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SMALL MINISTERIAL GROUP MEETING 6 SEPTEMBER

PAPER BY THE DEPARTMENT FOR HEALTH AND SOCIAL CARE

TEST, TRACE AND ISOLATE AUTUMN WINTER PLAN

1. The country is ready to move to a new phase of 'living with Covid' but the epidemiology remains unpredictable particularly due to the inherent uncertainty about socio-behavioural variables including return to school and increased international travel. With prolonged global prevalence the virus will continue to circulate, and there remains considerable risk through the remainder of 2021 and into 2022. We must remain vigilant to multiple factors including waning vaccine efficacy, potentially dangerous variants, and unsustainably high hospitalisations, particularly with seasonal pressure on the NHS.

2. This paper considers the strategic purpose and objectives of publicly funded test, trace and isolate (TTI) policies through autumn/winter, specifically focused on the proposed approach to **asymptomatic testing, self-isolation and support for those who must isolate**. There are other key challenges and areas of focus for TTI over autumn/winter, such as how to manage increased demand for symptomatic testing posed by increased prevalence of winter illness, detecting those at highest risk of infection or transmission and introducing use of new technologies, however this paper is focused on the outlined policy areas only. TTI policies will also help reduce the incidence of infection, protecting NHS capacity, reducing the risk of long COVID, whilst also reducing the risk of importing new variants and ensuring economic, educational and social activity can function close to normal. The ongoing requirements for critical PCR tests for travellers is not covered in full in this paper nor is the maintenance of clinical testing within the NHS.

RECOMMENDATIONS

3. That the Committee:

   a. Agrees to continue PCR testing at scale for symptomatic individuals with broader symptoms and testing of all contacts;

   b. Agrees to continue free access to asymptomatic testing through existing channels to manage the uncertainty of the Delta variant until the end of December, with a view to scaling back testing at key decision points;

   c. Agrees to extend the legal duty and financial/practical support for self-isolation until March 2022 and simplify the eligibility criteria for Test Trace Support Payments (TTSP); and

   d. Agrees, subject to the outcome of the public clinical trial, that daily contact testing should be offered to any member of the population who is an unvaccinated close contact of a positive case as soon as practically possible, meaning that only those who with symptoms or who test positive would need to self-isolate.

CONTEXT

Autumn winter considerations

4. Whilst the vaccine is effective in reducing serious illness, hospitalisation and death, there will still be many people who become infected, and who will be capable of spreading the virus. The current available evidence suggest vaccine effectiveness will wane over time. In addition, there is medium confidence that fully vaccinated individuals infected with Delta may still have a high viral load, albeit for a shorter duration compared to unvaccinated people who become infected, although more evidence is needed. This supports continued guidance for regular testing by the asymptomatic population, so that we can identify positive individuals quickly, encourage them to isolate and prevent further onwards transmission of COVID-19, saving others from possible exposure.

5. Variant forms of COVID-19 may pose different levels of risk in terms of the transmission or severity of illness. Across NHS Test and Trace and PHE, we have developed a programme of work to contain variant forms of COVID-19, and aims to screen all travel imported cases and a representative proportion of all other viable positive PCR tests for variants where capacity allows. Testing and tracing services are also in place in support of border controls, aiming to minimise the entry of new variants to the country. Importantly, about 30% of genomic sequencing results shared internationally come from the UK, making it one of the most significant contributors to international efforts to track new variants. Ensuring sufficient coverage of tests performed and positives detected and therefore genotyped or sequenced, is crucial in order to rapidly detect variants of concern (VOCs) and variants under investigation (VUIs).

