1. **A brief overview of the history, legal status and aims of the organisation or body. Please explain whether the work of the organisation or body is UK wide, or is instead confined to England, Scotland, Wales or Northern Ireland only.**

2. **A brief description of the group(s) which the organisation or body supports or represents.**

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.

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. This aspect of our work is the most relevant to module 2 of the Inquiry and accounts for most of the material shared below. While the Foundation works across the UK, the majority of the work covered by our response relates to England only.

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.

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. We 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.

We are 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.

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. We are independent from government and not linked to any political party. We have no donors, supporters or members.

We receive 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.

3. **A brief overview of the work of the organisation or body in supporting or representing the relevant group(s) between January 2020 and Spring 2022 as it relates to the response to Covid-19 of (a) the UK Government; (b) the Scottish Government; (c) the Welsh Government; and/or (d) the Northern Ireland Executive.**

The Health Foundation has undertaken a range of work looking at the impact of COVID-19 and the national policy response. Our aim was to apply our pre-existing knowledge, expertise and organisational assets to:

- Contribute to public, policymakers', and media understanding about the impacts of COVID-19 and how the government and health and care system is responding
- Analyse and assess the UK response to the pandemic and how it has been handled by government and the health and care system, with a particular focus on the response in England
- Inform and influence national policymakers and those working in health and care services seeking to manage the pandemic and mitigate its impact on people and society

Throughout the period covered by this module of the Inquiry, the Health Foundation undertook a wide range of work to understand, assess, and inform the COVI-19 response. This includes analysis of the health and equity impacts of COVID-19, service changes in health and social care, and the policy response to the pandemic and its effects.

Tracking the overall policy response to COVID-19. This included producing the COVID-19 policy tracker of national government and health and social care system responses to COVID-19, and how they changed; analysis and assessment of national government policies on adult social care; analysis of Test and Trace policy and performance; and commissioning public polling on attitudes to the government handling and specific policy interventions. The Foundation also continued to co-fund the WHO European Observatory on health systems, which collaborated with country partners to track and describe international responses to COVID-19 to enable rapid sharing of information and contacts across Europe.

Understanding the impact of COVID-19 and the response to the pandemic. The Foundation established a COVID-19 impact inquiry to examine how pre-existing health and health inequalities influenced people's experiences of the pandemic and the likely impact of the pandemic response on the nation's health and health inequalities. This also included analysis of excess mortality – including regional variation, international comparisons, and drivers, work to understand 'non-COVID' excess mortality, analysis of deaths (and service use) among people using and providing adult social care and providing commentary on ONS mortality data primarily linked to adult social care.

Identify lessons for the future. This included work on how the NHS and social care responded to the pandemic; how COVID-19 affected health-seeking behaviours and demand for NHS 111, primary care and urgent and emergency care; priorities for the recovery from the pandemic; and developing a shared vision for the long-term research and evidence requirements to support the UK to become more resilient to future health shocks like COVID-19.

During the initial wave of the pandemic, the Health Foundation sought to rapidly reorient 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, we supported people to capture, review and learn from the rapid improvement and innovations driven by COVID-19. We made the first of a series of donations to charities working directly with the people most affected by the social and financial impacts of COVID-19 and the pandemic response (further details available on request). Several of our clinical, public health and other specialist staff were released to be redeployed to front-line NHS care, or seconded to NHS England, Public Health England and the Department of Health and Social Care to assist with the pandemic response.

The Foundation was not formally commissioned to undertake work on behalf of government or arm's length bodies, but routinely shared emerging findings of relevant analysis. We also contributed to discussions with policymakers where appropriate, particularly in terms of where the Foundation could provide analytical support for the pandemic response. We did not offer advice, commentary or analysis of various aspects of the pandemic that lay outside the scope of our knowledge and capabilities. We did not, for example, undertake modelling of the progression of the pandemic, advocate for specific changes to clinical practice, or offer medical or legal advice about COVID-19 or the measures taken to contain the virus.

