IN THE COVID-19 PUBLIC INQUIRY

BEFORE THE RT. HON. BARONESS HALLET

DEPARTMENT OF HEALTH AND SOCIAL CARE

OPENING SUBMISSIONS FOR MODULE 7

INTRODUCTION

1. The Department of Health and Social Care ("the Department") expresses at the outset its deepest sympathies to all those who lost relatives and friends during the pandemic and to those who continue to deal with the consequences of the pandemic. The disruption and effects of COVID-19 on our society were profound and were particularly felt through the health and social care system.

2. The Department repeats its thanks to everyone in the health and social care system who worked as part of the response to COVID-19.

3. The public also experienced hardship and challenges as a result of the introduction of non-pharmaceutical measures to help slow down the spread of the virus, including self-isolation for people with symptoms or those who tested positive and their contacts. Although self-isolation was a necessary part of the response to the COVID-19 pandemic, we recognise, and recognised at the time, that it impacted upon people socially, psychologically and economically.

4. In combatting any pandemic, there are likely to be four main types of tools: (1) non-pharmaceutical interventions for the general public, such as social distancing and mask wearing; (2) self-isolation of people who have tested positive or those who are deemed at higher risk of infection by virtue of either their symptoms, recent international travel or recent contact with a positive case; (3) therapeutics; and (4) vaccines. Whilst those four tools are all theoretically available in combatting a pandemic, and the Department commenced work on the development of all four tools right at the start of 2020, the only available options at the start of the pandemic were social distancing measures for the whole public and self-isolation for returning international travellers and those who had COVID-19 symptoms and other members of their households.

5. At this early stage, the Department prioritised the rapid development of a COVID-19 test, both to support clinical diagnosis and treatment, in addition to seeking to contain the spread of the virus by isolating people who tested positive and their close contacts. As community transmission became more widespread, testing was also vital in preventing people from routinely having to self-isolate for extended periods of time if they had COVID-19 symptoms,

with symptomatic testing initially targeted at NHS workers, then extended to other key frontline workers and then rolled out to the general public. The later development of lateral flow devices enabled testing to play an even wider role in helping people start to return to their lives pre -pandemic, including meeting with their wider family and friends, returning to work and education, and participating in society. This supported the Department's aim to reduce the spread of the virus, protect the vulnerable and protect the NHS, whilst also seeking to mitigate the economic and social impacts of the virus.

6. The initial budget for the NHS Test & Trace (NHS T&T) service, made up predominantly of funding for testing, was £15 billion for April 2020 to March 2021. The November 2020 spending review introduced a further £7 billion of funding to support the rollout of mass testing, as well as the continued increase in testing capacity. This raised the total budget to £22 billion for 2020-21. In practice, NHS T&T spent £13.5 billion in 2020-21, of which £10.4 billion was on testing. A further £15 billion was allocated to NHS T&T in 2021-22.

TESTING

7. During the pandemic, three types of COVID-19 tests were used. These were the reverse transcription polymerase chain reaction (RT-PCR) tests (more commonly referred to as PCR tests), the rapid antigen or lateral flow device (LFD) tests, and antibody blood tests.

8. The corporate statements provided by the Department set out in some detail the history of testing, when various tests were made available and the purposes for which those tests were used. There is also technical detail in the 'Technical Report on the COVID-19 pandemic in the UK' written and edited by the Chief Medical Officers (CMOs) for the UK, the Government Chief Scientific Adviser (GCSA) and other leading scientists and clinicians.

PRE-PANDEMIC AND THE INITIAL PHASE

9. Prior to the COVID-19 pandemic, the Department was not involved in the testing of individuals for pathogens. The Department's role in testing was limited to its oversight of Public Health England (PHE) and NHS England (NHSE). In 2019, there was a low level of diagnostic testing capacity across NHS and PHE laboratories of around 1,000 tests per day. At the start of January 2020, the UK had neither a test for COVID-19 nor the infrastructure to scale up diagnostic capacity quickly.

10. Testing was vital for a range of reasons, including to support clinical diagnosis and treatment of acutely ill patients, to monitor and track the spread of the virus, to identify infected individuals so that they and other household members continued to self-isolate, and to enable people with symptoms (particularly, in the early stages of the pandemic, NHS and other key frontline workers) to return to work if they had a negative test result.