Strategic Purpose

6. UKHSA's strategic purpose through its Covid Test and Trace activities is to **limit the spread of infections to support recovery and return to normal societal activity, prevent importation, transmission and establishment of variants, and protect vulnerable and disproportionately impacted people and high-risk settings.** The priority activities follow the recommendations set out in the **Public Health strategic framework for COVID-19**, in particular by prioritising the rapid identification, management and sequencing of cases, and ensuring those people with symptoms and their contacts have access to PCR tests, are able to receive results rapidly, and self-isolate if they have symptoms or test positive. In the short to medium term, this should be supplemented with asymptomatic testing of people in high risk settings, including via PCR in high risk settings such as Adult Social Care and the NHS, targeting testing for the risk management of most vulnerable, and providing tests for people who wish to use them to take personal risk-based decisions. Should asymptomatic testing be reduced or stopped altogether, Public Health England has advised that this would lead to a reduction in asymptomatic positive people self-isolating and therefore spreading the infection. Since the end of restrictions in Step 3 and 4 of the Roadmap, LFDs have played a crucial role in stopping onward transmission. Between 19th July and 28th August 2021 (the 6 weeks following the end of restrictions), 278k positive LFD tests were registered with Test and Trace (which

would have not otherwise have been detected). This demonstrates the ongoing importance of asymptomatic testing in identifying positive cases and stopping onwards transmission at a time where fewer restrictions exist.

7. The actions of TTI within UKHSA have a direct impact on reducing the reproduction number (R_t), with latest modelling indicating that these interventions have been critical in reducing R_t to below 1 at crucial times in the pandemic, thereby avoiding exponential growth in infections and overwhelming the NHS. It is estimated that over the past year test, trace and self-isolation has typically reduced COVID-19 transmission rates by around 20%. In the case of secondary school-aged children, nearly one in three (29%) cases were picked up through LFD testing, and potentially a further 4,500 cases through tracing contacts of those infected. Cases first detected by positive LFDs currently account for around 25% of all Pillar 2 cases, which would equate to approximately 5% transmission reduction. Continued LFD testing from 1 September to end December is estimated to reduce cumulative infections by approximately one million compared to a scenario without LFD testing. This is estimated to result in approximately 8000 fewer hospital admissions and 1400 fewer deaths (based on the JBC Simple Model which is a deterministic model and should be used illustratively). UKHSA's role in autumn/winter is therefore crucial in enabling the country to move forward to a new normal, whilst providing the necessary protections, and reducing the need for the re-introduction of more economically restrictive NPIs, such as lockdowns or social distancing.

8. Over autumn/winter, many viral illnesses – including influenza and Respiratory Syncytial Virus (RSV) – will present with similar COVID-19 symptoms initially, so we are likely to see increased demand for COVID-19 tests, especially with a potentially expanded symptoms list. Further details on capacity planning are set out in Annex A.

ASYMPTOMATIC TESTING OPTIONS

9. Given ongoing concerns around the Delta variant and uncertainty over vaccine effectiveness (see Annex E), we recommend continuing to provide tests to the general public until at least December, but plan for a gradual scale back of regular asymptomatic testing (Option A), although further options are set out below.

A. Under our recommended option, we will **continue offering free LFD tests to the general public until December**, with a view to gradually scaling back asymptomatic testing at key decision points. This will require an additional 171m LFDs. We will extend testing in secondary school until mid-October, when we will review our approach, assessing data from the return to school in September and the forthcoming JCVI decision on vaccinations for 11-15 year olds. Extending testing in secondary schools will require an addition 46m LFDs. After that, and subject to public health advice, we would expect to further reduce regular asymptomatic testing. A targeted approach will enable us to maintain access for vulnerable settings and individuals that rely on these channels for testing e.g. NHS trusts, personal care assistants, visitors to adult social care settings, some special educational needs schools and disproportionally affected groups, as well as keeping an option open to ensure that we can quickly increase testing if we need to in the future (e.g. in the event of a vaccine-evasive variant or PCR test capacity crunch). Measures to reduce testing could include discouraging fully vaccinated members of the public from testing by ending communications and mass marketing activity and making changes to messaging or checks in the ordering system.

