HOUSE OF COMMONS

Transport Committee

Oral evidence: Airlines and airports: supporting recovery of the UK aviation sector, HC 683

Wednesday 15 December 2021

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Watch the meeting

Members present: Huw Merriman (Chair); Mr Ben Bradshaw; Ruth Cadbury; Simon Jupp; Robert Largan; Karl McCartney; Gavin Newlands; Greg Smith.

Questions 253–334

Witnesses

I: Dr Jenny Harries, Chief Executive, UK Health Security Agency; Edward Wynne-Evans, Director of All-Hazards Intelligence, UK Health Security Agency; and Jonathan Mogford, Senior Responsible Officer for Borders and Managed Quarantine Service, UK Health Security Agency.

Examination of witnesses

Witnesses: Dr Harries, Edward Wynne-Evans and Jonathan Mogford.

Q253 **Chair:** This is the Transport Select Committee's evidence session on supporting the recovery of the UK aviation sector and a stable system for international travel. We have two panels before us this morning. The second panel will be the chief executive of the Civil Aviation Authority and the Aviation Minister. The first panel, whom I am delighted to see this morning virtually, are from the UK Health and Security Agency. Could I ask the witnesses to introduce themselves for the record?

Dr Harries: Good morning. My name is Dr Jenny Harries. I am the chief executive of the UK Health Security Agency.

Edward Wynne-Evans: Good morning. My name is Dr Edward Wynne-Evans. I am director of all-hazards intelligence at the UK Health Security Agency.

Jonathan Mogford: Good morning. I am Jonathan Mogford. I am the senior responsible officer for borders and the managed quarantine service.

Q254 **Chair:** Good morning to all three of you. Thank you very much for being with us. We have a number of questions that we want to ask you. Obviously, we will be looking back, but since we invited you there have been more restrictions in place, so the current is relevant as well.

Dr Harries, by way of an opener, can I ask you about your involvement in the rules and restrictions process for international travel?

Dr Harries: The work of the UK Health Security Agency is primarily to provide evidence-based advice to Ministers. That is exactly what we do in relation to travel and any border changes that are brought in. It is primarily achieved through a risk assessment. I might in due course turn to Dr Ed Wynne-Evans, who leads much of the work on that.

We carry out a risk assessment. The methodology for that process is publicised and is in the public domain. It has changed over time to ensure that we continue to learn as we go forward. It gives Ministers a confidence level and a biosecurity risk level, based on which they can then make choices and decisions about how they wish to handle borders.

Q255 **Chair:** Thank you. Ben Bradshaw will drill into that a lot more, so I will not probe further on that front. I want to turn to the threat posed by the Omicron variant, which is incredibly relevant now. How significant a threat does the variant pose to public health in the UK?

Dr Harries: It is probably the most significant threat that we have had since the start of the pandemic. For example, I am sure that the numbers we will see on data over the next few days will be quite staggering compared with the rate of growth that we have seen in cases for previous variants.

The real potential risk—I underline that, because we are still learning a lot about the variant—is in relation to its clinical severity and, therefore, whether those cases turn into severe disease, hospitalisations and deaths. We are still at too early a stage for that. In fact, the world is probably still at too early a stage to be clear.

The difficulty is the growth of this virus, which at the moment has a doubling time that is shortening; in other words, it is growing faster. In most regions of the UK, that time is now under two days. When it started, we were estimating about four or five. We have that growth rate right across the UK. We are starting to see it and feel it now, particularly in London, but, yesterday, particularly around Manchester. We are very sure that levels are growing across most communities in the UK now, although there is still quite a lot of regional variation.

The real risk issue is that we can see that there are so many unusual mutations on this virus that it runs the risk of evading our natural and/or vaccine immunity. We have early studies looking at immune serum from patients who have been ill and have been vaccinated. We see that protection against symptomatic infection from two doses of vaccine is much reduced. We do not know yet about severe disease. We know that the booster dose will push that right back up, but it still comes back to a level below that which we had with the booster effect for Delta, our previous wave. That is highly significant because of the number of individuals who are potentially involved. A small degree of vaccine immune evasion could have a very significant impact on our health services.

Q256 **Chair:** You talk about the doubling rate now being under two days. For Delta, it was seven days. Where do you expect that to go, with current trends?

Dr Harries: It is difficult to say because it has changed very quickly. Clearly, there is still a degree of bias in our early data, in the sense that once we find cases we go looking for more. In order to try to contain it and to understand more, we do deep and enhanced backward tracing, but we now have so many cases across the community that that is less relevant. In most areas, it is now settling at somewhere around 1.9 days. It is difficult to predict where it will go. It is a very unusual variant.

Q257 **Chair:** I will now rein myself in and focus on the travel side of your work. Do you believe that the UK's travel restrictions will help to slow the spread of Omicron in the UK?

Dr Harries: Travel restrictions have a time and a place. I am sure that Committee members have seen this morning—I am strongly supportive of this in public health terms—that very early restrictions were placed on countries where we had good evidence of high rates of Omicron at a time when we had low knowledge of rates in the UK, as a delaying tactic. It gives us time to prepare, to understand and, in particular, to boost our population.

It is really important that, where there is not a benefit, countries are freed from those restrictions. At the moment, as I have just explained, the rate of growth in the UK is significant and the benefit of those border controls against particular countries is reduced. However, because we now have widespread global cases of Omicron, there is still value in preventing that variant or other cases from coming into the country when we do not need them to be here, not least because we do not want hospitals to be under any increased pressure than they are under currently.

Q258 **Chair:** I have heard it remarked that still having in place these international travel measures, which have really decimated the industry yet again, was akin to the stable door being open and the horse having truly bolted in terms of community transmission. Do you share the concern that these travel measures have not been required for some days, perhaps even for over a week?

Dr Harries: Actually, the Omicron case has been an exemplar case. The UK has developed and now has a sequencing capacity of around 65,000 per week, so we can sequence really tightly. We always prioritise travel. Red-listed countries with testing that comes from the managed quarantine service get prioritised so that we can look at those sequences. In many ways, it has allowed us to track down cases and get our own samples of virus so that we are able to do tests against the vaccines that we have used in this country within this time period.

In scientific terms, the Republic of South Africa has been exemplary in doing what we would like every country in the world to do, because it has aided the world in understanding the variant and being able to take appropriate measures. It is quite right that, when that is no longer beneficial, no harm is done to that country.

It is three weeks today since the sequence for this variant was first uploaded on to the international GISAID database. At the start of the pandemic, it would take us four to six weeks to sequence a single variant. This has moved the whole world forward. In particular, as I have noted, having more countries able to do this gives us time to allow the population to be boosted, and for us to learn about that, before cases take off. It is moving very quickly. It is unusual, first, in that we found it very quickly and have acted extremely quickly; it would not have been possible to do it any quicker. Secondly, we are able to share our learning back to the world as well.

Q259 **Chair:** You talk about South Africa having aided the world with regard to putting its hand up for the Omicron variant and the concerns. In return, it has been put on a travel ban, so there is no economic incentive for countries to do that. How concerned are you that countries will not reveal variants of concern for fear of being put on international travel red lists?

Dr Harries: Clearly, it is an important point. It is for me to advise on public health risks—I am not here as an economic expert—but I

absolutely recognise the issue that you raise. In fact, I am co-chairing a WHO group in relation to trying to implement a pandemic surveillance network. It is really important that countries feel able and supported to develop their genomic capacity and to signal that to the world, and that the world supports them in return. It is a critical component of response.

That does not take away from the fact that we have to protect our populations as well. I think that what has happened in public health terms is proportionate for protection, but it is absolutely appropriate that when there is no further benefit border controls are released—exactly as it should be.

