Witness Name:
Statement No.:
Exhibits:
Dated:

UK COVID-19 INQUIRY

WITNESS STATEMENT OF
DR JENNIFER DIXON, CHIEF EXECUTIVE, THE HEALTH FOUNDATION

I, Dr Jennifer Dixon, will say as follows: -

1. I am chief executive of the Health Foundation, a role I have held since 2013. Previously I was chief executive at the Nuffield Trust from 2008 to 2013, director of policy at The King's Fund and policy advisor to the chief executive of the National Health Service between 1998 and 2000. I trained in medicine and hold a master's in public health and a PhD in health services research from the London School of Hygiene and Tropical Medicine. Alongside, I was appointed a non-executive board member of the UK Health Security Agency in April 2022 and have previously served as a non-executive on the boards of the Health Care Commission, the Audit Commission and the Care Quality Commission.

2. The Health Foundation is an independent charity committed to bringing about better health and health care for people in the UK. Our aim is a healthier population, supported by high quality health care that can be equitably accessed. We learn what works to make people's lives healthier and improve the health care system. From giving grants to those working at the front line, to carrying out research and policy analysis, we shine a light on how to make successful change happen.

3. The Foundation produces, commissions and uses evidence and analysis to understand how national policy and the health and care system can contribute to

a healthier population, supported by high quality health and social care. Our in-house research and policy analysis draws on our expertise in health and social care policy, economic analysis and data analytics and access to secure data about how people use and benefit from health and social care services. The Foundation also funds research and practice on improving health care and the wider determinants of health, ranging from small, one-off sums to multi-year demonstration programmes and fellowships. This accounted for £16.6m of the £30m we spent directly on furthering our mission in 2021, but is likely to be less relevant to this module of the Inquiry. While the Foundation works across the UK, the majority of the work covered by my statement relates to England only.

4. As an independent charity, the Health Foundation is not part of the statutory health and care system. The purpose of the Health Foundation is to bring about better health and health care for people in the UK. Our strategic priorities are to improve people's health and reduce inequalities, support innovation and improvement in health and care services, and provide evidence and analysis to improve health and care policy. We aim to achieve this by building evidence, shaping policy and practice, building skills knowledge and capability, and acting as a catalyst for change.

5. The Health Foundation's origins lie in the London Association for Hospital Services – a mutual health insurance scheme set up in 1938, prior to the formation of the NHS, and later known as the PPP Healthcare Group. When PPP was bought by Guardian Royal Exchange Assurance (now part of AXA insurance) in 1998, an endowment of £560m was provided to establish the PPP Healthcare Medical Trust, renamed the PPP Foundation in 2001. The organisation became the Health Foundation in 2003 to signal our independent status as a grant-making charity – the Foundation retains no connection to PPP or AXA insurance.

6. The Foundation is accountable to our independent board of trustees and the Charity Commission. Our endowment – currently valued at over £1bn – continues to fund our charitable activities and means we do not need to fundraise

to generate income. This model is essential to our independence and ability to plan and fund work for the longer term.

7. We seek to apply an equity lens to our work where possible and highlight where parts of our population are at greater risk of ill health or are less well served by the health and care system. Beyond this, we do not represent, support or advocate for the interests of any specific groups on an ongoing basis. The Foundation is independent from government and not linked to any political party. We have no donors, supporters or members.

8. The Foundation receives a small amount of funding from grants, commissions and from our co-ownership of the *BMJ Quality & Safety* journal and grants from other organisations. Our website provides details of our key partnerships – including those with public bodies operating at arm's length from government such as the Q Community and the Improvement Analytics Unit. A short history of the Health Foundation, published in November 2022, is available on our website.

The state of the UK's emergency and pandemic planning, preparedness and resilience at the outset of the COVID-19 pandemic

9. I am asked to outline the Health Foundation's views on the UK's emergency planning, preparedness and resilience, the extent to which emergency planning took account of pre-existing health inequalities among the population and to identify areas which could have been done better prior to the pandemic.