B. **Introduce charging models for testing to replace the free provision of tests to the general public and lower risk settings.** Under this option, we would_continue providing free tests to high risk/vulnerable settings, including the NHS, adult social care, independent healthcare providers and prisons until March 2022. For the general public and other settings, free provisions of tests would end in January 2022 to coincide with the introduction of paid for testing. HMG could directly charge for LFD tests under its powers under the Public Health Act. This can be done in one of two ways, either to individuals through existing channels such as home or pharmacy channels, or direct to organisations. This would send a strong signal to the general public that HMG is stepping away from the free supply of tests but would also deter private providers from entering the private testing market for asymptomatic testing given that HMG will be supplying the tests at cost. Any decision for HMG to sell tests requires a 2-4 month lead time. We do not yet have the research evidence to estimate the public health impact of charging on test utilisation and case

detection however it is likely that costs would become a disincentive. Removal of free testing risks discouraging the most vulnerable, including those with less economic capacity, from being able to engage in regular testing. People in disproportionately impacted groups / health inclusion groups are still less likely to be vaccinated, and (with a range of drivers including employment types and housing) remain at higher risk of infection, serious illness and death. Annex D contains further information on these impacts.

C. **End free provision of LFD tests to the general public, except high risk/vulnerable settings that can access tests through alternative channels (i.e. most adult social care and prisons) at the end of September.** Under this option, some high risk and vulnerable settings that can access tests through alternative channels (for example, prisons and the NHS) could continue to access free tests. Additional provision would need to be established for the NHS who rely on the universal testing channels. Smaller high risk/vulnerable settings (for example, some adult social care such as personal care assistants) would be unable to access free tests unless they can access them by Community Testing. Whilst the general public could theoretically rely on the private sector market to provide testing, current market conditions has meant that domestic providers are not sufficiently incentivised to step-in. In addition, so long as free testing routes remain available and accessible through existing channels then it is unlikely that we will see a significant uptick in interest from the private sector to supply tests – or from individuals/businesses wishing to buy them unless certain conditions on access to free testing are put into effect.

10. **Risks:** Whilst approaches that rely on paid-for testing (B & C) reduce the financial burden of testing to the State, they risk exacerbating inequalities further by discouraging disproportionately affected groups, including ethnic minority groups, to test (See Annex D). This could result in more local outbreaks within these communities. Behavioural insights also suggest that people currently use an LFD or PCR test if they have symptoms or are contacts of a case, as they are motivated to use LFDs at home. A paid-for approach therefore risks driving the general public to alternative free channels, such as PCR testing, increasing pressure on scarce supply. If asymptomatic testing is scaled back or removed completely, this will also

likely have an impact on the public's overall perceptions of the virus and the pandemic and will likely have an impact on other behaviours.

Do you agree that whilst there remains significant uncertainty over the Delta variant and vaccine properties, we should continue to make asymptomatic testing available for free to the general public until at least December, with a view to gradually scaling back asymptomatic testing at review points?

DAILY CONTACT TESTING, FINANCIAL SUPPORT AND SELF-ISOLATION

Regulations

11. Self-isolation remains an essential part of our targeted response to this pandemic and has been vital in reducing transmission. It is estimated that over the past year test, trace and self-isolation has reduced COVID-19 transmission rates by around 20%. At the end of September, the Self-Isolation Regulations come to an end. In order to reinforce expected social norms around self-isolation, and send a clear message to the public that self-isolation remains an important tool in our efforts to contain and manage the spread of COVID-19 and new variants, **we recommend extending self-isolation regulations for a further six months.** This means retaining the **legal duty to self-isolate for all positive and for unvaccinated adult close contacts**, but with the aim of exempting those who agree to take part in daily contact testing (with home LFDs, subject to clinical approval and funding) – see para 13. This sends a clear message to the public that self-isolation remains an important tool in our efforts to contain and manage the spread of COVID-19 and new variants.

12. **Alternatively, we could include a legal duty and enforcement only on those who have tested positive.** However, this would simply free those contacts who have chosen not to get vaccinated from the legal duty and would remove any potential enforcement against those who failed to comply with daily contact testing when that is available. As a result, we believe there is merit in rolling over the current arrangements for six months to ensure consistency of message and prevent removing the legal duty from a group of close contacts whose behaviour we are keen to influence.

Do you agree that the self-isolation regulations for all positive cases and unvaccinated close contact be extended until end March 2022?