11. The rapid development and scaling up of testing capacity required intense work on a national scale, in collaboration with public laboratories and the university and private sectors

12. Work to develop testing capabilities began as soon as the genetic sequencing of SARS-CoV-2 was published on 11 January 2020. By 28 January 2020, the Scientific Advisory Group for Emergencies (SAGE) had confirmed that a PCR test would be available within days. This was initially limited to 400-500 tests per day. Throughout the initial phase, the decisions taken by the Department and PHE were guided by advice from SAGE, Scientific Pandemic Infections Group on Modelling (SPI-M), Scientific Pandemic Insights Group on Behaviours (SPI-B) and the available data at the time.

13. The starting point for testing was a single laboratory with diagnostic capacity in England. As a result of the limited number of testing sites and the restricted availability of testing kits and their components, such as reagents, testing had to be prioritised carefully based on clinical need.

14. By early March 2020, testing was being carried out by eight PHE laboratories in England. PHE was working to roll out PCR testing to a further nine laboratories, which would increase capacity to 3,600 tests per day and ease pressure on laboratory capacity in London. PHE also worked on validating testing technologies from the private sector that would allow capacity and capability to be further expanded. This was carried out by the COVID-19 Testing Scientific Advisory Panel.

15. On 18 March 2020, the government announced that it was working to increase testing capacity in PHE and the NHS to 25,000 tests a day, an ambition that would form a key part of the Testing Strategy. By the beginning of April 2020, with testing capacity at around 12,750 tests per day, an additional network of new laboratories and testing sites were being rolled out across the UK. As testing capacity grew, symptomatic testing was made available initially to NHS staff and other members of their households to relieve pressures caused by staffing absences, then to other key frontline workers and in May 2020 to all members of the public (other than under-5s initially).

16. In addition to increasing capacity, the Department also focused on measures to promote the take up of tests, although testing was never made compulsory it was very important to ensure that messages were communicated clearly and coherently, and that testing was easily accessible, particularly for groups that health services often struggle to reach. To widen accessibility, the Department developed mobile testing units, local testing sites and a home delivery service that meant people could take tests in their own homes. Tests could be ordered both online and by telephone.

FIVE PILLAR APPROACH

17. On 2 April 2020, the Department published its five-pillar testing plan, including a target to increase COVID-19 testing to 100,000 tests a day by the end of April:

a. Pillar One - Scaling up NHS diagnostic testing, aimed at critical key workers

b. Pillar Two – Partnering with universities, research institutes and commercial partners to create capacity for mass testing for the general public

c. Pillar Three – Developing antibody testing in co-operation with a private sector provider

d. Pillar Four - Surveillance testing to learn more about the disease and help develop new tests and treatments

e. Pillar Five - Diagnostics National Effort - building a mass testing capacity at a completely new scale.

18. Daily testing capacity continued to increase throughout April and May 2020 and by 30 April 2020 the aim of delivering 100,000 tests per day had been met.

19. The fifth pillar was designed to grow the UK's diagnostics industry substantially and to rapidly create a new mass testing capacity. This relied heavily on the introduction of lateral flow device (LFD) tests, which were developed, tested and trialled during mid-2020, and introduced for use in the national testing programme in late 2020.

20. Throughout the autumn of 2020 and spring of 2021, work continued on increasing capacity and strengthening partnerships with local authorities, with the aim of providing a universal testing programme. The Community Testing Programme, launched in December 2020, gave local authorities a key role in adapting testing to the needs and circumstances of local populations. From 9 April 2021, everyone in England, including those without COVID-19 symptoms, was eligible for free LFD tests to use twice a week. This was in line with clinical guidance, to help create a new testing habit that, coupled with the vaccination roll out, would help reopen society and help the country get back closer to normality.

21. On 21 February 2022, the Living with COVID-19 strategy was published. It set out the plan for removing the remaining legal restrictions while protecting people most vulnerable to COVID-19 and maintaining resilience, beginning the move to treating COVID-19 like many other endemic respiratory illnesses through public health measures and guidance. The Plan was underpinned by the following principles:

a. removing domestic restrictions while encouraging safer behaviours through public health advice

b. protecting the vulnerable through pharmaceutical interventions and testing

c. maintaining resilience against future variants, including through ongoing surveillance

d. contingency planning and the ability to reintroduce key capabilities in an emergency

e. securing innovations and opportunities from the COVID-19 response, including investment in life sciences

22. As part of this strategy, the government progressively reduced the use of COVID-19 testing, culminating in the ending of the universal testing offer on 1 April 2022, with free testing continuing only for a small number of at-risk groups and health and social care staff.

