Witness Name:
Statement No.:
Exhibits:
Dated:

UK COVID-19 INQUIRY

WITNESS STATEMENT OF
DR JENNIFER DIXON DBE, 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. I have previously served as a non-executive on the boards of the Health Care Commission, the Audit Commission, Care Quality Commission and the UK Health Security Agency.

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.

4. 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.

5. 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, is not linked to any political party, and does not have donors, supporters or members. The Foundation receives a small amount of funding from grants, commissions and partnerships with other organisations (details of which are available on our website).

6. The Health Foundation is committed to improving health and health care across the UK. However, the bulk of the organisation's policy analysis is focused on England reflecting the devolved nature of health and care policy in the UK. The Foundation's work on Test, Trace and Isolate (TTI) related to England and, as such, the contents of this statement apply to TTI in England.

7. During the relevant period, the Foundation reoriented some of its work to focus on COVID-19. Key areas of focus included tracking the overall policy response to the pandemic, and understanding the impacts of COVID-19 and the impacts of the policy response. The main objective was to inform the UK's recovery from the pandemic and to identify lessons for future resilience. 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. Of this work undertaken by the Observatory, an analysis of European countries' approaches to testing and tracing COVID-19 cases is most relevant to this module of the Inquiry. This found that, as well as testing capacity, mobilising a range of state and public health capacities at pace and in sequence was needed to effectively identify and break chains of transmission. The report also highlighted the importance of providing practical support to help people follow isolation guidance when they tested positive. [JD-7/00a - **INQ000475178**

8. In relation to the work undertaken directly by the Foundation, two strands are particularly relevant to TTI. First, between approximately May 2020 and May 2021 the Foundation tracked and reported on the operational performance of the NHS Track and Trace system and analysed some of the successes the scheme delivered and challenges it encountered. Second, over roughly the same period colleagues analysed policies implemented to support adult social care services, which included consideration of the role of testing policy. The findings of these strands of work inform the reflections outlined in this statement.

Research and publications by the Health Foundation relevant to TTI

9. I am asked to provide a high-level overview of the Health Foundation's publications related to TTI and conclusions relevant to the scope of Module 7. Below I list the Foundation's relevant publications, and parliamentary submissions, in chronological order and briefly summarise their relevant findings and conclusions.

10. **Adult social care and COVID-19: assessing the policy response in England so far** (July 2020) [JD-7/01 - INQ000475075]

11. This report analysed government policies on social care in England between 31 January 2020 and 31 May 2020. It examined policies on funding, testing, infection prevention and control, workforce, and oversight – as well as the role of social care in the overall policy and political narrative. In each of these areas, it described the policy timeline and available data on how these policies were

implemented and reached an assessment of the policy response and identified lessons for the future.

12. COVID-19 testing was largely unavailable to social care at the start of the pandemic. The government initially stopped community testing on 12 March 2020, with testing prioritised for critically ill patients in hospitals. A few days later, national NHS bodies instructed hospitals to rapidly discharge all patients who were medically fit to leave. This included discharging patients to care homes and other settings, and there was no national policy requirement to test patients before discharge.

13. There was no regular data published on the number of tests delivered in different social care settings during the first wave of the pandemic – either for care users or staff. Press releases and other government announcements often included high-level figures on testing, but this did little to tell us how far the testing programme was meeting the social care system's need for testing.

14. Social care leaders reported major gaps in testing throughout the early months of the pandemic. An ADASS survey, carried out in May 2020, found that the majority (78%) of social care leaders surveyed were not, or not at all, confident that there was an adequate supply of tests for people receiving care and support. [JD-7/01a - **INQ000475182**

15. Compared to the NHS, it appears that protecting and strengthening social care services was given far lower priority by national policymakers – with slow access to testing, personal protective equipment (PPE), and less certainty for councils about funding.

16. Government policy, including in relation to testing, focused disproportionately on care homes and did not reflect the range of other settings in which service users receive social care support. A government announcement on 28 April 2020 stated that testing would be expanded to all asymptomatic NHS and social care staff, but the testing expansion in social care only covered staff in care homes.