4. **A list of any articles or reports the organisation or body has published or contributed to, and/or evidence it has given (for example to Parliamentary Select Committees) regarding the impact on the group(s) which the organisation or body supports or represents of the response to Covid-19 by (a) the UK Government; (b) the Scottish Government; (c) the Welsh Government; and/or (d) the Northern Ireland Executive. Please include links to those documents where possible.**

The Health Foundation published or contributed to a large volume of articles, reports, submissions and presentations between January 2020 and March 2022 relevant to the provisional scope of module 2 – listed in an appendix to this response.

With the aim of assisting the Inquiry, these items are listed in chronological order, with hyperlinks included where possible and major outputs highlighted in yellow, and grouped into the following categories:

- The use of data and analytics
- The impact of COVID-19 and the pandemic response
- Recovery from the pandemic

If the Inquiry would prefer these items to be grouped into different categories (e.g. health care, social care or health inequalities), we stand ready to assist.

5. **The view of the organisation or body as to whether the group(s) it supports or represents was adequately considered when decisions about the response to Covid-19 were made by (a) the UK Government; (b) the Scottish Government; (c) the Welsh Government; and/or (d) the Northern Ireland Executive. Please also explain the reasons for the view expressed by the organisation or body in this respect.**

6. **Whether the organisation or body raised any concerns about the consideration being given to the group(s) which it supports or represents with (a) the UK Government; (b) the Scottish Government; (c) the Welsh Government; and/or (d) the Northern Ireland Executive, when the Government(s) and/or Executive were making decisions about their response to Covid-19. Please provide a list of any such correspondence or meetings with the UK Government, Scottish Government, Welsh Government and/or the Northern Ireland Executive, including the dates on which the body or organisation wrote or such meetings were held, to whom the correspondence was addressed or with whom the meeting was held, and any response received from the UK Government, Scottish Government, Welsh Government and/or Northern Ireland Executive addressing such concerns.**

The Health Foundation does not support or represent any specific groups on an ongoing basis. Listed below are the key instances we have identified where the Health Foundation drew attention to concerns about an aspect of the pandemic response in meetings or correspondence with policy leads within part of national government or arm's length bodies.

April 2020 – NHS England
Health Foundation staff corresponded with an analyst in the behavioural science unit of NHS England about why people were not accessing NHS services for non-COVID conditions during the initial wave of the pandemic. Advance findings from our public polling, showing high levels of public anxiety about using health services due to fear of being exposed to COVID-19, were shared with NHS England and may have informed the subsequent public campaign to encourage people to come forward.

May 2020 – Department of Health and Social Care
Health Foundation staff shared the draft report of our assessment of the measures taken to protecting adult social care in England during the first wave of the pandemic with DHSC officials. This was followed up by meetings with officials to discuss the concerns raised by our findings in July and October 2020), as well as a meeting with Sir David Pearson, chair of social care taskforce in DHSC in August 2020.

June 2020 – NHS England
Jennifer Dixon and Health Foundation staff joined a briefing on COVID-19 with Professor Stephen Powis, National Medical Director at NHS England. The Foundation highlighted the importance of tracking capacity in NHS community services and social care services as well as hospital capacity, especially if informal care provision diminished as furlough was wound down and this created extra demand.

June 2020 onwards – Department of Health and Social Care and arm's length bodies
Health Foundation staff shared the first of several iterations of analysis of evidence regarding the broader impacts of COVID-19 and the national response with strategy leads in

the DHSC, Health Education England, CQC, NICE, MHRA, NHS England and Improvement, NHS Resolution and Public Health England. Drawing on our Shaping Health Futures programme that encourages long-term thinking to be incorporated into national policymaking and planning, this analysis was intended to support officials to think through different scenarios for the pandemic and the implications for the post-COVID recovery, based on available evidence about the impacts of COVID-19 and the national response. No specific concerns were raised beyond the evidence summarised in the analysis. This work has not been published but full details can be provided to the Inquiry if needed.