Those comments are from a public health professional view. I recognise that many people on this Committee and the public will have different perceptions.

Q260 **Chair:** Would either of your colleagues like to add anything?

Jonathan Mogford: Not at this point.

Chair: Super. I will hand over now to Ben Bradshaw. We want to go through the Government system for international travel. We are really keen to hear about the role that you have played, and the role that you have not played, as regards who has been responsible.

Q261 **Mr Bradshaw:** Dr Harries, it might be useful to take the last two or three weeks as an example of how the decision making works and to drill down on that a little. Can you or, if you would rather, Dr Wynne-Evans talk us through the timeframe of what has happened over the last three weeks in terms of the advice that has been given to Ministers about re-establishing the red list and hotel quarantine, the increased testing regime and the decision in the last 24 hours to drop the red list? How has that actually worked?

Dr Harries: I will start and then pass to Dr Wynne-Evans to answer on the formal risk assessment, which is the fundamental area for ministerial decision.

We keep an eye out, particularly in the current pandemic, for new variants. This new variant was uploaded to GISAID. The very next day, it was made a variant under investigation by the UK Health Security Agency. It was flagged because of the very unusual and, potentially, very dangerous mutation, which particularly affects the spike protein.

You will have seen, I am sure, that that was replicated in many countries around the world. Within 48 hours, I think, it was declared a variant of concern, including by the WHO. Clearly, we have to alert Ministers to such concerns in terms of both clinical requirements and the need to review the medicines, vaccines and treatments that we have available, and potential ways of preventing transmission or ingress. First of all, the key thing is to try to detect the variant in the country and to see whether we have any cases.

At this point, I will hand over to Dr Wynne-Evans, who will explain how the risk assessment works.

Q262 **Mr Bradshaw:** Thank you.

Edward Wynne-Evans: These are the key points about the risk assessment. It is a dynamic, international public health risk assessment. On the usual cycle, it runs every three weeks. It brings together a range of qualitative and quantitative indicators. It does not use hard thresholds, as different countries test differently and have different sequencing capacity and different reporting capacities. It is passed through a triage mechanism, so all countries are looked at. Where there is a significant change in what is happening in-country, we take that information to decide which countries need a particular deep dive and the information is pulled together.

The key factors I look at are what is happening to the epidemiological picture in-country and whether there are any variants of concern that may be causing us particular worry at that point. Those are then risk-assessed by the team carrying out the assessments and reviewed by senior colleagues and clinicians in UKHSA and across the public health family to give us an understanding of what the risks might be there. That information is presented to Ministers, who are then able to take decisions around red-listing.

As regards the robustness of the process, it is done on a four-nations basis. There are embeds from the devolved Administrations directly involved in the risk assessment process. The methodology itself has been agreed between the CMOs and CSAs across the four nations. It has evolved over the preceding months to focus on what has become of most concern. Currently, it is variants of concern. We also focus on whether there is uncontrolled epidemiological change within a country, which may indicate that there is a new variant of concern there.

With particular regard to Omicron, as Dr Harries said, after the sequences were put on to GISAID a rapid assessment was made because of particular concerns about the structural nature of the virus and the initial data that we were seeing in South Africa. An assessment was then made of both South Africa and Botswana to give us an understanding of what might be happening in-country. The biosecurity risk assessment was conducted at that point. Ministers then made clear decisions about the red-listing of South Africa, Botswana and other southern African countries.

Subsequently, we repeated the risk assessment. Normally the deep-dive risk assessments are conducted on a three-weekly basis. They were then conducted on a 48-hourly basis so that we could continue to review whether there were further concerns from other countries. At this point, Nigeria and some additional countries were flagged as being of concern. At a subsequent point, Nigeria was also highlighted as a high biosecurity

risk, as were a number of other southern African countries. Ministers then made a decision about the red-listing there.

Q263 **Mr Bradshaw:** Can I stop you there? It is really the process of decision making that interests me, rather than the epidemiological background, which I think we are all aware of. When you present this evidence to Ministers, do you actually make a recommendation about red-listing, traffic-light systems and testing regimes? For example, would you have recommended the red-listing in this case?

Edward Wynne-Evans: We do not recommend red-listing to Ministers. Ministers make that decision. We provide the biosecurity risk assessment to Ministers. Ministers make the decision about red-listing at that point.

Q264 **Mr Bradshaw:** What about the testing regime? It was not just the red-listing that was introduced because of Omicron, was it? We significantly increased the complexity and severity of the testing restrictions. We reintroduced a post-arrival PCR test.

Edward Wynne-Evans: Apologies, Mr Bradshaw—my internet connection is unstable. I am stabilising it now. Would you mind holding for one second?

Dr Harries: Mr Bradshaw, shall I step in for Edward?

Mr Bradshaw: Yes, why don't you step into the breach?

Dr Harries: I will add to some of what Edward said, as he disappears.

In relation to any public health risk, we will be asked what sorts of interventions could be employed. As I said, that might be treatments in the UK or minimisation of risk as regards infections coming into the country. It is still for Ministers to decide what those interventions are, but we try to offer evidence, where we have it, around what the risk mitigation would be from any particular measure. It might be changing medical treatments, for example, and being ready to receive patients in this country. It might be trying to minimise ingress of a particular variant.

One of the real concerns with this variant, as I have noted, is the propensity for immune evasion. It was so strong in this variant. You will have seen that with Delta, for example, that has not been the case, because we knew that our vaccines were effective. With this one, we could predict pretty well from the structure of the variant that vaccines were much less likely to be as effective. We could not decide exactly how much—

Q265 **Mr Bradshaw:** I think the Committee understands that. What I am trying to get at is this. In this instance, we reintroduced post-arrival PCR tests, for example. Following that, we reintroduced a pre-departure lateral flow test, before you come back into this country, on top of the existing regime. Other western European countries did not do that. Was it your advice that led us to do that, or was it purely a ministerial decision

that put us out of sync with the rest of western Europe?

Dr Harries: There are a number of different testing regimes across Europe and the globe. Clearly, we can provide further details of those. In this particular case, we will be asked for evidence of risk mitigation. That will apply to any intervention. We provide evidence on whether we think that various testing regimes would work and which ones would be most effective if they were employed. It is then for Ministers to decide which they wish to introduce.

Q266 **Mr Bradshaw:** Can I take it from that that the decision yesterday to scrap the red list was based on your advice? Did you give renewed advice to Ministers that it was no longer necessary because we have significant community spread in this country?

Dr Harries: That evidence contributes. I might go back to Dr Edward Wynne-Evans when he reappears. The premise of having red-listed countries in the first place is that countries should never be held on a list any longer than is absolutely necessary. That means when it is beneficial. It is more that we are looking for evidence to say that it is no longer helpful to do that. Then a country will always be released.

Q267 **Mr Bradshaw:** In that case, why has the testing regime not reverted to what it was before Omicron? The testing regime was changed significantly in response to Omicron, yet it has remained the same. According to the Government, it will remain the same right up until January, which, as this Committee is well aware, is devastating the Christmas travel industry.

Dr Harries: Omicron has not gone away. It has gone more widely. The focus was on South Africa and the southern African region, which appeared to have been the epidemiological epicentre of Omicron initially. We now know that there are cases globally, so focusing on those countries is a relatively inappropriate mechanism. Trying to prevent ingress of any infections, including Omicron, remains a key point, particularly when we can foresee a very large wave of Omicron coming through and our health services potentially being in serious peril.

Q268 **Mr Bradshaw:** The testing regime as applied to travel is far stricter than the testing regime domestically for people wandering around or moving around the United Kingdom. I do not understand what the public health benefit of maintaining that is now that we have Omicron spreading at such a rapid rate here. People who happen to be moving from another country to Britain are tested before they are allowed to get on to a plane, must have a PCR test after two days of being here and must self-isolate before that. That is a much more stringent regime, and is having huge impacts on jobs in the travel industry and keeping families apart at Christmas. It is much stricter than anything we are subjecting people to domestically.