[JD-7/01b INQ000475172] And personal care assistants and unpaid carers were not added to the list of essential workers until the beginning of May.

17. The report identified a number of lessons for national policymakers going forward, including: a need to give the same political priority to protecting social care services as hospitals and the NHS; continuing to improve the availability of regular testing and PPE for the social care sector; and ensuring that plans to manage and prevent further outbreaks take into account the diversity of social care services and the varied requirements of staff and users in different settings.

18. **NHS Test and Trace: the journey so far** (September 2020) [JD-7/02 - INQ000475081]

19. This long read outlined how the NHS Test and Trace programme worked, analysed the key stages in the development of the testing and contact tracing regime in England, and highlighted some of the ongoing challenges faced by NHSTT.

20. Testing for COVID-19 to identify cases and close contacts of those who tested positive, alongside asking those close contacts to isolate, was essential to control the spread of the disease.

21. NHSTT launched in May 2020 and within roughly four months the system was conducting over half a million tests and managing over 10,000 cases and reaching 40,000 contacts a week (based on data from the Coronavirus (COVID-19) in the UK dashboard and summarised in section 2 of this long read). Notwithstanding these successes, by September 2020 it was not the 'world-beating' contact tracing programme that was promised, with ongoing challenges around test capacity and contacting both cases and their contacts.

22. Despite significant investment, only between 50% and 60% of contacts of known cases were being advised to isolate at that stage (based on analysis of the Coronavirus (COVID-19) in the UK dashboard data, set out in section 4 of this long read). The government's Scientific Advisory Group for Emergencies (SAGE)

had suggested that for a contact tracing system to be effective, it needed to trace around 80% of contacts of an index case. [JD-7/02a - **INQ000475175**

23. At the time, the leading challenges hampering the effectiveness of NHSTT could be divided into three categories: i) challenges due to lack of knowledge about the virus; ii) uncertainty around public responses to government policy and messaging; and iii) issues related to creating new national infrastructure at pace.

24. As cases in England were likely to rise, the government needed to urgently learn from the NHSTT journey to that point to ensure that tests were available for those who needed them and that policies aimed at improving contact tracing did not further exacerbate the inequalities already exposed by COVID-19.

25. The long read set out a group of recommendations for how NHSTT could improve its performance: i) increase case and contact identification; ii) ensure adequate funding of local government public health departments to implement a contact tracing service; iii) focus on social support and financial protection for people isolating; and iv) address delays in regular testing for social care staff and residents in social care settings.

26. Lastly, some opportunities to learn from NHSTT's experience to date through rapid evaluation were identified. Those were:
    a. Work should be undertaken to identify the causes and potential solutions for variation in the success rate of NHSTT in different parts of the country.
    b. Work should be undertaken to understand how difficulties in accessing tests impacts different population groups, including by deprivation, demographic and region.
    c. The COVID-19 app should publicly report uptake and effectiveness by different population groups to help with the targeting and prioritisation of local contact tracing plans to address inequalities.

27. **Is NHS Test and Trace exacerbating COVID-19 inequalities?** (December 2020) [JD-7/03 - INQ000475082]

28. This letter, published by the *Lancet*, was based on the Health Foundation's analysis of NHSTT's operational performance data. It focused on analysing NHSTT performance (between May to November 2020) across upper tier local government footprints in England based on deprivation of those areas.

29. It showed that during that period, the percentage of positive cases and their contacts who had been successfully contacted was lower in the most deprived areas than in the least deprived. In the least deprived 20% of areas (based on index of multiple deprivation scores), 86% of cases were successfully contacted compared with 83% of cases in the most deprived areas. And 62% of contacts were successfully contacted in the least deprived areas compared with 56% in the most deprived areas (percentages of cases contacted and traced are based on NHSTT's reported statistics and set out in a supplementary appendix to the letter [JD-7/03a - **INQ000475173**

30. The analysis highlights that it was not possible to pinpoint the reasons underlying these differences. The analysis was not able to adjust for possible explanatory variables, such as age, sex, employment status, socioeconomic status, ethnicity, or type of residence, because these data were not publicly available. Notwithstanding, it highlighted that understanding these differences was important not only to improving NHSTT's performance but also to ensuring that the inequalities that were exposed by COVID-19 were not exacerbated further.

