary.

Pre-Pandemic Preparedness

3. The government, in its response to the Module 1 report has concluded that the UK government should have "*been better prepared for and more resilient to the pandemic*", in addition to "*a failure to learn sufficiently from past civil emergency exercises and outbreaks of disease*". The Department has already accepted, in a lessons learned document dated 10 September 2020, that it "*would have benefitted from a fuller understanding of the response by Asian countries … earlier in our planning, which might*

have enabled us to start to build testing systems earlier".[1] It has also accepted that it did not have at the start of the pandemic the systems in place to scale up the size of testing which was required to combat this pandemic. As has been said in other modules, there is a need to have a toolkit of capabilities to be able to scale up both testing and tracing quickly in any future pandemic.

4. In 2019, there was a low level of diagnostic testing capacity across NHS and Public Health England (PHE) laboratories of around 1,000 tests per day. The Department accepts that it took until 18 May 2020 to have sufficient tests for all those who were symptomatic and that there had to be a phased approach to asymptomatic testing beginning with hospital discharges to care homes on 15 April and then rolling out to NHS staff, social care staff, care home residents and other groups. It recognises there was not a large-scale diagnostic industry in the UK, unlike other countries in Western Europe such as Germany, prior to the pandemic, and so that industry had to be built and/or tests imported. It would indicate, however, the following:

a. PHE quickly developed the first COVID-19 test in early January 2020

b. By 8 March 2020, there was the capacity to undertake 2,100 tests per day, growing to around 5,000 tests per day by the middle of March 2020 and 10,949 tests per day by 27 March 2020.

c. In late March and early April 2020, the National Testing Programme was put in place to lead an unprecedented expansion in testing capacity, including testing kits, manufacturing components, laboratory capacity, testing sites, and the logistical systems and digital infrastructure needed to send out, receive, process and report on the results of tests. This involved collaboration across public health laboratories, the NHS, academic and private sector partners, bringing together public health and scientific expertise with expertise in supply chains, logistics, procurement and digital development. By the end of April 2020, testing capacity had expanded to 100,000 tests a day, with testing available not only to essential workers but also to anyone who couldn't work from home and all over-65s. By the end of May 2020, capacity had expanded to 200,000 tests a day, with testing available to anyone with symptoms (over the age of 5) and with asymptomatic testing in place for NHS staff and starting to be rolled out across the care home sector.

[1] **INQ000544686**

d. The first regional testing sites were in place by 25 March 2020, with 412 sites in place by 28 April 2020. Mobile testing units were set up from 19 April 2020, with 96 mobile units in place almost immediately to provide support to local authorities in locations such as care homes, prisons or factories.

e. A home delivery service was set up in early April 2020 working with the Royal Mail and Amazon so that people could receive tests at home.

f. The first Lighthouse laboratory was established on 9 April 2020, in Milton Keynes.

g. During this early phase of rapid expansion in testing capacity, the rate-limiting factors were not only laboratory capacity, but a worldwide shortage of the materials needed for COVID-19 testing, particularly reagents.

h. As well as rapidly expanding testing capacity, both the National Testing Programme and, from 28 May 2020, the NHS Test and Trace programme also prioritised from the start the need for rapid turnaround times for testing and the need for making testing as accessible as possible to different groups. The development of lateral flow device (LFD) tests made possible a major expansion of asymptomatic testing in 2021, both through the community testing programme and then the universal testing offer, helping both to detect more cases and to support social and economic recovery.

5. Having large-scale testing capacity on permanent stand-by is not a realistic solution.[2] It is essential, however, to have the knowledge, expertise, systems and relationships in place to be able to scale up testing rapidly where it is necessary to do so.

Prioritisation of Testing

6. The constraints on available testing at the outset of the pandemic meant that decisions had to be taken to prioritise how testing was used. There were limitations not only because of diagnostic capacity, but also the availability of reagents and supplies.[3]

7. From the earliest stages of testing, the first priority was to test people who were seriously ill in hospital to ensure rapid diagnosis and support their clinical treatment. On 18 March 2020, the government agreed that the next priorities after critical care and other hospital admissions were clusters of disease in residential care settings (e.g. long-term care settings and prisons) and community patients.