Dr Harries: I recognise the points you make, in the sense that different individuals will be affected in different ways. From a total population

perspective, as I noted, we have to be careful about trying to manage the total number of infections. We are trying not to add infections where we do not need to. In fact, the domestic arrangements are designed to minimise the risk of ongoing infection. Where we know that there are cases coming into the country, it seems prudent to try to prevent them from transmitting onwards, where we can.

Q269 **Mr Bradshaw:** Will the decision to retain these testing rules over Christmas and into the new year have been taken on your collective advice as well, or will Ministers have made that decision? Yesterday the Health Minister said to me in the House that he thought that they were pointless. In the Division Lobby last night, the Transport Secretary told me that he thought that they were pointless, too. Someone is obviously keeping them in place. Who is keeping them in place?

Dr Harries: It is not for us to make decisions. We give advice to Ministers. Clearly, I cannot speak on behalf of either of the Ministers you have just mentioned. We will continuously provide public health advice, when asked, including around domestic and international, and border testing.

Q270 **Mr Bradshaw:** Do you think that it is currently sensible to keep this testing regime in place until January?

Dr Harries: I do not think we have put any specificity on the timeframe because we continuously watch the epidemiology. It is highly likely that the number of Omicron cases will continue to rise very significantly. It is also likely that our health services will be under significant pressure in the next few weeks. All of those need to be kept under—

Q271 **Mr Bradshaw:** We accept that. The point I am getting at is that that is happening domestically, so why retain a much stricter testing regime for travel than any other comparable western European country?

Dr Harries: I have to go back to my original answer, which is that we do not want any cases that we do not need to have in the country. We can prevent some of those coming in. We also want to control spread within our domestic situation. We have ways of doing that. They have changed recently. We are using lateral flow devices, which we did not have before this particular really significant wave to manage cases in quite the same way. We are utilising those.

One of the other issues is that, as we have seen, this variant has come along in three weeks and is already causing very significant pressure. One of the important things is that a new variant could arise at any time. A PCR test allows us to sequence samples and, therefore, keep an eye on other variants that might pop up. That is quite critical to the health security of the nation.

Q272 **Mr Bradshaw:** Stepping back from the immediate situation, what assessment have you made of the overall effectiveness of the travel restrictions since Covid began? We follow this issue very closely. In

general terms, the UK has had far more stringent controls. We had the hotel quarantine system when other countries did not have it. We have had multiple testing. We charge a lot of money for tests.

What assessment have you made of how that has helped us as a country? If you look at our overall performance on Covid, it is not very good, is it? We have had a combination of some of the tightest and most stringent travel rules, but some of the worst Covid outcomes in western Europe for hospitalisation and deaths.

Dr Harries: Clearly, this is not a matter for this Committee in total, and there will be an inquiry, but, with respect, I would not necessarily agree with either of those statements. In Australia, for example, the whole country has been shut down and there has been quarantine for everyone coming in. In fact, over the summer period, when Delta was a fairly stable wave, we were very open to travel. We have sustained relatively high rates with relatively low deaths in this country. We are a very dense population in terms of individuals per hectare of land, or however you would like to measure it, so these are very difficult things to compare. I think I have said once before, at a previous Health Select Committee hearing, that comparing at any point in time through a pandemic that, as we can see, has not yet run its course is probably not the thing to do. At some point, we will be able to look back.

On the main point, we do actually compare. We work directly with professionals in other countries the whole time. For example, we work routinely and continuously with colleagues at CDC, in Israel and in the far east to try to assess what is evidentially beneficial. Often we find that because of the particular backgrounds to the population, especially the exposure history of individuals, there may be a different impact on immunity. For example, in South Africa there has been a big Beta wave. We have not had that. We have particular vaccination histories here. Sometimes it is not easy to compare directly.

Q273 **Mr Bradshaw:** I would suggest that western Europe is probably more comparable to us than Australia in our similarity. It rather surprises me that no ongoing assessment is made of the efficacy of the travel restrictions, given that, as you say, this pandemic has some time to run and is having a huge impact on a vital industry and on families who are separated. Are you seriously saying that we do not need to reassess our travel regime, how well it has worked or whether it has worked at all until we have a public inquiry?

Dr Harries: You could hear from what Dr Wynne-Evans was saying that we continuously review our contribution to the methodology of the risk assessment. That is why we moved very quickly in this particular case.

As I said at the beginning, it is our responsibility to provide public health advice, which we do very willingly and conscientiously. That is a contributory element to the totality of the Government's decisions about how to manage economic prosperity, international travel and all sorts of

other things. It would be inappropriate for me to review that. That is not my specialist skill.

Q274 **Mr Bradshaw:** Have you or Dr Wynne-Evans ever been surprised by the decisions that Ministers have taken after your advice? We had the example last year of France, which was briefly put on a list. I cannot remember which one, but it caused absolute havoc to thousands of British families and to the holiday industry. The decision was promptly reversed. At the same time, there were many other European countries that had a worse infection rate. Are you satisfied that Ministers are always logical in the decisions they make based on your advice?

Dr Harries: We provide evidence. You give the example of France. On the one hand, I absolutely recognise the situation of families, including our own, I might add. I have a son studying overseas. We are not immune to any of these decisions and we understand how it feels on a personal basis as well.

We recognise that the changes can be quite abrupt, but changing abruptly is probably the right thing to do for fast-moving variants. There is a message that has probably been difficult for all of us to absorb, which is that our lives are going to be quite upset through a pandemic.

We can provide more detail on the France decision, but there was an underlying epidemiology about the Beta variant and, again, we were acting with caution to understand whether that was going to become a dominant feature. If it had, it might well have become a risk to the UK. It did not, and we have had other examples. As soon as we can see that a variant is not going to be dominant—in that case, as happened for a number of other countries, it was out-competed by Delta—clearly that country should not be held in any different respect from the UK.

Q275 **Mr Bradshaw:** Dr Wynne-Evans, do you have anything to add?

Edward Wynne-Evans: To pick up specifically on the France point that Dr Harries was making, clearly we were concerned about the number of Beta cases in France, but also at the time, in England particularly, we were on a different point of the road map. We were about to open up. In opening up further, we would have increased the risk of transmission potentially in this country.

The other reason why we may have taken a different approach is that France, and other European countries, have a different vaccine profile from ours. We predominantly used more AstraZeneca, and there were concerns about the efficacy of the AstraZeneca vaccine against the Beta variant. As Dr Harries laid out, what we found, and did not know when the decision was made, was that Delta, because it was so transmissible at the time, was able effectively to out-compete Beta. We saw that across a number of other countries.

As Dr Harries said earlier, South Africa and many southern African countries had had a significant Beta wave. When Delta was introduced

into the country, it was effectively able to out-compete it. We could see that Delta could out-compete Beta, and that changed the risk assessments.

Q276 **Mr Bradshaw:** Thank you. Finally, before we move on, Jonathan Mogford, you are responsible for managed quarantine. I assume that includes hotel quarantine.

Jonathan Mogford: It does.

Q277 **Mr Bradshaw:** Could you give us an update, please, because there are reports overnight of families fleeing the quarantine hotels at Gatwick given the scrapping of the red list? In theory, they are breaking the law and subjecting themselves to £10,000 fines. What is going on?

Jonathan Mogford: The standard practice has been that, if you have started hotel quarantine, you need to complete it. For this delisting, where Omicron has moved unexpectedly fast, we want to release people early. We are sorting out the arrangements for that as quickly as possible. We need to make sure that we are not releasing Covid or Omicron-positive guests immediately, and to get logistics like travel. We are expecting to be able to confirm the arrangements today.