31. **Submission to the Public Accounts Committee inquiry on 'Test, Track and Trace'** (January 2021)

32. In January 2021, the Health Foundation submitted evidence to the Public Accounts Committee's inquiry into Test and Trace, drawing on the Foundation's work analysing the performance of NHSTT. It summarised some of the key challenges NHSTT faced as of January 2021 and made recommendations for how those could be addressed. I set out relevant conclusions from that submission below.

33. Survey data from spring and summer 2020 indicated that people from more socioeconomically deprived backgrounds were less able to identify symptoms of COVID-19, and were less likely to fully comply with isolation guidance when they had symptoms (but before having a test result). [JD-7/03b - **INQ000475182**

34. Analysis of NHSTT data up to November 2020 suggested that fewer cases and contacts were reached by NHSTT in more deprived local authorities. [JD-7/03 - INQ000475082] There were likely a number of factors contributing to this including differences in local population demographic profiles, and challenges establishing local contact tracing systems. Demographic profiles impacted on the local pressures on NHSTT in a number of ways: people in more deprived areas may have been less likely to be able to work from home; local areas needed to translate materials into relevant languages for people who did not speak English as a first language based on local communities; and polling evidence at the time found that how likely people were to download the NHSTT smartphone contact tracing app varied across groups of different ethnicity, occupation and education level. The challenges of creating local contact tracing systems included capacity and resource for staff to deliver local systems, particularly where there were different case rates and different related pressures facing local areas (such as testing requirements, isolation requirements, and sizes of teams). [JD-7/03c - **INQ000475176**

35. People needed to be supported to isolate at home and be confident that they would be no worse off for having to done so. It was clear at the time that isolation compliance was higher where people had access to social, practical, and economic support.

36. The use of rapid antigen testing through lateral flow devices for people who were asymptomatic was being trialled in settings like schools and workplaces. Lateral flow devices had potential to be a valuable intervention to identify otherwise unknown cases. However, with all complex interventions there is a risk that they widen, rather than narrow, inequalities between richer and poorer areas. This is because generally more complex interventions rely more on people's agency to

benefit – people have to know about the test, be able to access it, know how to use it properly, know what to do depending on the result, and have the necessary support and ability to isolate when required. More socioeconomically advantaged people may have more resources supporting them to exercise their agency, and may have home and work circumstances that mean they are better able to isolate (such as being able to work from home or isolate without fear of loss of income, and have housing circumstances that allow them to stay away from others in the household). As such, there was a need for close evaluation of roll out of lateral flow devices to understand any impacts on inequalities and to involve local government directors of public health in the design and implementation of asymptomatic testing policy.

37. It was imperative that NHSTT did all it could to avoid widening the inequalities that had already been exacerbated by COVID-19. Measures to address inequalities needed to be in place beyond vaccine rollout, such as such as steps to ensure testing was accessible for more socioeconomically deprived communities, that there was clear and consistent information about testing and isolation requirements, and that there was practical and financial support for people to self-isolate when they tested positive.

38. **NHS Test and Trace performance tracker** (May 2020 to May 2021) [JD-7/04 - INQ000475080]

39. In this performance tracker, the Health Foundation monitored statistics on the number of positive cases reached across pillars 1 and 2 of the programme and the number of contacts who were asked to isolate each week from the launch of NHSTT on 28 May 2020 to 5 May 2021. The tracker was updated with latest performance data week-by-week, explored trends over time, differences between local authorities and identified possible explanations. It also identified challenges NHSTT needed to address to improve performance. To illustrate the approach taken in the tracker, some key findings from the tracker as it ended in May 2021 were as follows.