10. The Health Foundation's mission is to improve health and care for people in the UK, and we do this through a mix of generating evidence and analysis, influencing policy and practice and building skills and knowledge to support service innovation and improvement (as outlined above). The Foundation does not have a specific objective to further understanding of how to prevent and manage outbreaks of infectious disease, to assess or improve emergency planning and preparedness, or to examine the UK's readiness to manage infectious diseases, as areas of national policy or operational practice. We were not closely or frequently engaged in national policy discussions on those topics

though our work does have implications for long-term planning and resilience in the health system. There was relatively limited information on emergency preparedness in the public domain prior to COVID-19 and we did not possess the institutional knowledge and expertise to comment on the strengths and weaknesses of the UK's emergency planning prior to 2020.

11. Given the nature of my career prior to COVID-19, I was aware that the UK government considered pandemic influenza and the emergence of a novel virus as risks that could lead to major national emergencies. I knew that the UK government had developed national plans for responding to pandemic influenza, as well as other health threats, and that national and local government, emergency services and the wider public sector had legal responsibilities for developing contingency plans for a range of emergencies and other incidents. I was also aware that exercises were regularly held to test and improve such plans and that the pandemic influenza plan had been at least partially implemented during the H1N1 global influenza outbreak from 2009 to 2010. However, I had no direct involvement in emergency or pandemic planning and have no specific knowledge of the development and testing of these plans.

12. Following the initial outbreak of COVID-19 and the declaration of a pandemic, the Health Foundation reoriented some of our work to focus on tracking the overall policy response to COVID-19 and understanding the impact of COVID-19 and response to the pandemic. Our objective was to inform the UK's recovery from the pandemic and identify how the country could be more resilient to future health emergencies. The Foundation also continued to co-fund the WHO European Observatory on Health Systems and Policies, which collaborated with country partners to track and describe international responses to COVID-19 to support sharing of learning across Europe.

13. Based on this work, I focus my response below on three key areas: i) the state of the health and care system and its resilience as it entered 2020; ii) the health of the population and inequalities between groups at the point when COVID-19 emerged as a major threat to public health; and iii) the communication of public health advice to the population during the pandemic.

i) The health and care system

14. The health and care system went into 2020 with limited capacity and under major strain after a decade of weak investment, which left services vulnerable to a national health emergency like a pandemic. A range of factors contributed to this lack of resilience:

15. **A decade of austerity.** Over the decade leading to 2019/20, day-to-day spending on public services fell in real terms by 13% per person (JD/1 – INQ000108744). These reductions affected the resilience of public services and influenced the social and economic conditions of people's lives which impact their health and health inequalities. While NHS spending was protected in real terms, funding increases were constrained over this period and did not keep pace with growing demand for health care, and other parts of the health and care system saw real reductions in spending (explored further below).

16. **Constrained NHS capacity.** Prior to the pandemic, the NHS continued to enjoy strong public support but was coming under increasing operational pressure. The NHS was protected from real-terms funding cuts experienced by other public services, but funding growth from 2009/10 to 2018/19 was severely constrained at around 1.4% per year – compared to an average of 3.6% per year from 1949/50 to 2018/19 (JD/2 – INQ000108749). In 2019, per capita public spending on health in the UK was £2,646.95 – substantially below that in France (£3,307.54) and Germany (£4,131.21) (JD/3 – INQ000108750). Spending on capital – buildings, equipment and IT – was materially lower than other comparable advanced health systems and there were large backlog maintenance needs. If the UK had matched other EU14 countries' average investment in health capital, the UK would have invested £33bn more than it did between 2010 and 2019 (JD/4 – INQ000108751). The NHS's limited capacity to manage demand shocks was noted before COVID-19, with hospitals operating with high levels of bed occupancy and persistent staff shortages (JD/5 – INQ000108752). Before the effects of the pandemic were felt, performance against a range of

important service indicators – including waiting times in emergency departments, and waits for cancer and routine hospital treatment – was the worst on record.

17. **Political neglect of social care.** As the pandemic emerged, England's system of adult social care – care and support for adults of all ages as a result of illness or disability – was underfunded and understaffed (JD/6 – INQ000108753). This indicates to me that central government undervalues social care. The publicly funded system is only available to people with the highest support needs and lowest means. Public spending decisions had exacerbated capacity issues in social care. When adjusted for an ageing population, funding per person fell by around 12% in real terms between 2010/11 and 2018/19. Despite rising needs, fewer people were receiving support from local authorities over that period. Workforce shortages were estimated at approximately 120,000 and many care homes relied on agency staff working across multiple sites. The organisation and delivery of social care in England is also complex and fragmented.