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[2] 77/13 - Transcript of Module 7 Public Hearing on 22/05/2025 - HANCOCK
[3] Ben Dyson – 15/6

8. As testing capacity started to grow, the government also prioritised testing for NHS workers and their families who had COVID symptoms, so that staff could return to work more quickly if they or other household members had symptoms but tested negative. There were 71,961 COVID-19 related absences in hospital trusts on 25 March 2020.[4] Rolling out symptomatic testing to NHS workers from 27 March 2020 helped save lives by easing staff shortages in frontline staff. On 12 April 2020 this approach was then rapidly extended to domiciliary care staff and care home staff, and – by 24 April 2020 – all essential workers. It is submitted that this decision was the correct one to take as discussed by Lord Vallance.[5] The difficulties and challenges faced at that time are set out in the submission of Ms. Dudley which the Inquiry referred Mr. Dyson to in his evidence. [6] There was no choice but to adopt the approach of prioritisation during the first wave of the pandemic, and it is highly unlikely that even with a larger diagnostic industry and greater capacity to scale up that there would have been sufficient tests to meet demand given the worldwide constraints then in place.

9. The Department introduced on 15 April 2020 asymptomatic testing for people discharged from hospital to care homes, with asymptomatic testing then rolled out on a phased basis to NHS staff, social care staff, care home residents and other groups and settings.

10. Thanks to the successes of implementing Pillars 1 and 2 of the Testing Strategy, eligibility for testing was expanded on 28 April 2020 to include anyone over the age of 65 with symptoms and anyone with symptoms whose work could not be done from home and on 18 May 2020 to include anyone with symptoms over the age of 5. On 28 April 2020, the government also announced that it would be rolling out testing of asymptomatic residents and staff in care homes and of asymptomatic patients and staff in the NHS.[7] From 13 May 2020, asymptomatic testing for whole care homes began to be rolled out – beginning with care homes whose primary clients were older people or those with dementia.

11. There has been much criticism in relation to whether the government should have been testing asymptomatic care staff and those being discharged from hospital or others. Given the limitations in testing capacity early in the pandemic, the clear public health advice was that testing should be prioritised for symptomatic people. Additionally, understanding of

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[4] INQ000587347 – Para 126
[5] 180/7 - Transcript of Module 7 Public Hearing on 22/05/2025 - VALLANCE
[6] INQ000546879
[7] INQ000587347 – Para 135

both the sensitivity of the test in asymptomatic people and the role of asymptomatic people in transmission was still evolving, but the primary consideration in the public health advice was the need to prioritise testing for symptomatic people with a constrained supply.

Scaling up of Testing

12. As identified above, given the importance of scaling up testing more rapidly, the Department launched the National Testing Programme in April 2020. The National Testing Strategy published on 2 April 2020 set out the five pillars of work led by the National Testing Programme to expand the capacity of public health and NHS laboratory testing (Pillar 1), partner with other sectors to develop new capacity for PCR testing (Pillar 2), develop antibody testing (Pillar 3), develop surveillance testing (Pillar 4) and build a mass testing capacity at a completely new scale (Pillar 5). In May 2020, the Department took the decision to combine this national testing programme with a new approach to large-scale contact tracing to ensure a more coordinated approach to testing, contact tracing, self-isolation and support for local outbreak management. This led to the launch of the NHS Test and Trace service on 28 May 2020.