40. In the week to 5 May 2021, there was significant variation across the country in lateral flow device testing rates (based on tests registered through the national testing programme digital infrastructure) – from a low of 3,400 tests per 100,000 in the London Borough of Tower Hamlets, to a high of 15,100 tests per 100,000 in Rutland and 13,900 per 100,000 both in Wokingham and in North Somerset.

41. In relation to contact tracing, 91% of cases were reached with 82% providing details of close contacts. However, the percentage of contacts reached had dropped over the previous 6 weeks, from 90% to 84%. This was mainly due to fewer contacts being from the same household as the case – falling from 66% to 46% of contacts over the same period – and that these contacts were inherently more difficult to reach.

42. The proportion of overall cases among international travellers impacted on contact tracing. In the 2 weeks from 22 April to 5 May 2021, over 800 international arrivals tested positive, and in the preceding 2 weeks it was over 1,400 arrivals. In these circumstances, contact tracing everyone on an aircraft was inherently more arduous and time consuming. This was reflected in test and trace end-to-end time where the percentage of contacts reached within 3 days of the case being tested fell from 80% at the end of March to 59% two weeks later.

43. Testing remained just one part of the pandemic response and could not be thought of in isolation. The impact of testing on transmission was intricately related to contact tracing performance and isolation support, to the vaccine roll-out, and to the wider social and economic circumstances in which people lived.

44. Research at the time showed an emerging picture of more vulnerable and deprived population groups – people in crowded housing and on low incomes, with caring responsibilities or in insecure employment, people from minority ethnic groups – being disproportionately impacted by the pandemic, being less likely to access regular testing, and being less likely to be able to adhere to isolation guidance, and experiencing worse outcomes. An example of analysis in

this vein is Public Health England's August 2020 work exploring disparities in the risks and outcomes of COVID-19. [JD-7/04a - INQ000475177

45. These disparities would continue to widen inequalities unless COVID policy – both in relation to NHSTT and broader government COVID policy on housing, employment and welfare – was targeted at, and co-designed with, the people who needed support.

46. Rising case rates in Spring 2021 seen in places such as Bolton and Blackburn with Darwen (places that had borne the brunt of pandemic throughout the previous 15 months) raised concerns that the spread of new variants of concern would yet again do disproportionate harm to largely socioeconomically deprived communities. This highlighted how future policies needed to address the underlying drivers of inequalities, such as insecure work and poor housing, that fuel viral spread if the government was to tackle the virus effectively and realise a genuinely inclusive socioeconomic recovery.

47. **Adult social care and Covid-19 after the first wave: assessing the policy response in England** (May 2021) [JD-7/05 - INQ000475077]

48. This report analysed central government policies on adult social care in England after the first wave of the pandemic – from 1 June 2020 to 28 February 2021. It set out a timeline of key policy decisions relevant to social care (including on testing), made an assessment of the policy response following the first wave, considered how policies changed over time, and identified priorities for the future. The conclusions relevant to Module 7's scope are as follows.

49. Lack of access to COVID-19 testing was a major problem for social care at the start of the pandemic. Social care workers and care home residents with COVID-19 symptoms were only guaranteed access to tests in mid-April 2020.

50. Greater testing capacity subsequently enabled government to introduce and extend new testing programmes in social care. In addition to polymerase chain reaction tests (PCR) carried out in laboratories, 'rapid' lateral flow device tests (LFD) – swab tests that do not need to be processed in a laboratory and give

results in less than an hour – were introduced in December 2020. The reported number of tests conducted among care home staff in England increased significantly between September 2020 and early 2021.

51. Despite this progress, social care services continued to encounter challenges accessing testing. In August and September 2020, social care leaders reported delays in obtaining testing kits and slow turnaround times for results, partly due to national laboratory capacity.