18. **Fragmentation of the health and care system.** The health and care system that entered the pandemic was complex and fragmented. The Health and Social Care Act 2012 introduced sweeping changes to the English NHS, including abolishing some organisations, creating new ones and re-arranging responsibilities. The 2012 reforms established Public Health England (PHE), replacing the Health Protection Agency. PHE was established as a national agency combining health protection and health promotion functions previously carried out by several organisations, under the direct control of ministers. Adult social care in England is provided by around 18,500 organisations. Governance and accountability arrangements for adult social care are split between around 150 local authorities and three government departments. The effect is a complex web of national and local organisations with more limited national oversight and coordination of policy than in the NHS.

19. **Shortcomings in data and infrastructure.** Challenges in using data effectively across government, including the risk of decisions based on poor quality data and inconsistency across government departments, were identified prior to the pandemic (JD/7 – INQ000108754). Data availability and quality was a significant

barrier to the pandemic response in some areas, for instance, the lack of a care home register; difficulties in identifying care homes residents in routine data; and lack of reliable data presented difficulties for local authorities working to prioritise certain groups, such as unpaid carers and vulnerable people, for COVID-19 vaccinations. Relatedly, in some cases, identifying frontline staff groups eligible for vaccination, and administering vaccinations and monitoring take up, was made more difficult by incomplete data for staff employed via external contractual arrangements.

ii) Population health and inequalities

20. Much of the debate about the response to COVID-19 focused on the ability of health and care services to respond. This reflects the value that people place on high-quality health and care services and the prominence of the NHS in political and policy debates on health. But evidence shows that staying healthy depends on much more than health care: people's health is shaped by the circumstances in which they are born, grow, live, work and age – often referred to as the 'wider determinants of health'. In the years prior to the pandemic, the health of the UK population was showing some concerning trends, including widening inequalities linked with a corresponding deterioration in many of these wider determinants of health (JD/8 – INQ000108755). It was in this context that the pandemic did such damage to people's health and wellbeing, including having a particularly significant impact for some groups already facing poor health outcomes (JD/9 – INQ000108756). A range of factors contributed to this lack of resilience:

21. **Stalling improvements in life expectancy.** People in the UK today are living longer than at any time in the past thanks to steady declines in mortality over many decades. However, since 2010 there has been a marked slowdown in improvements in mortality (JD/10 – INQ000108745). And for certain groups, for instance, females in the most deprived 10% of neighbourhoods, life expectancy actually fell between 2010-12 and 2016-18. While a slowdown in life expectancy improvement was seen across several advanced health economies in Europe, the UK has been unusually affected. The UK is towards the bottom of life expectancy rankings in the OECD and has fallen since 2000. In 2017, female life

expectancy at birth in the UK was 83.1 years compared to 84.1 years in Spain and 87.3 years in Japan.

22. **Pre-existing inequalities.** In the decade prior to 2020, income and wealth inequalities widened in England, leaving individuals in lower socio-economic groups more vulnerable to the effects of the pandemic. The impacts of austerity were most significant in areas of greatest need, reinforcing inequity in public service delivery: the least deprived local authorities saw a 16% decrease in net expenditure per person since 2009/10, while expenditure fell by 31% in the most deprived areas. There has also been a rise in the prevalence of multiple long-term conditions (LTCs) since the early 2000s, with those living in more deprived areas and from some ethnic minority groups more likely to have multiple LTCs (JD/11 – INQ000108746).

23. **Public health funding cuts.** The public health grant supports local authorities in England to provide services that are central to maintaining and improving people's health, such as obesity services, drug and alcohol services and sexual health services. It also supports public health teams to influence the development of wider local policies and services such as housing and children's services to support good health. Reductions in central government funding for public health saw spending 22% lower per person going into 2020 than it was in 2015 (JD/12 – INQ000108747). The budget for PHE, England's national public health agency at the time, also fell by around 17% between 2015/16 and 2019/20 (though its spending on protection for infectious diseases actually increased by 53%) (JD/13 – INQ000108748).