13. On 16 August 2021, close contacts who are fully vaccinated or under the age of 18 were exempted from the requirement to self-isolate, ensuring more people can continue to work to support the economy. This change has significantly reduced the number of people who are eligible for financial and practical support, with only those who test positive and adult contacts who are not fully vaccinated under a legal duty to self-isolate. Assuming positive results from general public clinical trial, **we recommend that daily contact testing should be offered to close contacts who are not fully vaccinated as soon as possible,** further restricting the number of people required to self-isolate and supporting the economy.

    Do you agree that DCT should be offered to unvaccinated contacts?

    Financial and practical support

14. Self-isolation can be difficult or impossible without financial and practical assistance. Many individuals may have been forced to leave self-isolation if they did not have the support that the Government has made available. However, self-isolation support ceases at the end of September. Failure to provide continued support could result in individuals leaving self-isolation and spreading the virus, thereby putting others at risk. To provide certainty to the public and to local authorities, we **recommend that financial, practical and emotional support should be extended until end March 2022.** While exact costs are dependent on prevalence over the autumn and winter, current estimates suggest that the support package could be delivered in Q3 and Q4 for around **£133m.** Given the reduction in numbers eligible for the £500 payment, we also recommend simplifying the eligibility criteria for TTSP, in line with the income-based model used by many councils which has successfully seen incidence levels reduced locally, beyond the national average.

15. Annex C sets out that, if we do not address these barriers, people will not self-isolate and the rate of transmission will increase as people fail to comply with the public health advice, even if they would like to. **As such, we recommend continuing to provide practical support and the Medicines Delivery Service at the same level as at present, targeted at the smaller group of people who we need to self-isolate.**

    Should self-isolation requirements be extended, do you agree that financial, practical and emotional support be funded until March 2022?

Cost Implications

16. NHS Test and Trace has re-baselined the £15bn budget to incorporate identified savings and efficiencies and recognise pressures which have been absorbed in-year. We anticipate Local Authority funding for Community Testing and all of the associated LAMP costs for Q3 and Q4 as well as LFD costs for all settings other than Education and DCT to be affordable until December. A change in policy or extension such as the continuation of mass regular testing beyond December, testing of school children beyond September or DCT roll-out, is not factored into current forecasts and may create further pressure on our budget allocation. Alongside this, self-isolation support and daily contract testing are not currently factored into the forecasts alongside education and university settings in Q3. In Q4, LFDs are also not currently included within forecasts and we anticipate this could cost up to £584m. These financial numbers are based on current assumptions and demand may fluctuate in the future. Please see Annex B for the cost breakdowns.

17. Introducing a charging model for testing will incur costs in the millions, however, it will depend on whether this cost is passed onto the general public as part of the cost incurred to provide this service. Current expectation is that if a charging model were to be introduced, then this would be cost neutral due to these costs being recharged to the general public.

18. We will also need to consider the timing of costs for the charging model across the financial years as it could create a budget pressure if we were to incur the cost in FY21/22 but were unable to generate the income until FY22/23 onwards. If there was a need for additional funding which crossed financial years, then this would require HMT agreement on this.

ANNEX A – PCR Testing Capacity

19. We continue to scale the laboratory network in order to accommodate PCR testing demand over autumn/winter. Using a combination of our Lighthouse labs (LHLs), the Rosalind Franklin lab (RFL) and surge/commercial suppliers we seek to deliver total testing capacity of 760k max. tests per day (610k operational). This agreed capacity level will be sustained until March 2022.

20. Where possible, we aim to deliver testing capacity using our LHL network and the RFL which represent better value for money. Where this is not possible (e.g. as we ramp up), we can bridge short-term capacity gaps using surge/commercial capacity. This is secured on a no-use, no-fee basis and is turned off as LHL and RFL capacity comes online but provides a useful buffer in periods of high demand.

21. Expanding the symptoms list would increase symptomatic demand as we move into autumn/winter and Influenza and other respiratory illness increases. This increases from ~50k tests per day in autumn, to ~150k tests per day in Winter. Although there is no request for further funding at this time relating to changes to the symptoms list, there is a risk that the unquantifiable potential impact on PCR demand that this could bring may require purchasing additional PCR kits and lab capacity (with requisite HMT approval) of approximately £429m. This end-to-end cost assumes 15m additional PCR tests to the end of the year.