52. The start of regular testing in care homes was announced in July 2020. This involved weekly PCR tests for staff and monthly tests for residents, initially prioritising care homes for older people and those with dementia. The programme was due to reach all care homes that registered by the end of that month, but quickly ran into problems. In a letter to directors of public health dated 31 July 2020, the Department of Health and Social Care cited 'rising demand', 'unexpected delays', and problems with the test kits used, and pushed back the date for reaching all older adult care homes to 7 September 2020. [JD-7/05a – **INQ000475170**] Yet in mid-September, the chief executive of Care England – a representative body for providers of social care services – told the *Times* newspaper that there were still 'delays […] and problems with the labs getting the results back in time'. [JD-7/05b – **INQ000475183**]

53. Problems with the timing of government policy were a common theme. During the first wave of the pandemic response, government intervention to support and strengthen social care arrived too late. After the first wave, policies in key areas still came slowly. For example, expansions of COVID-19 testing programmes in social care often arrived late. And regular testing – as with other support – reached some staff groups much later than others. Regular testing in older adult care homes was announced in July 2020, but its implementation was delayed and then only extended to other care homes at the end of August. [JD-7/05c – **INQ000475174**]

54. Poor employment conditions in social care affected support for the workforce during the pandemic. Unlike NHS staff, social care workers were not guaranteed

sick pay above the statutory requirement, and the prevalence of low wages and zero-hours contracts meant staff incomes were precarious. The prospect of losing earnings is likely to have been a barrier to staff getting tested and self-isolating if positive for COVID-19. Research evidence at the time found lower levels of infection among residents in care homes where staff received sick pay.

Engagement with UK government related to TTI

55. I am asked to describe the extent of the Health Foundation's engagement with the UK Government during the relevant time period in respect of TTI matters. I am also asked to set out the nature and timing of that engagement and indicate where responses (if any) were generated.

56. For context, prior to 2020 the Health Foundation was involved in regular dialogue and engagement with national policy makers about a range of health and care policy topics. Before the pandemic, the Health Foundation's focus generally meant we 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.

57. As indicated above, once the threat from COVID-19 became clear, the Health Foundation reoriented some of its work to focus on monitoring the overall policy response to the pandemic, understanding the impacts of COVID-19 and the impacts of the policy response, and generating lessons for the future.

58. In that context, the Foundation's engagement with policymakers continued throughout the acute phases of the pandemic spanning a range of issues. Specifically relating to test and trace, or touching on it, a few instances of engagement are worth highlighting:

59. In July 2020, Health Foundation staff shared the draft report of our assessment of the measures taken to protect adult social care in England during the first wave of the pandemic, which included content relevant to testing policy and

performance, with officials at the Department of Health and Social Care (DHSC). [JD-7/05d – INQ000475179] This was followed up by meetings with officials to discuss 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. [JD-7/05e – INQ000475180]

60. In December 2020, Health Foundation staff shared with Dr Susan Hopkins, national strategic response director at Public Health England, 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 (details of that analysis published in the *Lancet* are outlined above at paragraphs 27-30).

61. In March 2021, Health Foundation staff convened a roundtable event with adult social care stakeholders to discuss the initial findings of an analysis of the support for adult social care in England, which included consideration of testing, following the first wave of the pandemic. The event was attended by Kate Terroni, then chief inspector of adult social care at the Care Quality Commission.

62. In April 2021, Health Foundation staff shared a draft briefing on developments in the arrangements for supporting adult social care in England following the first wave of the pandemic with Sir David Pearson for review and comment. [JD-7/05f – INQ000475181] Letters summarising the concerns highlighted by the findings of the report were sent to Helen Whately (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).

63. In late 2020 and early 2021, Health Foundation staff contributed to the National Audit Office's (NAO) programme of work assessing NHS Test and Trace. This included staff sharing information with NAO colleagues through interview, presenting to NAO staff and reviewing draft analysis and content.

64. Additionally, during much of this period the Health Foundation seconded a member of staff, Dr Adam Briggs – senior policy fellow, to work in NHS Test and

Trace on a part time basis. Between November 2020 and September 2021, Adam served as a public health strategy advisor to the chief medical advisor at NHS Test and Trace, and then from October 2021 to September 2022 as interim deputy director for health equity, strategy and partnerships at the UK Health Security Agency. This was alongside Adam working as a public health consultant in local government.