13. As the Department rapidly scaled up testing from April 2020 onwards which is illustrated in the table below, it became clear that the scale and speed of testing needed, coupled with the importance of making testing services as accessible as possible to the public, was best achieved through introducing industrial-scale testing laboratories alongside a wide network of testing sites and home testing.[8] The Department has listened to the criticism of Professor Sir Paul Nurse and Professor McNally. The Crick Institute and other university laboratories contributed to the scaling-up of testing, but a decentralised laboratory network could not have provided the large-scale, high-throughput national laboratory capacity needed and would have been logistically much more challenging to connect with the growing network of testing sites and home testing[9]

Number of Tests	Date Announced	Date Achieved
100,000	2 April 2020[10]	1 May 2020[11]

[8] 51/22 Transcript of Module 7 Public Hearing on 22/05/2025 - HANCOCK
[9] 11/16 to 12/18 - Transcript of Module 7 Public Hearing on 15/05/2025 - NURSE
[10] INQ000049228
[11] INQ000512820

200,000	6 May 2020[12]	30 May 2020[13]
500,000	17 July 2020[14]	31 October 2020[15]

14. The focus upon large-scale, high-throughput laboratory capacity was necessary and appropriate because smaller scale providers lacked scalability and interoperability with other systems and facilities.[16] The Rosalind Franklin testing centre became capable of processing 30,000 tests in an hour, which far exceeded anything that could have been provided in a decentralised model.[17]

15. Lord Bethell explained the limitations of university laboratories in growing testing capacity.[18] The evidence before the Inquiry also demonstrates that this avenue was initially explored, but it was confirmed that it would not be a sustainable approach at the scale needed.[19]

16. The Inquiry has repeatedly heard the need for nation-wide, real-time data, and this depended on test data being available. There was a need for consistency in data systems and to ensure that testing sites could not only feedback data but exchange data between one another; reliability was key, and this was not guaranteed in a decentralised approach.[20] The approach to data handling is best understood through the evidence of Christopher Molloy where he explained that personal health data was not exchanged, it was limited to an identifying barcode.[21] The challenges that data posed, across testing, tracing and self-isolation as a whole, is a consistent theme in the module, and the Department worked constantly to resolve these issues.[22]

The Approach to Contact Tracing

17. Prior to the pandemic, PHE was operationally responsible for contact tracing systems (working with local directors of public health). These systems in place before the

[12] INQ000565944
[13] INQ000527952
[14] INQ000088032
[15] INQ000565944
[16] 53/20 - Transcript of Module 7 Public Hearing on 22/05/2025 - HANCOCK
[17] 119/1 - Transcript of Module 7 Public Hearing on 22/05/2025 - BETHELL
[18] 129/15 - Transcript of Module 7 Public Hearing on 22/05/2025 - BETHELL
[19] 112/1- Transcript of Module 7 Public Hearing on 22/05/2025 - BETHELL
[20] 90/25 to 94/9 - Transcript of Module 7 Public Hearing on 19/05/2025 - MOLLOY
[21] 77/24 to 79/12- Transcript of Module 7 Public Hearing on 19/05/2025 - MOLLOY
[22] 20/9 - Transcript of Module 7 Public Hearing on 22/05/2025 - VALLANCE

pandemic were not designed or resourced to provide surge contact tracing capacity over a whole population national pandemic. Contact tracing had to be scaled up to take place during the pandemic at an unprecedented level in modern history and required a new delivery model.

18. During February and March 2020, SAGE and PHE advised that, once there was widespread community transmission prevalent, contact tracing would no longer be effective in containing the spread of the virus, but this did not mean that it stopped altogether – PHE's regional health protection teams, working with local directors of public health, continued to undertake contact tracing in high risk settings (such as prisons and care homes).[23] It is not agreed that Prof. Martin McKee's view is correct,[24] there was a wide contemporary view from scientific experts that the approach of small scale local tracing, whilst useful, would not have resolved the position and that the virus was beyond being contained by this approach.

19. In April 2020, however, the Department and PHE began to prepare for a new phase of the government's COVID-19 response, which – as lockdown measures began to be relaxed – would use testing, tracing and self-isolation on an entirely new scale to help control transmission and support the gradual easing of other non-pharmaceutical interventions. The Department and PHE rapidly put in place an expanded contact tracing system, based on three tiers, with tracing in high-risk settings or as part of local outbreak management continuing to be led by regional health protection teams and local authorities (Tier 1), but with a combination of health professionals (Tier 2) and trained call handling staff (Tier 3) recruited to manage more straightforward contact tracing, supported by digital systems developed by PHE.