24. **Trends in the wider determinants of health.** Trends observed in the wider determinants of health were fundamental in shaping population health and resilience ahead of the pandemic. Between 2010 and 2018 there was an increase in insecure employment (including a five-fold increase in the number of people on zero-hours contracts), increased rates of child poverty (with over 4 million, or roughly one in three, living in poverty after housing costs by 2018), alongside significant increases in food insecurity and homelessness. As well as detrimentally impacting on health, these factors often increased vulnerability to

COVID-19 infection, for example through overcrowded housing or reduced financial ability to comply with isolation guidance. There is an interplay between some of these socioeconomic factors and ethnicity. In the case of housing, for example, 30% of Bangladeshi households were classified as overcrowded in 2018 compared with just 2% of white households.

iii) Communication of public health advice

25. Effective communication is needed to promote compliance with public health measures during a pandemic. I am unable to assess the extent to which pandemic planning had considered the demands and challenges of clear and effective public communication during a national emergency. However, the Health Foundation's work on public perceptions during 2020 suggests some of the public health measures introduced by government in response to COVID-19 were not well understood, which may have affected the extent to which people were able to adhere to the relevant guidance.

26. During 2020, the Foundation commissioned Ipsos UK to undertake three surveys – in May, July and November – of a representative sample of the population in England, Scotland and Wales to understand how public attitudes and experiences changed during the pandemic. The surveys undertaken in July and November 2020 asked about the perceived clarity of different aspects of the official advice on complying with restrictions.

27. The July 2020 survey found that nearly four in five of the public (78%) thought the guidance on travelling safely was clear, while around two-thirds also thought the guidance on self-isolation (68%) and staying safe outside the home (62%) was clear (JD/14 – INQ000108983). However, a significant minority thought the advice was not clear (for example, 46% thought the guidance on visiting places safely was not clear) and a majority of 54% thought the guidance around who and how many people they can meet with was not clear. For each public health measure, there was a strong correlation between the proportion of people who said the guidance was clear and the proportion saying that people were following

this advice well. This suggests that greater clarity may have aided adherence to guidance.

28. The survey in November 2020 showed the perceived clarity of the official guidance continued to vary. Guidance on travelling safely was thought to be particularly clear (86%), as was the guidance on staying safe outside the home (79%) (JD/15 – INQ000108984). The guidance on who and how many people it was permissible to meet with was clearer to the public than in July, prior to the rule of six (with 59% saying this guidance was clear in November, compared with 44% in July). However, a significant minority thought the advice was not clear on who and how many people they could meet with (40%), attending university (33%) or going to work (31%), and when people should stay at home to self-isolate (31%).

29. Both surveys found considerable variation in the perceived clarity of the guidance between different groups of the population. For example, across all the advice, people from white ethnic backgrounds were more likely to think the government's advice was clear than those from non-white backgrounds. This work also highlights the wider importance of understanding how public attitudes and experiences change over the course of a prolonged national emergency and the need to confirm that important public health advice is widely understood across the population.

Engagement with government and policymakers regarding emergency planning and resilience

30. I am asked to describe the extent to which the Health Foundation engaged with government regarding the state's emergency planning and resilience ahead of January 2020, subsequent to that date, and how the Health Foundation corresponded with colleagues in government about emergency planning.

Before 2020

31. The Health Foundation was involved in regular dialogue and engagement with national policy makers prior to 2020. Before the pandemic, the Health Foundation

shared evidence and analysis and raised a range of points with national decision makers regarding the health of the population, health inequalities, the performance and quality of the health and care system, and priorities for national policy on the NHS and social care. Much of this dialogue was relevant to the UK's resilience to a major health emergency. But our engagement with policymakers was not specifically focused on the risks of a pandemic or the implications for emergency preparedness and pandemic planning.

2020 onwards

32. During the initial wave of the pandemic, the Foundation reoriented our work to provide immediate and direct support for the health and care system and the national response to COVID-19. Our existing programmes and partnerships provided data and analysis to understand the impact of COVID-19, particularly on vulnerable groups, support analysts to share and collaborate, and find new ways to solve the deficit of data in social care. Through the work of the Q Community, the Foundation supported people to capture, review and learn from the rapid improvement and innovations driven by COVID-19.