65. Please note that this summary of relevant engagement excludes:

a) 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.

b) 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.

c) Any concerns expressed by Health Foundation staff while seconded to the Department of Health and Social Care, Public Health England, NHS Test and Trace, UK Health Security Agency or NHS England, unless such concerns were raised on the Foundation's behalf.

d) Briefings provided by government departments, Public Health England, NHS Test and Trace, UK Health Security Agency or NHS England that were attended by Health Foundation staff.

e) Discussions between Health Foundation staff and government departments, Public Health England, NHS Test and Trace, UK Health Security Agency or NHS England to discuss analytical needs and where the Foundation may be able to provide analytical support, rather than to discuss the policy response.

Observations about TTI – key issues and challenges

66. I am asked to provide an overview of the Health Foundation's observations in relation to the UK's approach to TTI systems and policies in relation to the COVID-19 pandemic. In doing so, I am asked to outline what the Health Foundation considers the key issues and challenges to have been.

67. NHS Test and Trace was launched in May 2020 as part of the government's COVID-19 recovery strategy. It faced a significant challenge in mobilising a national testing and tracking infrastructure in the face of a fast-moving pandemic health threat about which the evidence base was emerging. At the same time, national policy was developing at pace with material changes to testing modalities and policy and the evolution of national policy on contact tracing. Below I outline the key challenges NHSTT faced based on the Health Foundation's work.

68. National testing capacity in England was not designed to support a test and trace approach in response to a pandemic health threat. Test and trace infrastructure in England at the start of the pandemic was soon overwhelmed by the sheer number of COVID-19 cases and their contacts. Many of the challenges encountered by NHSTT stemmed from the fact that it was tasked with assembling an infrastructure at pace in the face of a rapidly changing health threat from COVID-19. This led to policymakers facing sub-optimal policy choices. Subsequently, testing capacity increased hugely, but there continued to be operational pressures that affected timely testing, and hampered the ability of NHSTT to effectively deliver case identification.

69. Testing policy struggled to reflect the centrality of adult social care services to the health and care system. Early in the pandemic, social care services reported major problems accessing tests. Social care workers and care home residents with COVID-19 symptoms were only guaranteed access to tests in mid-April 2020. Subsequently, operational pressures on testing services saw the adult social care sector continue to experience a lack of timely access to testing. Moreover, the testing approach did not adequately reflect the variety of settings in

which people accessed care services, and the diverse needs of service users, eg younger adults with disabilities, and unpaid carers.

70. Testing and tracing relied on people following self-isolation guidance to effectively break chains of transmission. However, in practice there were a number of factors which meant people lacked appropriate support to self-isolate. For example, the UK's sick pay regime was unusually frugal by international standards, and government support payments for people self-isolating were limited and subject to eligibility tests. Surveys at the time, for example those conducted as part of the CORSAIR study, made clear that substantial proportions of people felt unable or unwilling to follow self-isolation guidance. [JD-7/03b - **INQ000475176** The failure to join up testing and broader policy, including with respect to financial and practical support to self-isolate, materially hampered the overall effectiveness of NHSTT.

71. For NHSTT to work effectively and people to follow guidance on isolation, there needed to be widespread public awareness, trust, and use of the system. A public health campaign was launched during summer 2020 to encourage more people to have a test, with the aim of increasing public awareness of NHSTT. However, national media and social media do not reach everyone, and local communications were essential during local outbreaks. Health Foundation survey work during the pandemic, conducted with Ipsos UK, found that there were challenges for the state in communicating public health messages in ways that resonated across the population. For example, in November 2020 our polling highlighted a significant minority of people (31%) felt national guidance was not clear regarding when people should stay at home to self-isolate. These challenges highlight the importance of understanding public attitudes and experiences to inform national communications, and to consider how public health messages can be widely understood across diverse groups. [JD-7/06 - INQ000475076]