22. Should the decision to expand the symptoms list be taken, demand will likely exceed (for several weeks, mid-November to end of January 2022) the maximum capacity of 760k agreed with HMT. Any consistent demand exceeding the previously agreed level of 760k, which at 80% operating capacity provides for 608k tests, will therefore require either aggressive and active demand management to prevent the system being overwhelmed, or a further increase in capacity which would likely need to be from overseas suppliers/new market entrants/new labs and DHSC accepting that this is likely to be at greater cost per test, lengthen turnaround times and invite media criticism. Capacity may temporarily exceed 760k to allow demand to remain within operationally sustainable levels, using no-use, no-fee surge capacity. The Lab Directorate would require a

permission from the Ministers and the HMT to exceed the 760k max capacity limit as otherwise the demands would not be met.

23. This decision would also place significant strain on the supply chain network that makes and distributes PCR kits. Supply Chain & Logistics currently have capacity to make ~500k kits per day across the existing partner Kuene & Nagel and with support from the Test sites making kits on site. We are building further capacity with DHL, who should begin making kits in early October, followed by 1-2 new medical device manufacturers ramping up from November. These new suppliers will enable kitted supply to Test Sites to switch back in November and have full capacity to be in place at the end of the year. The end-to-end supply chain also has storage constraints which will be addressed by setting up Regional Distribution Centres, starting with a DHL site to provide additional capacity from November. Any Supply Chain & Logistics requirements will be facilitated by Commercial category teams noting that procurement ramp up times can be up to 6 months for changes to kitting requirements / volumes in Consumables, Reagents and Equipment.

24. Across the LHL network and in the RFL, we currently cherry pick all positive samples. Positives are then run through the Reflex assay, a secondary PCR assay which detects known VOCs in the laboratory and then sent onwards to the Wellcome Sanger Institute to be sequenced. This process is not currently in place for surge/commercial laboratories.

25. Delivery of the agreed to network capacity of 760k until at least March 2022 is contingent on securing additional funding to:
    I. Increase permanent LHL capacity by ~105k (extending a ~60k proportion of the summer LHL increase and accept a further 45k capacity offer from Glasgow)
    II. Continue or replace 80k of capacity at Alderley Park. This will need to be publicly competed.
    III. Continue to use up to 155k of no-use, no-fee surge/ commercial capacity. Once we meet 760k capacity, this will be rolled off.

Annex B – Financial Considerations

Finance breakdown - testing

Intervention	**Period**	**Test Volume from Oct – March 2022**	**Costs from Oct - March** *incl VAT and relevant DA contributions*
Secondary Schools/FE	3.5 weeks	Est additional 46.3m LFDs (38.9m for England and 7.4m DA) and 0.5m PCR required for the remaining weeks until October half term.	Total Estimated Cost £143m for 3.5 weeks until October half-term. Estimated LFD Cost is £130m for the 3.5 weeks until October Half-Term. Estimated PCR Cost is £12.92m for the 3.5 weeks until October Half-Term.
Home and Pharmacy Channel	Q3 & Q4	Est additional 171.4m LFDs and 2.0m PCRs for UK* **Demand may change subject to further policy decision*	Est. £595.81m for Q3 & Q4. Estimated LFD Cost is £540m for Q3 – Q4. Estimated PCR Cost is £55.81m for Q3 – Q4.
Targeted Community Testing	Q3 & Q4	Est additional 72m additional LFD tests as LA costs are within existing budgets	Est £281m for Q3 & Q4 for LFDs £159m for LA funding
Adult Social Care	Q3 and Q4	Estimated 97.1m LFD Tests from Oct – March at a rate of 16.2m tests per month.	Est £389m for Q3 & Q4
NHS	Q3 and Q4	4m direct LAMP saliva tests via NHS labs Estimated 51.2m LFD Test Kits for Oct – March. Continuation of current demand with increased uptake over peak winter months. Starting with	Est. £52m direct LAMP tests Estimated £143.8m for Oct - March for LFDs