July 2020 – Department for Culture, Media and Sport
Jennifer Dixon wrote a joint letter with Greg Allen of Future Care Capital to Oliver Dowden, then secretary of state for culture, media and sport, to call for the explicit inclusion of social care in the upcoming National Data Strategy. The letter highlighted that the lack of comprehensive, high quality data about social care was deeply concerning and that there were still major gaps in what was needed to tackle COVID-19. The letter was copied to ministers and special advisors in the Department for Health and Social Care, as well as officials in the Department for Culture, Media and Sport.

July 2020 – SAGE social care working group
Health Foundation staff presented analysis of hospital data in England highlighting concerns about high levels of hospital discharges of permanent care home residents and signs of reduced access to elective and emergency inpatient hospital care for care home residents.

July 2020 – Department of Health and Social Care and NHS England
Health Foundation staff presented analysis of the impact of COVID-19 on the delivery of primary care, drawing on our access to patient-level data held by the Clinical Access Research Datalink (CPRD). We raised concerns that the lack of access to CPRD within the DHSC and NHS England was an important blind spot within the pandemic response and offered support with coding and analysis. We understand that, to date, neither the DHSC nor NHS England have subsequently secured access to CPRD.

July 2020 – 10 Downing Street
Jennifer Dixon wrote to Patrick Carey of the Number 10 and HM Treasury taskforce on health and social care to set out the Foundation's high-level assessment of key priorities for the government. This included: better management of complex health needs, addressing staff shortages, focusing on productivity, social care access, funding reform and workforce, and ill health and prevention.

December 2020 – Public Health England
Health Foundation staff shared with Dr Susan Hopkins an advance copy of a letter to the Lancet and accompanying press release raising concerns that NHS Test and Trace was tracing fewer COVID-19 cases and their contacts in more deprived areas.

March 2021 – Roundtable discussion event with adult social care stakeholders
Health Foundation staff convened this event to discuss the initial findings of an analysis of the support for adult social care in England following the first wave of the pandemic. The event was attended by Kate Terroni, the Chief Inspector of Adult Social Care at the Care Quality Commission.

April 2021 – Department of Health and Social Care

Health Foundation staff shared a draft briefing on developments in the arrangements for supporting adult social care in England following the first wave during the pandemic with Sir David Pearson for review and comment. Letters summarising the concerns highlighted by the findings of the report were sent to Helen Whatley (then minister for social care), Jeremy Hunt and Greg Clark (then chairs of the health and social care and science and technology select committees respectively).

May 2021 – Department of Health and Social Care and NHS England
Health Foundation staff presented analysis showing the pandemic had led to greater falls in urgent referrals with suspected cancer and diagnoses of cancer in more deprived areas despite lower levels of disruption to primary care services. Along with updated analysis of CPRD data (see July 2020), this analysis was included in the DHSC's submission to the 95th meeting of SAGE in September 2021.

July 2021 – Department of Health and Social Care
Health Foundation staff met officials from the DHSC COVID-19 Volunteering Policy team to share analysis of the clinically extremely vulnerable population during the first and second phase of shielding. Concerns about the impact on the mental health and access to hospital care for this population were raised with officials.

Please note that this list excludes:

- The various concerns highlighted in the Health Foundation publications listed above, including publicity and press materials, unless raised directly with any specific individual or part of government
- Any concerns expressed via the personal social media accounts of Health Foundation staff members, which may be used to support the dissemination of our publications but may not represent the views of the Foundation
- Any concerns expressed by Health Foundation staff while seconded to the Department of Health and Social Care, Public Health England or NHS England, unless such concerns were raised on the Foundation's behalf
- Briefings provided by government departments, Public Health England or NHS England that were attended by Health Foundation staff – except those where Foundation staff raised specific concerns in discussion
- Discussions between Health Foundation staff and government departments, Public Health England or NHS England to discuss analytical needs and where the Foundation may be able to provide support, rather than to discuss the policy response.