Q278 **Mr Bradshaw:** What is your advice to families who are still incarcerated and have had daily tests that are negative? Should they just hang on in awful rooms having to eat terrible food, or can they go home?

Jonathan Mogford: On the quality of the hotels, we pitched that at a decent quality. The advice at the moment is that we are asking people to remain until we can confirm the exact arrangements for their departure, which we are looking to do today.

Q279 **Mr Bradshaw:** It appears that quite a lot are not taking any notice of that advice. No one is going to prosecute them or do anything to them if they leave, are they?

Jonathan Mogford: We need to make sure, and we have notified those who are Covid-positive that they need to remain in the hotels.

Mr Bradshaw: Thank you.

Q280 **Chair:** We are trying to get to the bottom of exactly who makes the decisions and your involvement in the decision-making process. Do you mind if we just focus on France and the amber-plus decision that was made? That was the starting point of our engagement with you, or indeed the Joint Biosecurity Committee, when we wrote asking about that decision.

You talked about the Beta variant. It was peculiar that France, over the previous 28 days before that decision had been made, had 0.8% new cases of the Beta variant. In Spain, that figure was 13.6%, and Spain remained on the amber list. In Bulgaria, it was 1.7% and they remained on the green list, and yet France was singled out despite having lower rates of Beta. Can you help us by explaining how that could have been

the case?

Dr Harries: I will probably pass that one to Dr Wynne-Evans because I joined the organisation from my previous role during that period.

Edward Wynne-Evans: When we reviewed France, as I think I said earlier, there was a triage mechanism. Countries that had a change in their risk assessment would have been flagged. We had picked up France a number of weeks previously and were concerned about the biosecurity risks there and had been flagging them.

As I said earlier, we were concerned about the changes, particularly in the UK at that point, and that is why France in particular was flagged at that point. The rest of Europe was reviewed across the whole of the Schengen area. There were a lot of particular flags raised about other countries at that point, but France was the one we were most concerned about when the decision was made there, on our advice. The key difference was that we were going to open up in this country, and we were concerned about potential travel volumes.

Q281 **Chair:** Does it work in the sense that your advice to Ministers was, "Quick, we need to do something immediately about France," due to geography or what have you, even though the rates were lower than in Spain and Bulgaria? Is it that, or do you literally just present statistics, country by country, and then Ministers come up with a policy off the back of that?

Edward Wynne-Evans: For the UK Health Security Agency, we present the risk assessments about what we think the biosecurity risk is to Ministers. It is then for Ministers to take the decision about what they wish to do about it.

Q282 **Chair:** What was your specific advice on France?

Edward Wynne-Evans: At the time, we were using a three-point scale. We were rating France as a high biosecurity risk at that time, and then it would be for Ministers to take that decision.

Q283 **Chair:** I am drilling in on one particular country, but can you remember what your advice would have been on Spain, where it seemed to be five times more, or higher?

Edward Wynne-Evans: Spain was not flagged by the triage mechanisms at that point, so we did not provide specific advice on Spain to Ministers at that point. We provided advice to Ministers on Spain a number of weeks later because we were concerned about the emergence of another new variant. This time it was Mu, and we were concerned about particular links between Spain and South America. Again, it was a variant on which we did not, at that point, have a good understanding. We were concerned about potential ingress of Mu from Spain to the UK.

Q284 **Chair:** When I described Spain over the previous 28 days as having 13.6% of its cases as Beta, whereas France was 0.8%, did that not get

flagged by you with regard to Spain just because you were not at that point assessing Spain?

Edward Wynne-Evans: We were concerned about ongoing transmission of Beta within France that we had not seen in Spain at that point. The level of Beta there was not flagged at that point.

Q285 **Chair:** Is that just because you do country reviews as and when you do them, rather than, "Okay, we've got a problem with one country so let's see how it compares with others"?

Edward Wynne-Evans: The triage mechanism has to flag a change within the country, and there were changes flagged for France. That would be why a deep dive was specifically done for France at that point.

Q286 **Chair:** I still do not understand why Spain would not have got the same treatment, given that rates were high and it was a variant of concern.

Edward Wynne-Evans: But Spain had not changed at that point, so we would not have engaged with a particular deep dive to review it. When there was a change with Spain, we were concerned particularly about Mu.

Q287 **Chair:** I still struggle with that. Again, I come back to the figures. Over the preceding 28 days, France was at 0.8% of cases, Spain was at 13.6% of cases, being Beta, and Ministers really struggled to describe it. They were talking about the prevalence in one particular overseas territory, which was actually on the amber list anyway.

Edward Wynne-Evans: It was not driven by what was happening in a particular overseas territory. There were particular concerns about what was happening in France at that time. There were reports that they had outbreaks of Beta. That was what was causing us concern. That was why the biosecurity risk assessment was made.

Dr Harries: Could I make an additional comment? I absolutely support what Dr Wynne-Evans has said. It is really important to compare numbers, and of course we do that all the time. That is evident in the methodology that we publish. It is also important to understand the context in which those numbers are operating. Sometimes you can see an opportunity where there has been a significant outbreak of something—we have this in the UK—that has been contained very carefully and closely in an area, and sometimes there appears to be growth without any evidence of containment.

At the moment, I cannot remember because I was not directly involved with some of the detailed work on France at the time, but it is important to understand that. I seem to remember that in Spain there was a very controlled, localised outbreak that was then curtailed. My point is not on those two specific countries but to say that the actual confidence in the containment of a variant is also an important element in understanding what the risk of onward transmission is.

Q288 **Chair:** I suppose part of the struggle with this is that there has been a lot

of questioning because people cannot see exactly why countries are placed on the list that they are placed on.

The Committee went over to Germany and heard a very different story. There was complete openness and transparency between health officials, transport officials and the industry. By and large, they were all in sync because they knew what the rationale behind the decision-making process was. Why do we not have the same openness and transparency in this country?

Dr Harries: I will speak on behalf of the organisation to start with. The UK Health Security Agency only came into being at the start of October. I have taken steps, broadly, not just in relation to travel, to ensure that we are, if you like, an open access organisation. It is really important as a leading scientific organisation globally that we set good trends in that direction. That is definitely the ambition.

Dr Wynne-Evans may add some comments about some of the details. The methodology is entirely open. Much of the data that we use is open, but there is some information that is not publicly available and therefore it is difficult for us to share. Where we can, we always will.

Q289 **Chair:** Dr Wynne-Evans?

Edward Wynne-Evans: The key point for us is that we use triangulation of information. We use publicly available information and information ourselves that we may have obtained from MQS tests, as well as other sources of information that are publicly available, to help with the risk assessment. There are also private sources of information. FCDO colleagues may ask in-country for specific sources of information. Some countries are willing to share confidentially, but they do not wish to have that data published. In order to see and better understand what is happening in a country, we have access to that data.

When a country was moved between lists, the information that was used to make those assessments that we could publish was published at that point. As Dr Harries said, the methodology and the steps used to drive the risk assessments have always been publicly available. That methodology was reviewed by both CMOs and CSAs, and at each iteration of the methodology it was made publicly available.

Jonathan Mogford: There is quite a lot of work that is done jointly across UKHSA, DHSC and DFT in engaging with all the stakeholders that are going to be affected by the decisions that are taken, including the ports and the carriers. That also relates to the ministerial decision-making processes and the decisions that need to be taken against the international health regulations work and prepared for the central Cabinet processes.

Q290 **Chair:** Mr Mogford, are you saying that you regularly engage with the chief executives of airports and airlines to explain the rationale behind your advice so that they would get the same insight?