33. Informed by this work and our broader understanding and analysis of the health and care system, the Foundation engaged in regular discussions with national policymakers throughout the acute phases of the pandemic. The Foundation engaged with government through the publication of in-house and commissioned analysis of the impact of COVID-19 and the national response, and the UK's recovery from the pandemic. A list of the Health Foundation's relevant publications is included as an exhibit (JD/16 – INQ000108985). Health Foundation staff attended briefings provided by government departments, PHE or NHS England and there were discussions between Health Foundation staff and government departments, PHE or NHS England to discuss analytical needs and where the Foundation, and other external organisations, may be able to offer support.

Government communication regarding emergency preparedness prior to, and during, the pandemic

34. I am asked to describe the Health Foundation's views on the extent and adequacy of the government's engagement and communication regarding its emergency planning preparations ahead of January 2020, and subsequent to that.

35. Given the focus of the Health Foundation's work, as set out above, we were not the focus of any government communication about emergency preparedness prior to the pandemic and nor did we expect to be engaged on this specific topic. Notwithstanding this, below is a brief summary of my understanding of the government's readiness before COVID-19 emerged and how the Foundation engaged with policymakers.

36. The Foundation was aware that the UK government's national risk register had included a pandemic health emergency as a high-priority risk since it was first produced in 2008. The national risk register assessed that pandemic influenza was a comparatively high-probability event and would be likely to cause significant social and economic damage. In line with this, the Foundation expected that public bodies – central government departments, national arm's-length bodies and local agencies – were fulfilling legal duties to make contingency preparations for emergency situations.

37. Following the national referendum on the UK's membership of the European Union (EU) in June 2016, the Foundation was aware that the UK government and national arm's-length NHS bodies were planning for possible operational consequences of a 'no-deal' exit whereby no withdrawal agreement or framework for future relations would have applied at the end of a transition period. Colleagues at the Foundation participated in a private briefing with senior NHS England colleagues outlining what preparations were being made. The Foundation's expertise meant we were not in a position to robustly assess the merits of no-deal planning or planning for other emergency scenarios.

38. Throughout this period, the Foundation's primary engagement regarding emergency preparedness was with NHS England. We did not have extensive discussions with other public bodies, or central departments, about national

emergency readiness and contingency planning. This was congruent with the Foundation's focus on health and health services.

39. As outlined above, following the start of the COVID-19 pandemic, I and other staff at the Health Foundation were in regular communication with national bodies regarding the operational response. This took the form of occasional private briefings on the nature of the response, understanding how the Foundation could support specific aspects of the response and sharing the findings of our in-house and commissioned work, where relevant. I, and colleagues at the Foundation, also had regular communication with government and national bodies about the wider health policy agenda, including provisions of the Health and Care Bill and development of the government's integration white paper, *Joining up care for people, places and populations,* which was published in February 2022. I do not recall any of these discussions addressing the effectiveness of the UK's preparations for the COVID-19 pandemic or plans for future emergencies.

Lessons for future pandemics and/or public health emergencies

40. I am asked to outline, with the benefit of hindsight, which decisions the government could have made differently and identify lessons which can be learned for future pandemics and other national emergencies. The Health Foundation's recent published outputs (set out at exhibit JD/16 – INQ000108985) point to a range of lessons regarding how the health of the population and health and care services could be made more resilient to future shocks. Below I identify a few key lessons based on the Foundation's work regarding the UK's pandemic response. The WHO European Observatory on Health Systems has also set out some lessons from an international perspective, which I include as an exhibit (JD/17 – INQ000108986).

41. **A lack of health service capacity constrained the COVID-19 response and, without sustained investment in increasing resilience, responses to future threats may be similarly hampered.** Many advanced health systems experienced disruption due to COVID-19, but the pre-existing constraints on the health systems in the UK risk prolonging the recovery of services and, without

sustained investment, risks leaving the UK vulnerable to future public health shocks. In order for the UK's health and care system to be ready for future emergencies action is needed to expand capacity. This should include addressing staff shortages across the NHS – spanning acute, community, mental health and primary care – and social care services, reassessing service capacity needs, and ensuring appropriate capital investment is consistently available to bring the system's equipment, estates and infrastructure into line with other advanced health systems.