		7.1m in October and gradually increasing to 10.7m in December before reducing again to 6m in March 2022.	
High Risk Workplaces	Q3 and Q4	Estimated 13.1m LFD Tests from Oct – March at a rate of 2.2m per month.	Estimated £41.8m for Q3 & Q4
Other Use Cases	Q3 and Q4	Estimated 2m LFD Test Kits for Oct – March at a rate of 0.3m per month.	Estimated £6.38m for Q3 & Q4
University	Q3 and Q4	Estimated 3.8m LFD Tests from Oct – March. Testing for unvaccinated students only. Peaking in October at 1.5m tests and then decreasing gradually to 0.5m in December and then 0.2m in March 2022.	Estimated £15.5m for Q3 & Q4
Saliva Testing (e.g. SEND and Prisons	Q3-Q4	3.5m direct LAMP saliva tests via LAMP Cell Hubs for England only	Est. £47m (including DA allocation)
Outbreak Response (MPU	Q3 & Q4	286k RNA LAMP tests via Mobile Processing Units	£49 millions (excluding DA allocation)
Outbreak Response	Q3 & Q4	N/A~~N/A~~	Up to £80m for Q3 & Q4

Finance breakdown - DCT

DCT and self isolation Options	**Period**	**Test Volume from Oct – March 2022**	**Costs from Oct - March** *incl VAT and relevant DA contributions*
DCT offered to unvaccinated individuals from as early as October, people given choice to do DCT rather than self-isolation – finance support comes to an end in October	Q3 & Q4	Additional LFD test estimates* (I) 0.4m - 0.7m LFD tests per month (ii) 4.2k - 8.4k PCR tests per month. *Will vary depending on prevalence and vaccine uptake	Est £10m - £20m for Q3 & Q4

No DCT for unvaccinated individuals from October, isolation regulations are extended and self-support payment stay in place until March 2022	Q3 & Q4	N/A	£133m for Q3 &Q4* *If national eligibility criteria are introduced.
No DCT for unvaccinated individuals from October, regulations are no longer in place	N/A	N/A	£0 - £133m as this becomes a choice as to whether TTSP should be extended

Annex C – Self Isolation support costings

26. Since September 2020, approximately 270,000 low-income workers have received £500 via the Test and Trace Support Payment scheme (TTSP), and since March 2021, nearly 70,000 people have accessed the practical and emotional support on offer, with an additional 320,000 deliveries via the Medicines Delivery Service (MDS).

Supporting self-isolation

27. As set out above, self-isolation, especially of positive cases, is an essential tool in limiting transmission. Financial and practical concerns continue to be raised in survey data and by health protection teams, directors of public health and community groups as the most common reasons as to why people break self-isolation or are reluctant/unable to get tested. To address this, in September 2020, the Government introduced TTSP, providing £500 to low-income workers required to self-isolate, unable to work from home and losing income as a result. Since March 2021, £20m per month has been made available to enhance the discretionary element of the scheme. This has enabled councils to support more people likely to suffer financial hardship as a result of self-isolating. In addition, over £100m has also been committed since March 2021 to fund practical and emotional support for those who need to self-isolate and a free Medicines Delivery Service.

Practical support

28. Since the additional funding was introduced in March 2021, nearly 100k people have accessed the practical and emotional support on offer. The most common service accessed is food delivery, but councils have also used the funding to assist people with caring requirements and mental wellbeing support. The practical support framework has recently been refreshed to share examples of best practice and encourage more work to be done with civil society to address poor testing uptake amongst particular communities – reflecting discussions with community groups and councils. Funding has previously been ringfenced and councils have only been able to use the allocated money to deliver the practical and emotional support services set out in the framework.

29. Since March 2021, the government has also provided funding to enable NHS England to commission a medicines delivery service (MDS), so that individuals who are self-isolating can still access their essential prescription medication during their self-isolation period. This is delivered through pharmacy contractors and dispensing doctors. From March to May 2021, we gave NHS England £3.2m per month to fund MDS and we have agreed £1.7m per month funding from June to September. In the first 10 weeks of the service going live, 320,911 deliveries were made.