Jonathan Mogford: There have been, particularly joined up through the DFT, regular contacts with the industry and their representatives. As MQS, we have dealt directly with the chief executives of the airports, particularly on a lot of the arrivals arrangements, dedicated terminals, and so on. That is not to say that there are not significant challenges that have also been brought by the sector, which is understandable. There have been a number of legal ones, in all of which the Government's actions have been upheld.

Chair: Let me bring in some colleagues. First of all, Karl McCartney.

Q291 **Karl McCartney:** Good morning, witnesses. Dr Harries, I have some specific questions on some stats later. Initially, you talked about giving advice to Ministers and Ministers making decisions. That is fine, but considering that the decisions Ministers have made have decimated the aviation industry, how many times have you given advice to Ministers and they have not gone as far as you wanted them to go?

Dr Harries: I think what I said is that we give evidence. We give a risk assessment to Ministers and they make the decisions. It is much less direct advice. If they seek advice on, for example, how effective a test might be on a particular virus at a particular place of travel, we give that evidence. It is advice to them, and they make decisions.

Q292 **Karl McCartney:** With the advice or the risk assessment that you gave them on the red list, were you happy with the decision that the red list should be scrapped, or not?

Dr Harries: On this particular occasion? My public health assessment of that, in line with what I said earlier, was that while we had other testing arrangements to manage Omicron ingress and other variants' ingress across the globe, which is where the cases were starting to appear, it was entirely appropriate that the risk was managed equally across countries rather than being focused on those particular ones. Clearly, we still recognise that the rates of infection in those countries are actually very high.

Q293 **Karl McCartney:** Indeed. We will come back to rates of infection in a second. This might be a question for you, or perhaps Mr Mogford. Of the people who have travelled from those 11 countries and have been put in isolation and tested continually, how many of them tested positive for the latest variant?

Dr Harries: I will pass that to Mr Mogford, who will have the latest data.

Jonathan Mogford: The latest indication is that we have seen unprecedentedly high rates of positivity through the hotels in this round. That is including after pre-departure testing. The latest figures suggest that nearly 5% of people in the hotels are positive.

Q294 **Karl McCartney:** Let me just be clear about that. That is 5%?

Jonathan Mogford: Yes, and of those at least 1% are Omicron positive, but probably as much as 3% because we are waiting for—

Q295 **Karl McCartney:** Of the 5%?

Jonathan Mogford: No, of the total arrivals.

Q296 **Karl McCartney:** The total arrivals are roughly how many thousands?

Jonathan Mogford: We have had roughly 5,000 guests through in this round of red-listing.

Q297 **Karl McCartney:** You just called them guests, but we have seen pictures of the food that they are being provided with and that some of them are paying over £3,000 for. Do you think that is fair? Do you think they should be given a rebate?

Jonathan Mogford: We have picked up with the hotels the reports of the food. There are strict conditions and standards that are set for MQS. The complaints that have been received are very low through the whole process of MQS. We share the concerns of what we have seen on social media, and those have been picked up with the hotels directly.

Q298 **Karl McCartney:** You look a bit like me; we have a healthy appetite. I don't think you would have been happy with the quality of food that has been provided. I certainly would not have been.

Dr Harries, I want to check some stats that have been provided. Is it right that for those who have been hospitalised with the latest variant, rather than the average being an eight-day hospital stay, it has been a three-day hospital stay?

Dr Harries: It is not possible to draw conclusions on average hospital stay dates at the moment. Do you mean in the UK?

Q299 **Karl McCartney:** No. That stat comes from South Africa.

Dr Harries: That is not a comparable population at all. We do not have the detail of it yet. We will start getting good data through. Clinicians speak to colleagues in South Africa very regularly. The average age of the population there is 27. We would not expect 27-year-olds in this country to become ill at the moment with Delta. Our average population age is 41 and we have underlying conditions. They are simply not comparable at the moment. We do not yet have the disease severity signal.

Q300 **Karl McCartney:** You talked about the doubling time being perhaps less than two days, whereas it used to be seven with previous variants. It is now 1.9 days, I believe. Extrapolating that with geometric progression, do you think that everybody in the UK will have had the latest variant by 29 December?

Dr Harries: No, I don't think anybody has ever suggested that.

Q301 **Karl McCartney:** But that is what your facts and figures are suggesting.

Dr Harries: No, because what they suggest is that there is a doubling time and then, at a point in the population, the exponential growth in the population, a number of things happen. One is that it is in different areas. We will see it in London, for example. It is rising hugely at the moment. It will peak as it runs out of people in different areas to infect. It will move across the country, and we will see it in different places. Equally, once you start seeing rates like that, people's behaviour changes as well. Although you can predict the exponential rise in cases at the start, it is much more difficult to understand what will happen as you go forward.

The other point about this is that we are still learning, as I said. We are very confident, for example, on reinfection rates. If you have had Delta, you may not expect to get it severely again. The reinfection rates for Omicron—having Delta and then having Omicron—are much higher, from what we have seen so far, so, even if you have had one case, you may get it again. If you have had Delta you may get Omicron. We can predict very rapid growth, but I would not predict that a whole population would get it. We do not see that. You tend to see waves of a pandemic spreading across.

Q302 **Karl McCartney:** Thank you for that. If the Minister had not taken your advice and removed the 11 countries from the red list, would you have gone on the "Today" programme on Radio 4, or do you believe in collective responsibility?

Dr Harries: To do what?

Q303 **Karl McCartney:** To undermine the Minister for not taking your advice and making the decision to remove the 11 countries from the red list.

Dr Harries: I probably have an unenviable role. On the one hand, I am a second permanent secretary in the Department of Health. On the other hand, I am a registered medical professional. I need to abide by both those principles, but at the end of the day my job in my current role for the Department of Health and as a medical professional is to protect lives and to enhance life. I will take whatever action is required.

Q304 **Karl McCartney:** My final question is to all three of you. Where are you, geographically, now and when was the last time you went into your office?

Dr Harries: I am currently at home in Wales. I am registered with a Welsh health practitioner, and I came to get my vaccination. I have actually stayed put ever since.

Jonathan Mogford: I am at home in Brighton. I was last in the office, I think, the week before last.

Karl McCartney: Dr Wynne-Evans? He obviously does not want to answer the question, Chair. He is somewhere his broadband is not very good, so maybe he is in Lincolnshire.

Dr Harries: We will get that answer to you, I am sure. I think his wi-fi—He is back.

Edward Wynne-Evans: I am terribly sorry. My wi-fi connection has become very unstable today. Sincere apologies. I am currently in Maidenhead. I think the last time I was in the office would have been at the end of November.

Ruth Cadbury: Sensible people working from home.

Q305 **Chair:** Coming back to the decision-making process, we will put it down to my poor questioning but I have checked with my colleagues and they still do not really follow how the decision that was applied to France on the amber-plus list did not apply to Bulgaria or Spain, having had higher Beta rates.

Could we use a different country example to better understand how these decisions are arrived at and what advice you give? Could we look at India? What advice did you provide on India's coronavirus health risk late in March and in early April 2021?

Dr Harries: I was going to pass it to Dr Wynne-Evans, but perhaps I could flag that through the process, as we have obviously seen this time with Omicron, we saw that it was a variant of concern and actions were extremely rapid. I will let Dr Wynne-Evans explain, because that might be part of the discussion on India.

Edward Wynne-Evans: India is a very good question to ask. India was flagged at the end of March via the triaging process. There were changes there that we were concerned about. The risk assessment on India was carried out four times throughout the end of March and through April. Those were out-of-cycle risk assessments. We were concerned about the changes in the epidemiology. At the end of April, Ministers made a decision to place India on the red list at that point.