CONTACT TRACING

23. Tracing contacts of positive COVID-19 cases, so that they could be advised to self-isolate or take other appropriate public health action, formed an important part of the wider set of measures designed to limit transmission of COVID-19. At the outset of the pandemic, tracing was carried out within the existing PHE infrastructure and included local government. The pre-existing PHE infrastructure could not be increased sufficiently rapidly to deal with the level of tracing that was estimated to be required upon advice given by SAGE. As such, the Department took the decision to create a new contact tracing service, bringing together national, regional and local public health experts, other health professionals and trained call handlers, alongside development of a contact tracing app.

24. NHS T&T, launched on 28 May 2020, brought together both policy and operational responsibility for testing, contact tracing and support for self-isolation, operating as an end-to-end service. The service was overseen by a unit in the Department, led by Baroness Dido Harding, and brought together a range of services run by the Department, PHE, NHSE and other partner organisations. On 24 March 2021, the Government announced that NHS T&T would form part of the newly created UK Health Security Agency (UKHSA). This transfer happened on 1 October 2021.

25. A key element of the NHS T&T service was that anyone testing positive for COVID-19 would be contacted, told to continue self-isolating (with other members of their household) and asked to share information about people with whom they had been in close recent contact so that they could also be asked to self-isolate.

26. The effectiveness of contact tracing depended in part on people's willingness and ability to come forward for testing, their willingness to share information about their contacts, the speed with which testing and contact testing were carried out and the willingness and ability of contacts to self-isolate when notified to do so.

27. As with testing, the effectiveness of contact tracing relied in part on using a combination of national infrastructure and local capabilities. From the start of the NHS T&T service, contact tracing for more complex cases or as part of local outbreak management was carried out by public health experts in regional or local PHE teams and in local authorities.

28. From July 2020, the Department also worked with local authorities to develop 300 local tracing partnerships that involved local authorities tracing people who had tested positive who had not responded to initial attempts by central NHS T&T contact tracing teams to reach them.

29. The launch of the NHS COVID-19 app significantly extended the reach of contact tracing and improved its speed by providing anonymous alerts to app users who had been in close contact with other app users who had reported positive test results. The app complemented rather than replacing conventional forms of contact tracing, with NHS T&T continuing to contact anyone who had tested positive and asking them to share information about their contacts. By extending the reach of contact tracing, the app had a material impact in reducing transmission and preventing deaths. It also increased the number of people self-isolating, leading to heightened concerns – particularly in the summer of 2020 – about the impact of self-isolation, further set out below.

SELF-ISOLATION

30. Self-isolation was an essential non-pharmaceutical intervention to limit the transmission of COVID-19, particularly prior to the vaccine roll-out. Self-isolation policies were informed by expert public health advice from PHE, UKHSA, the four UK CMOs and the various scientific groups supporting them. As the pandemic continued, the developing scientific understanding meant that changes were made to the periods of time for which people were advised or instructed to self-isolate.

31. The economic, educational and social impacts of self-isolation were plain to see throughout the pandemic, particularly for people on low incomes who could not work from home and could lose income. The Department took a wide range of measures to seek to mitigate those impacts.

32. The three main scenarios in which self-isolation was advised – or in some cases instructed – were:

a. an individual or a member of their household had symptoms of COVID-19

b. an individual or a member of their household tested positive for COVID-19, including situations where they had taken a test without having had symptoms ('asymptomatic testing') and were therefore unlikely to have been self-isolating up to that point

c. an individual had close recent contact with someone outside their household who had tested positive for COVID-19

33. From 28 September 2020, when the Health Protection (Coronavirus, Restrictions) (Self-isolation) (England) Regulations 2020 came until force, to 24 February 2022, there was a legal duty for individuals to self-isolate, with some limited exemptions, if they were notified to do so following a positive COVID-19 test result or having been identified as a close contact of a positive case. The legal duty did not apply to people self-isolating because of having COVID-19 symptoms nor to people self-isolating following a notification from the NHS COVID-19 app. From 16 August 2021, close contacts who were fully vaccinated, aged under 18 or subject to other exemptions, were no longer legally required to self-isolate; for other close contacts, the legal requirement to self-isolate continued until 24 February 2022.

34. The available evidence suggested that people who had symptoms but did not get tested were significantly less likely to self-isolate than people who tested positive and those contacts who were notified to self-isolate by NHS T&T. For the latter groups, there were high self-reported levels of adherence to self-isolation, although these were experimental statistics (and may have been affected by reporting bias).