30. The change in self-isolation rules for fully vaccinated adults and children on 16 August has significantly reduced the number of people who are eligible for practical support and the MDS. Should daily contact testing be rolled out to the general public, this would further reduce the numbers eligible, although it is worth noting that there may be some close contacts who do not need to self-isolate but may still require support – for instance, if they usually provide caring support to clinically extremely vulnerable relatives, councils may wish to support them at the point they are most likely to be infectious, as per public health advice. Based on current projections, we believe that in order to provide a consistent level of practical and emotional support over the autumn and winter, we would have to provide councils with **£5.5m** per month until the end of March 2022. NHS England has also projected that continuation of the MDS would cost an additional **£2.5m** per month over the same period. This would bring the total cost of practical support to **£48.1m**. These numbers would be kept under constant review to reflect changes in policy (such as daily contact tracing) and significant fluctuations in incidence.

Financial support

31. The proportion paid from the discretionary fund has increased steadily since this was increased in March 2021 – and now accounts for more than half of successful claims. Nearly 10% of successful claims have been parents or guardians, making use of the scheme extension in March to look after a self-isolating child or young adult with care needs. TTSP also effectively targets vulnerable and underrepresented groups. For example, Pakistani and Bangladeshi communities, who are at higher risk from COVID-19, are more likely to receive a TTSP payment and more likely to subsequently get tested.

32. Our analysis demonstrates that uptake for testing among individuals who received TTSP payments increased by 18%. This analysis is based on close contacts of cases who are identified by NHS Test and Trace. The analysis also highlights that the likelihood of receiving TTSP payments and positive effects on testing uptake were focused among certain target groups (e.g. people who live in deprived areas).

33. More councils have started to use the additional discretionary funding that has been made available (since March 2021). Based on the current (ongoing) review, one-third of local authorities (60/180) use an income criterion of people earning £500 or less to determine whether applicants are likely to suffer financial hardship. Our analysis suggests that this may have a greater impact on reducing incidence. For instance, the LAs that have spent the highest proportion of their funding for discretionary payments and who use a <£500/week income threshold for discretionary payments all showed falls in incidence in July-August that were much greater than the average for England.

LA	*Discretionary allocation spent (%)*	*Change in seven-day case rate per 100,000 population, 19 July-6 August 2021*	*England's change in seven-day case rate per 100,000 population, 19 July-6 August 2021*	**Percentage difference between LA's case rate change and England's case rate reduction**
South Lakeland	*157.09%*	*-65%*		**163%**
Carlisle	*131.73%*	*-80%*		**200%**
Rochford	*128.18%*	*-73%*		**184%**
Braintree	*122.22%*	*-57%*		**144%**
Solihull	*106.70%*	*-60%*	*-40%*	**150%**
Lambeth	*106%*	*-46%*		**115%**
Doncaster	*99.09%*	*-63%*		**156%**
Bradford	*94.10%*	*-51%*		**128%**
Barnsley	*83.23%*	*-57%*		**142%**

34. As with practical support, the change in self-isolation rules on 16 August has significantly reduced the number of people who are eligible for a TTSP payment, with the focus now on positive cases and adults who are not fully vaccinated. In terms of total cost, and based on projected actuals, we have calculated that, if we roll over the current scheme until March 2022, this would cost **£11.1m** per month and **£66.8m** over the six-month period. If we were to adapt the scheme to reflect the income-based threshold adopted by some of the most high-performing councils,

this is projected to cost **£14.2m** per month or **£85.4m in total** by March 2022. The difference between the two schemes is **£18.6m in total** for Q3 and Q4.

Self-isolation proposal

35. We also recommend that the reduction in people eligible for TTSP presents an opportunity to consolidate the main and discretionary schemes into one to provide more certainty for individuals and councils on eligibility, based on an income threshold of £500 per week.
36. On this basis, the total cost for self-isolation support from October 2021 to the end of March 2022 would be **£22.2m** per month or **£133.2m** over the six-month period. This cost would reduce if daily contact testing were introduced and would be kept under constant review to assess the impact of fluctuating case rates.