42. **Government support for social care services in England was too slow and limited, leading to inadequate protection for people using and providing care.** The social care system that entered the pandemic was underfunded and understaffed – and many people went without the care they need. During the first wave of COVID-19, protecting social care services and staff appeared to have been given lower priority by national policymakers than protecting the NHS. These shortcomings left the system, and people who rely on social care, vulnerable to the effects of COVID-19. A blend of investment and reform is needed to ensure the social care system can meet users' needs and be more resilient in the future. This should include steps to improve pay and conditions for staff working in social care and measures to increase workforce supply, increased central funding for social care to improve access to publicly-funded care, and reform to provide greater protection for individuals against social care costs.

43. **The comparatively poor health of the UK population and wide health inequalities shaped the impact of COVID-19.** A range of factors contributed to the poor state of population health in the UK in 2020, including inequalities in employment, housing and educational opportunities and fragility of the welfare state. Establishing true resilience ahead of future public health crises requires building good population health and reducing health inequalities across the UK. A coherent programme to deliver on this would involve long-term action across the wider determinants of health, including investment to promote high-quality employment (with a focus on areas with historically low levels of employment); addressing weaknesses in the welfare state; renewal of public services including

a greater focus on prevention; and a cross-government health inequalities strategy with clear measurable targets. The government's recent decision to not progress the planned white paper on health disparities is a concerning sign that the case for a holistic approach to health inequalities is yet to be fully understood within government.

44. **Data and the data infrastructure can support an effective emergency response, but require better quality data, better data linkage and greater analytical capability to realise that potential.** Data supported some of the more successful aspects of the pandemic response, including the rapid development and testing of vaccines and other therapeutics, but much of the infrastructure that enabled more efficient information sharing in the health care system was developed at pace in response to the crisis with emergency legislation allowing wider sharing and linking of patient data under the Control of Patient Information Regulations. A lack of high-quality, accessible national data on primary care services was a serious gap during the pandemic; and lack of data on care home staff and staff working patterns hampered understanding of care home infections despite non-pharmaceutical interventions; and local authorities' work to prioritise certain groups for vaccination, such as unpaid carers, was made more difficult by lack of reliable data. The national government and arm's-length bodies need to be able to draw on better data and improved analytical capabilities to inform future emergency responses. In particular, the government needs to build on the learning from the pandemic response by finding a permanent mechanism to enable appropriate data sharing and linkage that can command public trust and support without the justification of a national emergency,

45. **The national response to COVID-19 led to a step change in the use of technology to enable remote access to essential health care, but much remains to be learnt about the impact and implementation of these changes.** While the majority of those who reported increased use of technology for health care purposes had positive experiences, some groups were more likely to report a negative experience. A greater focus on evaluation and equity and inclusion will be important, to ensure that as many people as possible benefit

from the use of technology for healthcare purposes. In some areas a lack of infrastructure and appropriate equipment stifled uptake, so investment and support and training for staff to ensure effective implementation of new technology would help secure longer-term sustainability for service changes. Future emergency responses need to learn from the experience of using technology to enable maintenance of remote access to essential services during national emergencies.

46. **Public understanding of public health messaging varied across groups and over time, and may have affected the extent to which people were able to adhere to guidance.** Responding to COVID-19 presented an evolving challenge for public health messaging, with the national rules and guidance changing over time based on the epidemiological and operational situation. The Health Foundation's work suggests that there were times during the pandemic when a substantial minority of the public did not think the public health guidance was clear. Additionally, our work suggests there were differences in public understanding of guidance between demographic groups. This raises questions about the extent to which national communications were framed with an emphasis on health inequalities. Ahead of future national emergencies, central government departments and public agencies should learn from experiences of delivering public health messaging during COVID-19. This should include focusing on how to ensure guidance is widely understood across the public, approaches to monitoring any changes in public understanding, and how to respond to differences in understanding between communities.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Personal Data

Signed: _____

Dated: ____14 April 2023 _____