20. The pandemic showed that there needs to be contact tracing on a local, regional and national level. Whilst national tracing is useful for the majority of cases, it was essential that local authorities were involved in more complex cases – and local authorities also played an increasing role in tracing the minority of people who had tested positive who did not respond (or did not respond promptly) to attempts by national tracing teams to reach them and seek information about their recent contacts, of which the work of Calderdale was a strong early example[25]. Over the course of the pandemic, the national

[23] 12/6 - Transcript of Module 7 Public Hearing on 27/05/2025 - DYSON
[24] 13/5 - 79/3
[25] INQ000565591

contact tracing service developed increasingly mature relationships with local authorities to achieve an effective and efficient blend of national and local approaches.[2627]

21. NHS Test and Trace (NHS T&T), launched on 28 May 2020, bringing together policy and operational responsibility for testing, contact tracing and support for self-isolation, so that an end-to-end service could be operated. The Department also worked closely with local authorities to develop 300 local tracing partnerships to target those who had not responded to initial attempts by central NHS T&T contact tracing teams to reach them.[28]

22. The introduction of the NHS COVID-19 app was a brand-new way of contact tracing, and the modelling and statistical evidence shows that 1 million cases and, 44,000 hospitalisations were averted, and 10,000 lives were saved.[29] Criticism has been levied by Professor Spector that the ZOE app was not adopted instead of the NHS COVID-19 app, or whilst the NHS COVID-19 app was in development. This criticism is misplaced. The ZOE app was a symptoms tracker app. It would not have been of material assistance for contact tracing, as set out most cogently by Mr. Gould in his evidence. It is accepted that the development of the app required careful thought, particularly in respect of data protection and other ethical concerns but these were carefully considered by Professor Montgomery and the ethical team, with support from the Information Commissioner 's Officer (ICO) and others. The Department would suggest that this is or could be a model of future collaboration and of clear and pragmatic advice. [30]

23. The Department was a representative on the Regional Partnership Teams (RPTs) along with PHE, NHS T&T in each of the nine government regions in England. When UKHSA became operational in October 2021, it led the RPTs together with the Department's Office for Health Improvement and Disparities (OHID) in supporting local authorities and connecting the local and national response.

Data Challenges

24. NHSX was a joint unit of NHS England and the Department, established in early 2019. NHSX was created in part to improve data interoperability across health bodies. Matthew Gould explained the challenges that were faced as a result of slow data flows and a lack

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[26] Ben Dyson – 32/5
[27] 28/5 – Dido Harding – 16/16
[28] Ben Dyson – 32/21
[29] 175/8 to 178/5 - PHT000000167
[30] 133/17 to 135/18 – 15 MAY 2025 - GOULD

of compatibility between systems. NHSX sought to address this during the pandemic and NHS England (which took over the functions of NHSX in 2022) has continued to do so.[31]

25. In sharing data, it was essential to ensure appropriate arrangements were in place to protect personal information. Advice was sought on a regular basis as to how to share data whilst meeting regulatory requirements.[32] As was described by Mr Hancock, a two-page summary was drafted and released to health professionals explaining that data sharing for benefit of patients in good faith would not invite consequences.

Self-Isolation

26. During the summer of 2020, as set out in Mr Dyson's evidence, the Department sought to make the case for introducing a more bespoke system of financial support for people required to self-isolate who were unable to work from home and would lose income as a result of self-isolating, with the aim of offering a higher level of financial support than was available through Statutory Sick Pay or income-related benefits and making support available to people on low incomes or in self-employment who would not quality for Statutory Sick Pay. Following concerns expressed by HM Treasury about the value for money of self-isolation payments, the Test and Trace Support Payment Scheme (which offered a £500 lump sum payment to people on qualifying benefits who would lose income from having to self-isolate) was not introduced until September 2020.