Regulations

37. Currently, the requirement to self-isolate for positive cases and adults who are not fully vaccinated is underpinned by legislation. However, the Self-Isolation Regulations are due to expire in late September. It is not clear how much of an impact the legal duty and threat of enforcement has had on compliance levels, although it is worth noting that self-reported compliance rates (via ONS) remain high amongst those who are under the legal duty. According to ONS Survey Insights as of 19 August, 77.3% of those told to self-isolate following a positive test complied with isolation rules. Research suggests that risk of enforcement action is unlikely to be the primary reason for compliance. A survey conducted by Ipsos MORIR in October 2020 assessed convincing arguments for following government rules and found that whilst 64% of respondents said that avoiding the risk of being caught and fined was a very, or fairly, convincing argument, it scored the lowest out of 8 arguments. Communications around self-isolation has increasingly focused on why it is important and the support available, rather than the consequences for failing to comply in line with research findings that this can lead to increase legitimacy and compliance. However, removing the legal duty now could suggest that self-isolation was less important than before and result in fewer people taking the requirement as seriously.

38. From October, it is likely that only a small number of contacts would be under a legal duty to self-isolate if the Regulations were extended, with up to 90% of the adult population fully vaccinated and under 18s exempt. One option could therefore be to focus the legal duty and enforcement only on those who have tested positive. However, this would simply free those who have chosen not to get vaccinated from the legal duty and would remove any potential enforcement against those who failed to comply with daily contact testing when that is available. As a result, we believe there is merit in rolling over the current arrangements for six months to ensure consistency of message and prevent removing the legal duty from a group of close contacts whose behaviour we are keen to influence. This would send a clear message to the public that self-isolation remains an important tool in our efforts to contain and manage the spread of COVID-19 and new variants.

Annex D – Equalities implications of testing options

39. Those greatest at risk from COVID-19 are still those in the lower socioeconomic groups, high risk/ high contact professions and ethnic minorities, who are at greater risk both due to existing health inequalities and associated comorbidities and lower vaccination rates. In the short term, the younger population is also impacted as vaccination role out has not yet reached the second dose required for protection against the Delta variant. Many of the younger population are also in high contact/low pay jobs. Reducing access to testing through the universal channels is likely to have a two-fold effect:
    a) Reducing access for those in the most disadvantaged groups thus increasing existing inequality and making it challenging to engage these groups in the future.
    b) Increase the likelihood of local outbreaks within communities with associated risks.

40. Charging models, in particular, are likely to exclude all the key populations. It is essential that as we move through the next phase we promote and facilitate services that are designed for these core groups and the barriers they face, notably difficultly in accessing digital services, reduced car ownership and concern about sharing data. Pharmacy collect, locally led and available services with easy access, and home routes combined with the correct messaging will be essential to maximise the impact of testing on Covid control and economic confidence.

Annex E – Vaccine Effectiveness and Delta Variant

Table 1: Total number of confirmed/probable cases in May and August 2021 by variant

	Total confirmed and probable cases		
	Alpha	**Beta**	**Delta**
May (up to 20th May)	249,637	904	3,424
August (up to 20th August)	277,910	1,092	485,437

Table 2: Cabinet Office COVID-19 Vaccine Effectiveness – 20 August 2021

Outcome/vaccine	**Vaccine Effectiveness (2 doses) for each combination of vaccine, variant, and outcome**	
	Alpha variant	**Delta variant**
Any infection		
Pfizer	85% (65-90%)	75% (65-85%)
AstraZeneca	80% (65-90%)*	65% (60-70%)
Moderna	-	85% (80-90)
Symptomatic infection		
Pfizer	90% (85-95%)	85% (80-90%)
AstraZeneca	80% (70-90%)	70% (60-75%)
Moderna	-	90% (80-95%)
Severe disease (hospitalisation)		
Pfizer	95% (90-99%)	95% (90-99%)
AstraZeneca	95% (80-99%)	95% (80-99%)
Moderna	-	-
Mortality		
Pfizer	95% (80-99%)	95% (90-99%)
AstraZeneca	95% (80-99%)	80% (75-85%)
Moderna	-	-