7. **A brief summary of the views of the organisation or body as to any lessons, if any, that can be learned from any consideration which was given to the group(s) that the organisation or body supports or represents by (a) the UK Government; (b) the Scottish Government; (c) the Welsh Government; and/or (d) the Northern Ireland Executive when they were making decisions about their response to Covid-19.**

The Health Foundation's work identifies a mix of lessons and data on the impact of COVID-19 and the pandemic response, which are explored in more detail in our published output. Here we offer the Inquiry a brief summary of the broad lessons in four areas.

A lack of health service capacity constrained the response to COVID-19 and, without sustained investment in increasing resilience, responses to future health threats are likely to be similarly hampered. The NHS' exposure to shocks in demand were noted before COVID-19, and the UK entered the pandemic with fewer doctors, nurses, hospital beds, and equipment per capita than most comparable countries. Hospitals regularly operated with high rates of bed occupancy and growing staff shortages. Performance against key indicators – including access to general practice, waiting times in A&E departments, waits for cancer and routine hospital treatment – was the worst on record. The NHS was protected from the real-terms funding cuts experienced by other public services in the decade prior to COVID-19, but funding growth was severely constrained and public spending on health per head was substantially below that in France or Germany.
While disruption to health and care services occurred elsewhere, the pre-existing constraints in our health and care system risk prolonging the recovery of services after the pandemic and, without sustained investment, leaves the UK highly vulnerable to future shocks.

Central government support for social care in England was too slow and limited, leading to inadequate protection for people using and providing care. During the first wave of the pandemic, protecting social care services and staff appeared to have been given far lower priority by national policymakers than protecting the NHS. Central government support for social care came slowly and faced widespread problems, such as issues with access to COVID-19 testing and PPE. After the first wave, support in some areas improved and the priority given to social care appeared to increase. But significant issues remained. Policy was fragmented and short-term, and support in key areas, such as on regular testing in social care, still came slowly. There were also persistent gaps in the policy response, including support for social care staff and people providing unpaid care. Government policy also risked leaving out people using and providing care in some settings, including younger adults with learning disabilities and autism. The social care system that entered the pandemic was underfunded, understaffed, and undervalued. These and other structural issues shaped the policy response and made the system particularly vulnerable to COVID-19. A mix of investment and reform is needed to strengthen the system in future.

The response to COVID-19 was hampered by shortcomings in data and the data infrastructure. While data enabled some of the more successful aspects of the pandemic response, such as the rapid development and testing of vaccines and other therapeutics, the infrastructure that enabled more efficient information sharing in the health care system was only developed in response to the crisis. The lack of government or NHS England access to important sources data on primary care was an important blind spot for the pandemic response. Data quality was a significant barrier to the response in certain areas e.g. the lack of a care home register, the difficulties of identifying care home residents in routine data. Lack of data on care home staff and staff movements hampered understanding of why care home outbreaks were occurring despite early non-pharmaceutical interventions, and of the importance of staff testing. The lack of reliable data caused difficulties for local authorities working to prioritise unpaid carers for COVID vaccinations and missing or inaccurate NHS records made it more complex to provide support to vulnerable individuals. Governments should be able to draw on better data and stronger analytical capability to inform and shape future responses.

The response to COVID-19 did not take sufficient account of the importance of health inequalities that left some people far more vulnerable to COVID-19 and the adverse effects of policy measures than others. The policymaking process during the pandemic

should have placed far more emphasis on pre-existing health inequalities, underpinned by greater awareness and understanding of how pre-existing differences in health were likely to be impacted by the virus and by the policy response. Some groups - including young people, disabled people, ethnic minority communities and care home residents – have been more affected than others. Prisoners, homeless people and people experiencing sexual exploitation have also faced particular challenges. The response to the pandemic could never have fully offset past failures to make sustained investment in improving the nation's health, addressing health inequalities or building greater resilience in health and care systems. However, at least some of the unequal impact of COVID-19 and the pandemic response was foreseeable and foreseen. Future emergency responses should take far greater account of health inequalities and avoid unfounded assumptions that everyone will be equally affected by future health threats or the national policy response.