The key differences to notice were that at the time the concern was about what would go on to be called the Delta variant, but at that point the variant was noted as a variant under investigation. It was not designated as a VOC. We were less concerned about Delta at that point. It was only made a VOC subsequent to decisions about red-listing.

The key thing to notice is that the methodology subsequently was changed to be allowed to flag the risks of both variants under investigation and variants of concern at that point. In the case of Omicron, the decision was made rapidly within the UK to flag it. It was rapidly flagged as a variant of concern, so the process was speeded up. Had it remained a variant under investigation, because of the biological concerns, we would still have flagged the actions. We would have still taken the biosecurity position that we did.

Q306 **Chair:** Focusing on India, you said there was advice at the end of March. I think you said the decision was made by Ministers at the end of April.

What was the advice at the end of March? What were you saying to Ministers should occur for India?

Edward Wynne-Evans: Advice was not being given. The biosecurity risk assessment there was flagging that there were concerns potentially within India from a variant, but the variant was not designated as one that would have needed action at that point. Over time, we became more concerned. That was flagged a number of times to Ministers at that point. Ministers took the decision to then put India on the red list. Subsequently, Delta became a VOC as well.

Q307 **Mr Bradshaw:** I think probably the reason we are asking about this is that, from my recollection, Pakistan was on the red list earlier and there was a suggestion that India was treated differently because the Prime Minister was hoping to have a trade visit to India, which of course never took place. Was your assessment—you do not give advice; we have learnt that—on India the same as Pakistan, or different?

Edward Wynne-Evans: At the time, the assessments of Pakistan and India were that they were both considered to be high risk, but initially Pakistan was thought to be a higher risk. Ministers would have come to a decision around that, if you are distinguishing different risks between different countries.

Q308 **Mr Bradshaw:** In what respect was Pakistan assessed to be higher risk than India at that time?

Edward Wynne-Evans: We had further concerns about what was happening in Pakistan and that is why it would have been assessed as a higher risk at that point.

Q309 **Mr Bradshaw:** What sort of concerns?

Edward Wynne-Evans: About the particular variant and the potential changes. Comparing Pakistan to India, they have different sequencing and testing regimes. There were additional concerns about what was happening in Pakistan at that point.

Q310 **Mr Bradshaw:** Are you satisfied, and Dr Jenny Harries more generally, that the decisions that have been made have always been consistent with your assessments regarding various countries?

Edward Wynne-Evans: We provide a biosecurity risk assessment to Ministers. Ministers then have to make decisions about what they are able to decide from that. The biosecurity risk assessment is a part of their decision-making process, but they are the ones who ultimately have to take the decision about red-listing.

Q311 **Mr Bradshaw:** You have never thought, "Oh blimey, I'm surprised that one did not go on that list or that one did." You have always been completely confident and satisfied that the decisions that have been made by Ministers have been consistent with the biosecurity risk that you have highlighted to them.

Edward Wynne-Evans: I think the biosecurity risk is always flagged. Ministers then need to make a decision about how they might implement that biosecurity risk, but we have always flagged those decisions to them and then they have to take an appropriate decision from there.

Jonathan Mogford: I can perhaps help a bit on that. There are two parallel processes that are managed, essentially, right through the different phases of the risk assessments. There has not been a direct and mathematical relationship between the very high-risk rating and what goes on to the red list. The consistency of the decisions taken against the assessment from UKHSA has been a critical part of the decisions that Ministers have needed to take about the response to that analysis. A lot of the themes through a number of the countries that have been raised this morning is precisely where you draw the line, particularly at the really difficult interface between the very high risk, red-listing and the hotel and non-hotel response.

As has been flagged, there were some ad hoc decisions taken, particularly with France and with Spain, about the most appropriate public health based response, short of putting countries on to the red list. Those were particular decisions relating to the situation at the time, which was of course evolving and changing every time Ministers came to those decisions.

Q312 **Mr Bradshaw:** There has been no overall assessment of the efficacy of our travel restrictions on the course of the pandemic in this country, but are economic impact assessments made of these decisions, or is the economic impact on the industry and on jobs and the social impact on families separated and holidays ruined ever taken into account? Is that not considered at all?

Dr Harries: I think on all the points you raise, I hope I have signalled, as I am a health professional, that I recognise things like mental health concerns for individuals. That happens with a number of areas of our pandemic response.

The overall economic impact or broader impact is not one that we would do. That would be for the Government to consider more holistically. We can obviously provide the public health assessment of that. Where it is directly possible to do something—to take a different sector, around education and schools, where there is quite a lot of evidence around mental health issues for children, for example—it may be possible to take that into consideration in the public health assessment, but it is not as easy to do here.

Mr Bradshaw: Thank you.

Q313 **Chair:** You make your country assessments and those are handed to Ministers and then they make the decisions. Are you in the room when they make those decisions, when they decide, "Oh, we have all these different country assessments, so let's come up with a traffic light system

and classify them on the basis of colour"?

Dr Harries: There will usually be some representation to give factual information if there are queries in relation to the risk assessment piece of evidence.

Q314 **Chair:** But you are not involved in the decision making as to what to do with your country risk assessments.

Dr Harries: No. The decision making is with Ministers. I would frequently—not just me but other senior professionals as well—be asked simply to comment on observations, to confirm, for example, a statistic or the evidence base in relation to a testing protocol.

Q315 **Chair:** I am aware that you are not really in the room when those decisions are made, but it being your body of work, you will obviously have an interest in what they do with it. What is your understanding of the decision-making process? Who makes the decisions? Which Department? Is there any challenge with anyone in your team?

Dr Harries: It is genuinely a cross-government decision-making process. It is definitely not for one single representative from one part of the Government officials to comment on that generally. It is a far-reaching consideration, and particularly because of the points you have made there are far-reaching discussions. We contribute solely to the ones that relate to the public health intervention.

Jonathan Mogford: It is perhaps worth adding that the decisions that are taken are Cabinet and Government-wide, including the devolved Administrations. The decisions also have to be taken in the context of the international health regulations, which essentially mean that all of these decisions have to be public health based. Clearly, the discussions and the decision-making process itself bring together representations across the whole of Government.

Q316 **Mr Bradshaw:** It seems odd to me, though, that the Health Secretary has told me two days running in Parliament that, now that Omicron is rampant here, he does not think that the testing regime we have is appropriate any more. The Transport Secretary has said the same. Who is overruling them? Is it No. 10? Is it the Home Office? Is it the Home Secretary? Is it the Cabinet as a whole? I cannot understand why these restrictions are still in place, if the two Ministers that one would imagine would be in the lead on this policy share a view—unless they are not telling me the truth, and I have no reason to suspect that is the case—given the enormous damage they are doing to the holiday industry in what is a vital period for it. It is an industry that is already on its knees.

Dr Harries: With respect, I am not trying to avoid your question at all. Clearly, those are statements made by Ministers so I cannot respond on their behalf. I can answer questions on testing efficiency and all sorts of things, but not what Ministers have said.

Mr Bradshaw: That is fair enough. Thank you.

Q317 **Chair:** Building on that, you must feel this frustration as well. Ministers always say that they are following the science. That would seem to suggest to us that that is because there has been a recommendation from the scientists to put a country on to a particular red list, green list or amber list. But you are not doing that. You are just giving country assessments. It is the Government, the politicians, who are making those firm decisions and interpreting them, not yourselves. Doesn't your team sometimes feel a little blamed for that? This is your chance.

Dr Harries: I shall just comment by saying that it has been a long pandemic. How about that?

Science is quite grey. It is not black and white. That is an important thing. That is of relevance in relation to Omicron because I am sure it has not escaped you, through the pandemic, that you always find different scientific voices. One of the startling things about Omicron is that I have not heard a single scientific voice of dissent. When you see a whole science community deeply concerned about a particular threat, it is really noticeable. I think that is what we have now. It is an important point.