72. NHSTT needed to develop a national data infrastructure to support delivery of a test and trace model in England. This was a large undertaking given the government's policy choices and the scale of testing needed to respond to the

pandemic. However, the data infrastructure and how the data was able to be used was subject to a number of limitations. At times, there were barriers to sharing some data with local public health teams, such as case-level data from commercial laboratories at points in 2020, which hampered operational planning and response. There were also instances of data on local cases being shared with contact tracing teams in a form that was incomplete, or shared several days after a case was first identified leaving little – if any – time for local areas to intervene. Additionally, the publicly available data on NHSTT included gaps where data did not illuminate trends, for example data on who was not getting tested and who struggled to adhere to isolation guidelines. This made it more difficult for local public health teams to effectively identify and break chains of transmission and for national decision-makers to adapt the design of the testing programme to address these needs. These challenges echo issues seen in other aspects of the UK's pandemic response where data quality, rules about data sharing and limits in analytical capability acted as constraints on effective policy-making.

Inequalities and vulnerabilities

73. I am asked the extent to which decision makers considered inequalities and vulnerabilities in the design and implementation of the test and trace regime in England. The Health Foundation is independent of government and was not involved in the coordination of the operational response to the pandemic. I was not personally engaged in substantive policy discussions about NHSTT's design and operation. As such, I am not in a position to comment on the extent to which inequalities featured, and were seriously considered, in internal policy discussions about and within NHSTT.

74. However, the Foundation's analysis of COVID-19 and the state response, and specifically of NHSTT in England, points to a number of shortcomings in how health inequalities were addressed. Below I set out some observations about health inequalities in England, the impact of the pandemic, and how the test and trace system worked.

75. The health of the population of England in 2020, when the pandemic struck, was not what it could have been: life expectancy was flatlining and health inequalities were stark. Moreover, in the years before the pandemic struck, inequalities of wealth and income in England had widened. Austerity had seen parts of the country with greatest needs absorb larger reductions in funding in local public services: 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.

76. The COVID-19 pandemic had an unequal impact with some population groups and regions disproportionately affected. During the first wave of the pandemic, 40% of all UK deaths were among care home residents. 6 out of 10 people who died with COVID-19 between January and November 2020 were disabled. And people from ethnic minority communities had significantly higher risk of mortality – 3.7 times greater for black African men than their white counterparts during the first wave and Bangladeshi men more than five times more likely to die during the second wave. [JD-7/07 - INQ000475078]

77. The ability to access COVID-19 testing varied across communities, due to a range of factors. For example, surveys in 2020 for the CORSAIR study found that people from more socioeconomically deprived backgrounds were less able to identify symptoms of COVID-19. [JD-7/03b - **INQ000475176**] Additionally, at times when testing capacity was under pressure there were instances when travel times to testing facilities increased which were likely to have presented practical barriers to people who didn't have use of a vehicle or who were less able to take time off from work.

78. Contact tracing was characterised by sustained inequality in the rate of contacts being traced. In December 2020, the Health Foundation's analysis found that 62% of contacts in the least deprived areas were successfully contacted, compared with 56% in the most deprived areas. From the launch of NHSTT up until 26 May 2021, 84% of contacts were reached in the least deprived areas, compared with just 77% in the most deprived areas. [JD-7/08 - INQ000475083]

79. Support to isolate at home was another domain where social and economic inequalities had a real-world effect. Surveys, such as those in the CORSAIR study, suggested significant variations in people's ability and readiness to self-isolate for the prescribed amount of time. [JD-7/03b **INQ000475176**] This is likely to have impacted people's willingness to take a test. Barriers to self-isolating in line with national rules included being unable to take time away from work. Additionally, the government's self-isolation support payments were insufficient, offering £500, and were subject to eligibility criteria.

Lessons learned – observations as to what could have been done differently in TTI

80. I am asked to exhibit any lessons learned documentation associated with NHSTT. The Health Foundation has not conducted any lessons learned exercises focused on NHSTT. But drawing on the Foundation's work on NHSTT, broader research on COVID-19 and reflections on the progress of the pandemic and the UK state response, below I set out some observations relating to what could have been done differently in the implementation of NHSTT and lessons which could inform responses to future pandemic health threats which involve a testing and contact tracing approach.