27. Following the introduction of the Test and Trace Support Payment Scheme, the Department sought to make the case for strengthening the system of financial support, extending it to a greater range of people (not just those on income-related benefits) without such strong reliance on a system of discretionary payments by local authorities. The Inquiry has heard the evidence of Baroness Harding who stands by her view that further funding for those who self-isolated would have saved lives.[33] However, Ministers decided collectively (following discussion at COVID-O) not to expand financial support in the way proposed in the Department's submissions[34]. As set out in Mr Dyson's evidence, the key issue for the Department was not so much the proportion of people self-isolating when asked or instructed to do so (which both Test and Trace surveys and later surveys by the Office for National Statistics suggested was relatively high) but the proportion of people not coming forward for testing in the first place. The Department's primary aim in

[31] 152/21 to 154/19 – 15 May 2025 - GOULD
[32] 125/25 to 128/2 – 15 May 2025 - GOULD
[33] 70/17 - Transcript of Module 7 Public Hearing on 28/05/2025 - DYSON
[34] 75/14 - Transcript of Module 7 Public Hearing on 22/05/2025 - HANCOCK

seeking to improve both financial support and other forms of support for people self-isolating was to give more people the confidence to come forward for testing, in the knowledge that – if they tested positive – they would get the financial and practical support they needed[35]. The Department remains of the view that support for self-isolation should be seen as an essential part of the toolkit of capabilities available to use in a future pandemic.

28. The Department initially took the view that the potential benefits of making self-isolation a legal duty for those who tested positive and their contacts might be outweighed by the risks of discouraging people from coming forward for testing or, if they tested positive, sharing information about their contacts. In September 2020, Ministers decided collectively that there would be benefits in introducing a legal duty. There were, however, significant challenges in introducing a system that enabled the police to meet the evidential standards needed to enable them to issue Fixed Penalty Notices.

29. The guidance and rules on self-isolation evolved over the course of the pandemic to reflect both changes in scientific understanding of the virus and judgements about the balance of risks when weighing both immediate public health considerations and wider social and economic impacts. There was at times a difficult balance to be struck between adapting guidance and rules to reflect these dynamic factors and maintaining consistency of guidance and rules to help maintain consistent public behaviours.

Devolved Administrations

30. All four nations chose to have a UK wide testing programme, with the UK Government leading work to develop testing infrastructure. On contact tracing, the operations were largely separate with the exception of England and Wales having the same NHS COVID-19 app, but with protocols in place to support cross-border tracing. Although guidance on self-isolation was also a devolved matter, the guidance was generally the same in all four countries and reflected the technical advice of the four UK Chief Medical Officer (CMOs). The Joint Biosecurity Centre provided advice to all four governments. There were regular calls, if not daily then weekly, to share insights on all aspects of testing, tracing and self-isolation. [36]

[35] 98/13 - Transcript of Module 7 Public Hearing on 22/05/2025 - BETHELL
[36] 17/10 - Transcript of Module 7 Public Hearing on 28/05/2025 - DYSON

31. As outlined in Mr Dyson's evidence, testing capacity was allocated across the four nations on a fair shares basis, taking account of relative population size and relative population needs.[37]

Equality and Accessibility Considerations

32. The Department recognised from the start of the pandemic that providing testing and tracing would require careful consideration of equalities issues. The Department was mindful of these issues across all areas of testing, tracing and self-isolation.[38] The Department and the NHS also ensured that pilots focused on the risk of digital exclusion. The data from the Newham trial was fed into the development of 'app 2',[39] in addition to ensuring that the app complemented rather than replaced standard ('manual') forms of contact tracing.[40]

33. As the pandemic progressed, it became clear that some groups were less likely to test than others linked in part to socio economic status.[41] Both the National Testing Programme and then NHS T&T sought from the start to design testing in ways that would be accessible as possible to different communities and socio-economic groups, although the speed and scale with which initial systems had to be set up often meant that subsequent adaptations and iterations were necessary to improve accessibility. As community testing expanded, with a growing role for local directors of public health in adapting testing to the needs of local communities, there was an even stronger focus not only on the physical accessibility of testing but on new and innovative ways of engaging with local communities, for instance through voluntary organisations, faith groups and community champions, to help motivate and engage people to get tested and, if they or a close contact tested positive, to self-isolate.[42]

34. The Department carried out many actions to seek to ensure those who were most vulnerable were able to access testing and tracing services:

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[37] 24/5 - - Transcript of Module 7 Public Hearing on 28/05/2025 - DYSON
[38] 151/2 to 151/24 - Transcript of Module 7 Public Hearing on 15/05/2025 - GOULD
[39] 142/13 to 144/1 - Transcript of Module 7 Public Hearing on 15/05/2025 - GOULD
[40] 147/24 to 150/15 - Transcript of Module 7 Public Hearing on 15/05/2025 - GOULD
[41] 191/20 – 14 MAY 2025 - MIAN
[42] 151/10 - Transcript of Module 7 Public Hearing on 22/05/2025 - BETHELL

a. Investing in ensuring access to data for those areas where there were blind spots in understanding, such as certain geographies and economically deprived areas.[43]

b. To assist those who could not physically attend a testing centre, rapid mobilisation of mobile testing units was introduced on 20 April 2020 and there was rapid development of 'satellite' test centres.

c. From May 2020, the Department worked closely with the Royal National Institute of Blind People (RNIB) to mitigate barriers experienced by people with visual impairments and to create a more accessible testing service.

d. When the NHS T&T service was launched on 28 May 2020, communications emphasised that tests could be booked either online or over the phone by calling 119, thereby ensuring that people without internet access or who lacked confidence in using the internet could easily book a test.

e. To mitigate the impact of technology access, the Department ensured multiple routes to engage with the contact tracing system. From 28 May 2020, people who tested positive for COVID-19 could share information about their recent contacts, either via a web-based portal, or by speaking over the phone to a clinical contact tracer to maximise accessibility.

f. On 26 June 2020, the Secretary of State announced that specialised translation services would be offered across a range of 68 drive-through testing sites to support people who did not speak English as their first language.

g. The Department mitigated the risk to those without a fixed address by collaborating with local outreach organisations, shelters, prisons and community centres to deliver mobile testing units to vulnerable populations.

h. The NHS COVID-19 app was specifically developed with digital literacy in mind,[44] in addition to being guided by the substantial work that had been undertaken as part of the Newham pilot which led to an increase in the number of languages that the app was provided in.[45]

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[43] 97/1- Transcript of Module 7 Public Hearing on 22/05/2025 - BETHELL
[44] 150/9 to 150/21 - PHT000000167
[45] 165/22 to 166/20 and 193/16 to 194/2 - PHT000000167

Recommendations

35. The Department agrees with the central importance of having systems in place that will allow for rapid scaling up of testing and tracing services, where they are needed in a future pandemic. To be able to do this at scale requires investment before a pandemic. As demonstrated during COVID-19 by many countries, scaling up rapidly is not easy without either a pre-existing domestic industry or prior investment, noting Ministers have to consider this alongside other priorities. These systems should include not only the issues involved in establishing testing and tracing infrastructure, but also the issues involved in motivating people to engage in testing and contact tracing and to self-isolate when necessary. The experience of COVID-19 has underlined the importance of having clear protocols in place to support effective partnership between national government, local government, the NHS and other partners, allowing for the benefits of scale and speed that come from national infrastructure together with the vital role that local authorities can play in adapting testing, tracing and support for self-isolation to the needs of local communities.

36. The Department submits that there would be benefit in a standardised approach to data across local authorities and central government in order to ensure rapid compatibility of systems. Furthermore, there ought to be standing guidance considered and/or put in place for the purposes of future pandemics in respect of the approach to be taken to data sharing.

37. For any future pandemic, there should (as far as possible) be consideration given to possible inequalities issues which may arise.[46] This should build on the learning generated across all areas of testing, tracing and support for self-isolation, as identified above. This includes not only making sure that testing and tracing systems are as accessible to different groups but also having plans in place for how to engage with local communities to enhance people's willingness to engage with testing and tracing and their willingness and ability to self-isolate when it is necessary to do so. This involves (as has been said in previous modules), the development of greater levels of trust amongst groups who may consider themselves marginalised or excluded from healthcare services, and also consideration of how isolation can work for those on low incomes.

[46] 184/7 - 14 May 2025 (PM) - MIAN