The other point is that we are looking at this as a public health risk. As you and other Committee members have rightly said, there are different perspectives on public health risk. It is not simply about a country or a variant. It is about the totality of the public's health. The areas that we advise on are not simply about the risk assessment of the country. They will be, as I say, about clinical intervention.

For example, as we have seen with Delta, if you have a vaccine that works, once you have found out and are confident it works, even if it starts going off and you can boost people, you can afford to protect the population in different ways. When you do not have those tools in your armoury and you have a variant growing at this rate, different interventions are quite important. It is a combination. There is clinical science. There is epidemiological science. There are a number of different scientific inputs.

Chair: I think following the science needs a redefinition from Government Ministers. Simon will talk about testing.

Q318 **Simon Jupp:** Thank you, Chair; much appreciated. Good morning to the panel.

Clearly, PCR testing has a huge impact on our daily lives. It means that some people who test positive around now will have to be isolating at Christmas time. Of course, the speed at which people get their tests back impacts on their ability to go to work in many cases, if they cannot work from home.

I would like to ask you all, please, about the assessment you have made of NHS PCR testing capacity. I will go on to why that is applicable to transport in a moment. Dr Harries, I will come to you first.

Dr Harries: Can I clarify what you are interested in? Do you mean currently, at the moment?

Simon Jupp: Currently, at the moment, PCR testing capacity.

Dr Harries: We are seeing unprecedented demand, for the reasons I have outlined with Omicron, in this case. We obviously want people who are symptomatic to come forward for testing for some services—for example, those working in social care where it is absolutely vital that they regularly do PCR tests.

We had already planned to increase capacity over the winter because we predicted a difficult winter. We clearly could not predict a variant like Omicron. We have some flexibility there. Today, we currently have about 650,000 tests available. If you go back to when we had no tests or very few—about 1,000, going back to autumn last year—this is a huge achievement. We can run those safely at the labs at around 80%. We have more PCR tests coming on board.

Yesterday, the public may have seen some pressure on some sites. There are tests available, but, of course, in London, for example, we are seeing a sudden rise. I am in Wales. Some of the test sites here will be at 7% or 8% capacity. In London, they were quite full. People can still order tests at home. We have put in mobile testing units to try to boost supplies so that people can get tested. We have sufficient tests, both PCRs and LFDs, but the very rapid rise is causing some temporary pressure. I can go into more detailed plans about how we try to spread that around and ensure that people can access the right test.

Q319 **Simon Jupp:** If you could, I would appreciate it. Capacity is important. If people log on to a website and are told that they cannot get a lateral flow test sent to their home, or that the PCR testing site nearby is unavailable for a test that day or the next day, it is really quite concerning for people who are worried and want to do the right thing. If you could explain how you are upping capacity, it would be much appreciated.

Dr Harries: As a start-off, with the lateral flow test, as I say the capacity demands have been absolutely astounding. This morning, between 6 o'clock and 8 o'clock, 200,000 packs of seven LFDs were ordered. Yesterday, we were running at plus 83% compared with the same day last week. Some of this is clearly because of changes in policy so that we can support individuals to be in work. That is critical when we have a new variant wave and people are more likely to be a contact, as there will be so many cases and people are off sick. We recognise that.

One of the really important things today is not that we do not have tests in the country; it is about getting them delivered. There are two things that I think will be important perhaps for the public and Committee members listening. First, Royal Mail have been brilliant through this. They opened up their Sunday delivery at the start of the pandemic to allow us to return tests rapidly. They will be allowing us to more than double

delivery capacity from Friday. We will be going from 400,000 home deliveries to nearly 900,000. Obviously, we are really grateful for that, and we have other partners that we continue to talk with in case we need more capacity on that front.

The other thing is that we have been talking to Alliance, a partner for our pharmacies. I know that is another area that is really important for local communities. We have 6.4 million of these being shipped to them. There will potentially be some short interval times on this, but we are working really hard to do that. We have sufficient lateral flows in the country at the moment, but you can see from the level of demand, bearing in mind that we did not even have lateral flow devices this time last year, that it is quite a challenge to keep those stocks flowing.

Q320 **Simon Jupp:** Dr Wynne-Evans, is there anything you want to add?

Edward Wynne-Evans: No, nothing to add at this point, thank you.

Q321 **Simon Jupp:** Mr Mogford?

Jonathan Mogford: On the travel side, the arrangements for the PCRs and LFDs have all been for the private sector to provide, which is part of the early decisions about borders—

Q322 **Simon Jupp:** If I may, Mr Mogford, you have done a really neat segue into my next question, which is whether NHS PCR testing capacity and free costs of the test should be used for international travel. Surely there is now a need to do that to allow people to have access to the same service, but without paying to profiteer a private business.

Mr Bradshaw: Hear, hear.

Jonathan Mogford: The decision that was taken right at the beginning of the work on borders was that people who want to travel during a pandemic should pay the costs of that travel. It was also partly to make sure that any capacity demands created through that do not crowd out the need to provide testing as a priority for domestic purposes.

Q323 **Simon Jupp:** We have seen profiteering. I know that the Government have taken steps to address it, but we have seen profiteering from private providers who have just ripped people off with PCR tests. People do not just travel abroad for a holiday. They travel abroad to see friends, family and to be connected to others. It is not always a jolly.

I know at the moment, as we have just discussed with Dr Harries, there is a capacity issue, but in the longer term is there not a case, on a whole host of different bases, to look at free tests for international travel that are met by NHS capacity?

Dr Harries: Perhaps I could step in.

Simon Jupp: Bravely taken.

Dr Harries: I think this is probably not a public health question, which is why I am stepping in. I absolutely support what Mr Mogford said. It was a decision made for us at the start of the pandemic, and therefore what we have done is try to maximise the opportunities, if you like, in making it a good customer journey where we can.

We are not a regulator but we try to enhance the quality of the testing. We try to ensure, where we can, that we take steps—I think you have just alluded to them—to try to manage, where we are able to, some of the pricing and advertising approaches. Nevertheless, we still know that the public value having a Government website, which lists the providers that have passed those quality assurance tests. It is a really difficult area to work in, but I can assure you that we have done our very best to try to make sure that it is as accessible as possible.

Q324 **Simon Jupp:** Do you think it is confusing for consumers who may think, "Oh, I got a PCR test a couple of weeks ago because I felt a bit poorly. I want to go abroad, so surely I can go through the NHS"? What people have to do now is confusing and contradictory, with the hoops they have to go through to go abroad, for all sorts of reasons. Surely, there is at least a case to look at this, once capacity has been maximised in NHS testing and PCR tests, to make it free, and include international travel, considering that the number of people who are travelling internationally is low by any standards, and indeed by European standards at the moment.

Dr Harries: It is artificially low in some ways. I think it will change over time. If we get a variant, people's travel will tend to drop down a bit. It has varied right through the pandemic. It is difficult to predict what demand would be over a long timeframe.

I am going to give, hopefully, an intelligent public health response to this. In public health terms, it is always better to give very simple, clear messages to the public because it is easier for them to follow and to understand. It usually makes their interaction with whatever that system is as good for them as possible, but also good for public health. Simplicity is often a really good thing to try to follow.

Simon Jupp: Simplicity is not always in abundance in Government policy. On that note, I hand back to the Chair.

Q325 **Mr Bradshaw:** Can I come in very quickly? Things have changed, haven't they? We are now saying that if you choose to go to a night club or a large venue you get a free lateral flow test, but if you choose to go and visit a dying relative abroad you have to pay through the teeth. That is not consistent in public health terms, is it?