81. **Policy on testing and tracing partly overlooked the needs of adult social care users and services**. In the early months of the pandemic, adult social care services lacked proportionate access to testing. This and other shortcomings left the adult care system, and people who rely on social care, vulnerable to the effects of COVID-19. While capacity did subsequently improve, adult social care leaders continued to report challenges accessing timely testing. In addition, testing policy struggled to reflect the heterogeneity of social care services, the people it serves, and settings in which it is delivered. For instance, limited access to testing for younger adults with learning disability and autism was a persistent challenge. The response to any future pandemic threats should ensure it is shaped by an understanding of the diverse needs of people using and providing care – including services delivered outside care homes and unpaid carers.

82. **The balance between national and local leadership of England's test and trace regime was a recurring challenge, which failed to strike an optimal balance**. In particular, the role of local authorities – as the lead organisations for public health in England and with deep connections to local communities – was under-developed in NHSTT; similarly, the role of primary care services was overlooked which risked failing to capitalise on their local networks and understanding of populations. In 2020, for example, NHSTT initially led the role of contact tracing, but it gradually became clear that for non-complex cases, staff working in national bodies were less well positioned to lead contact tracing than local health protection teams based in Public Health England and local authorities. Over time, testing policy and the operational model for contact tracing did adjust to better support local leadership, and tap into the expertise of directors of public health. Looking ahead, if a test and trace approach is needed in future pandemic health scenarios, it should be developed in close collaboration with local authorities, local directors of public health and local health protection teams, ensuring they play a leading role and are able to meet local needs and address inequalities.

83. **The effectiveness of NHSTT was bound up with a broader policy regime which was poorly designed to support people to break chains of transmission**. NHSTT required people to follow self-isolation guidance to effectively break chains of transmission. However, there was evidence that people's ability to test and adhere to self-isolation guidance was a major challenge through the peaks of COVID-19. Key barriers to isolation included a sick pay regime in the UK which saw people potentially financially worse off for following the guidance and inadequate national policy support, including financial support payments, for people who tested positive. For future pandemic scenarios where self-isolation is required, a useful guiding principle would be that no one should be made worse off for having to self-isolate.

84. **Inequalities were a vital axis shaping COVID-19's impact on population health in England, and the test and trace regime was underpowered to address these**. The operational effectiveness of NHSTT varied across the country with – at least at times – a higher rate of successful contact tracing in

less economically deprived areas. At the time the Health Foundation conducted this analysis, it was not clear exactly what was driving these differences. But it raises the question that NHSTT may have been contributing to exacerbating, rather than closing, health inequalities in England. [JD/3 - INQ INQ000000]

85. **Data was an essential building block of NHSTT, and the operational data was – at times – limited and did not effectively enable local pandemic response or scrutiny from independent analysts**. For example, in June 2020, local authorities in England developed COVID-19 outbreak control plans to help manage outbreaks. However, local directors of public health were initially unable to implement some of these plans because they could not access necessary case-level data from commercial laboratories due to concerns surrounding data governance. Looking ahead, the national government and arm's-length bodies need to be able to draw on high-quality data and improved analytical capabilities to inform future emergency responses. As such, the government needs to build on the experience of the pandemic to develop a durable policy regime, and mechanisms, which enables appropriate health data sharing and linkage that commands public trust and support.

86. **Resilience to public health threats rests in part on long-term trends in the health of the population, and health inequalities, given these shape society's susceptibility to ill health and morbidity**. Looking across a range of indicators illustrates that the health of the population of England in 2020, when the pandemic struck, was not what it could have been. Life expectancy was flatlining; health inequalities were stark; and a constellation of factors were seeing the wider determinants of health – incomes, employment opportunities, education and local infrastructure – deteriorate. This made the task facing NHSTT materially more challenging and left more people vulnerable to the effects of the pandemic. Looking ahead, if future policy is serious about greater resilience it needs to focus on building good population health and reducing health inequalities across England and the UK.

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.

Signed Personal Data

Dated: _____ 21 March 2025 _____