Dr Harries: I think Mr Mogford might want to come in. For travellers coming back into this country, obviously there is a hardship fund for people using those travel services. Once again, the overall decision on these is that we give public health advice in relation to testing and vaccines, but not on the way the costing structure is provided.

Q326 **Mr Bradshaw:** Mr Mogford, do you see the inconsistency that there is now, given the Covid passes domestically?

Jonathan Mogford: I think there are judgments that have been made. As Dr Harries said, there are hardship arrangements in place. The decision that was taken right at the beginning of the work on borders was that the testing should be funded.

Mr Bradshaw: I was not even aware that there was a hardship fund and that you could apply for a free test.

Q327 **Chair:** I am going to bring Ruth Cadbury in on testing, and we will wrap up very shortly. What is the point in having tests for those who are already fully vaccinated? When we went to Germany, we just had to show evidence that we had been vaccinated. What does it give you over and above that in terms of health protection by having tests?

Dr Harries: Could I correct the statement before? There is a hardship fund for people re-entering the country who go into MQS services, not just for testing, to clarify that.

In relation to vaccination, it gets very complicated. Not unreasonably, and simply because of having quite simple messaging around it, until Omicron came along there was a perception that if you were vaccinated you could not be infectious. Let's put it that way. In actual fact, what we know is that you are very unlikely to suffer severe disease and end up in hospital, so vaccines are brilliant—this was against Delta—but you can still transmit infection. That is why there is complete logic in, for example, having a pre-departure test while still being vaccinated. It protects you as an individual and it protects the population as a whole, but it does not actually mean that you are not infectious when you get on the aeroplane or the boat.

What has happened with Omicron is that it has thrown that up in the air as well. We know from the very early vaccine studies that mild disease, but symptomatic, and the likelihood of you being infectious is quite high, even though you have been vaccinated with two doses of the current vaccines. We have seen that in reinfection rates. We should start to try to dissociate the fact that we have a vaccinated population who are likely to be protected against some variants themselves really well, so it is a brilliant thing to have the vaccination. If you have a booster, we hope that you are going to get lots of vaccination protection against severe disease, and we still need to understand that, but you will not necessarily not be a risk to others. You may still be infectious.

I think what that shows is that it is really important that we consider every variant as it comes through and really rethink each time and make sure we understand that variant in all its applications.

Q328 **Chair:** So it is to reduce the transmission risk. That is the reason why we have testing.

Dr Harries: Broadly, you are reducing the risk of the individual transmitting to somebody else, and then you are trying to reduce the risk of chains of transmission spreading out. On reducing transmission risk by testing, the benefit of the test is that it signals a risk and then the individual needs to isolate. It is the testing and the isolation together that mean that the individual no longer is a threat to anybody else.

Q329 **Chair:** Why focus just on the transmission risk and trying to reduce it when it comes to people flying into the country? We do not do that for getting the train to Edinburgh or even flying to Edinburgh. Why pick on international travel?

Dr Harries: We apply the same thing in-country in a different way. One of the differences with a border is that we have the possibility of new variants coming in. We have a better understanding because we have much higher testing levels in the UK than in many other countries, or we have access to that data. We understand what infections are likely to be circulating at any one time. Until very recently it has been dominated by Delta.

Q330 **Chair:** Dr Harries, you are bringing the justification on variants of concern whereas earlier you said it was to reduce transmission risk. Turning to variants of concern, at the Dispatch Box, Ministers tell me the reason we have to have these PCR tests, which are much more expensive and therefore have an impact on passenger numbers, is so that we can detect variants of concern.

If you look at July's data—I equate it to Germany, where they did not even test at all in July, but we did—there were 500,000 people in a three-week period tested on expensive PCRs. Of those, 7,000 tested positive, so a very small number. Of those 7,000, only 5% had their PCR tests tested for variants of concern. Doesn't that render it an expensive white elephant?

Dr Harries: All positive tests by travel providers should be put through for sequencing. That is one issue. On the particular data that you have just described, I would have to check what the positivity rate was in the UK at the time.

Q331 **Chair:** I can tell you. It actually came from the Government website. The rate in February was 50% of all cases being tested for variants of concern. In July, it had fallen to 5%.

Dr Harries: It will depend. I would have to come back with the detail. I am very happy to do that, to show the Committee the logic. Broadly, for example, all the tests that go into Mr Mogford's managed hotels go off for sequencing because we know they are high risk. We have prioritised them depending on higher and lower-risk countries, broadly to ensure that we always have coverage of high risk. It is the same with clinical patients. If you have a clinical patient in hospital, for example, or an immunosuppressed patient, we know that the risk from variants is higher.

It is important to realise that even with quite low percentages in travel terms—for example, if a pre-departure test is employed—we should not really see more than 1% of people coming through being positive, yet in some countries that is not the case. We have done some studies on this. I am very happy to answer the question in more detail by correspondence. It would probably be better for me to do that than to try to work through all the detail in this call.

Chair: That would be great. It would also be helpful for us to know this. You talked about what the mitigation is by having testing rather than no testing at all. It would also be helpful for us to know what further mitigation is then delivered by having two sets of tests, which is what we have right now.

Finally, over to Ruth Cadbury.

Q332 **Ruth Cadbury:** Thank you, Chair. Mr Mogford, you are the senior responsible officer for borders at the UKHSA. Since we have had the pandemic and international travel has opened up, we have seen instances of extensive queues at Heathrow, in particular, with passengers very distressed because of the time they are waiting. That must also mean a rise of infection risk both to passengers and the staff working in those waiting halls. Part of the extra time that people are queuing to go through border control is because of the extra checks needed for Covid passes and so on.

What is your view of the causes of the extensive queuing times at certain periods? What do you think can be done to reduce either the queuing time or, at the very least, the risk of cross-infection through the experience of very overcrowded arrival halls?

Jonathan Mogford: There has been lots of work done during the time that we have had the red route and hotels and the arrivals arrangements within and through the ports. We have worked very closely with Border Force colleagues and with the airports themselves.

At the peak period, which was very much over the summer, when we had anything up to 3,000 people a day arriving in the country, that was being largely handled through particular and dedicated arrangements. Heathrow is the largest port of entry, and that made a very significant difference in both the queuing and the segregated arrangements. There was a progressive set of steps made through the time that we have been running the hotels to address exactly those issues.

Q333 **Ruth Cadbury:** Is the solution to provide more space, or is there anything that the UKHSA can do to reduce your element of the checking time? Obviously, there is the immigration element as well. That is another area that we are also pursuing.

Jonathan Mogford: Those are all done together: the Border Force and the checking of the health arrangements. What has happened progressively through the period we have been running the hotels has been the development of dedicated routes for arrival, which have made a

considerable difference in queuing times. That does not rule out the fact that there were significant queues at significant times of arrival, but we have looked to segregate them, particularly the red route arrivals and the higher risk.

Q334 **Ruth Cadbury:** We have Christmas coming up, which is also a peak period for travel, if there are no further restrictions on travel. Is there enough space at Heathrow airport to enable passengers to queue safely? Should more space be made available?

Jonathan Mogford: There have been significant steps made on how much of the checking actually needs to be done at the border itself. For the most part, the reliance now is on carriers checking, particularly passengers' vaccination status and PLF, before they arrive. Everything that can be done has been done to minimise what actually needs to be actively checked at the border for health purposes. That is particularly helped by the relationship with the carriers for the carrier checking that they are doing, and making sure that everybody fills in the right forms before they leave.

Ruth Cadbury: Thank you.

Chair: Dr Harries, Dr Wynne-Evans and Mr Mogford, thank you all so much for giving us your time. We know that you are incredibly busy and doing quite an extraordinary job. Thank you for giving us such interesting evidence. I wish you all very well. As Mr McCartney said, you are all looking very well, and let's hope you continue in that vein. Thank you again for being with us this morning.