35. As set out above, self-isolation was not easy and caused hardship for individuals. Behavioural insights suggested that the main factors influencing people's willingness to self-isolate were their understanding of the rules, their understanding of the reason for those rules (i.e. the benefits that self-isolation had for other people) and the support available. In any future pandemic, it will be important to have clear and positive messages as to why self-isolation is necessary and important to protect society and to consider what forms of support are necessary.

36. The Department sought to reduce the extent to which self-isolation was needed by trialling the use of regular testing as an alternative to self-isolation for contacts of positive cases. Taking a single test was not an adequate alternative to self-isolation, because the incubation period for COVID-19 could vary, meaning there could be a relatively long period in which infection could not be detected through a test. The Department undertook 'serial contact testing' pilots to investigate the use of daily testing for contacts of confirmed COVID-19 cases, using self-administered LFD tests in December 2020 and January 2021.Trials indicated that daily contact testing, with people self-isolating immediately if any of these tests was positive, could be as effective as self-isolation in limiting the spread of COVID-19, but much hinged on behavioural factors (i.e. how far people were likely to follow daily testing protocols or how far they were likely to self-isolate in the absence of daily testing).

37. In July and August 2021, a Workplace Daily Contact Testing Scheme was extended to a number of sites providing essential public services to enable non-household contacts, who would otherwise have had to self-isolate, to attend work and undertake other essential activities. However, the need for further use of daily contact testing was largely superseded by the decision from August 2021 to exempt contacts who were fully vaccinated or under the

age of 18 from the requirement to self-isolate. The use of regular contact testing should be explored in the circumstances of a future pandemic, but its applicability would depend both on the characteristics of the relevant infectious disease and on behavioural factors.

SUPPORT FOR THOSE SELF-ISOLATING

38. There were three main forms of support developed for people self-isolating

a. The Test and Trace Support Payment (TTSP) scheme, a financial support payment of £500 to people on low incomes who had been told to self-isolate (both those who had tested positive for COVID-19 and their contacts) and who would lose income because they were unable to work from home. This was introduced on 28 September 2020, alongside the new legal duty to self-isolate for positive cases and their contacts

b. The Local Authority Practical Support Fund to enable local authorities to go further in providing practical, social or emotional support for those who had to self-isolate

c. The Medicines Delivery Scheme, an extension of the service initially implemented for vulnerable individuals who were 'shielding' and was later extended to people self-isolating, which involved community pharmacies to deliver prescription-only medicines to people who were unable to get their medicines via family or friends

COMMUNICATIONS

39. From the initiation of the Cabinet Office COVID-19 Communications Hub in March 2020, the Department's communications team, the Cabinet Office, other government departments, PHE (up to its closure in September 2021) and UKHSA (when it took over PHE's health protection functions in October 2021) worked closely on public health messaging. PHE/UKHSA provided expert public health input to ensure messages were grounded in the latest scientific evidence and the Department's communications team played a lead role in developing unpaid campaigns (social media etc). The Department and its arm's length bodies worked with teams across departments and local authorities to ensure communication of key messages about testing and self-isolation reached all communities across the country. This included a national campaign that spanned owned and paid-for channels to maximise reach and engagement. To increase accessibility, advice and guidance were translated into over 25 different languages, including Arabic, Bengali, French, Gujarati, Polish, Portuguese, Punjabi, Chinese (Mandarin and Cantonese) and Urdu.

40. The 'contain framework', published in July 2020, set out arrangements for how local authorities would play a leading role in preventing and responding to local COVID-19 outbreaks and how the Department and other national bodies would support them. These arrangements included a key role for local authorities in engaging with community groups to communicate key

messages and promote participation in testing, contact tracing and self-isolation.

41. The app and all key explanatory materials were designed with a readability level of eight years of age. This ensured the app was accessible to those who had low literacy levels, or where younger members of a household needed to support older generations in downloading and using the app.

EQUALITY IMPACT AND INEQUALITIES

42. The Department conducted both Equality and Health Inequalities Impact Assessments (EHIAs) and Equality Impact Assessments (EIAs) throughout the pandemic, including in relation to testing, contact tracing and self-isolation.

43. The Department identified equality issues in respect of testing, such as barriers getting to a testing site for people without access to a car and those with physical and mental disabilities, as well as barriers to booking a test, such as language barriers, low levels of digital literacy and digital exclusion. Digital literacy was also flagged as a barrier, which was a particular issue for some older people.

44. The Department carried out many actions to address these issues and similar issues in relation to contact tracing:

a. To assist those who could not physically attend a testing centre, rapid mobilisation of mobile testing units was introduced on 20 April 2020 and there was rapid development of 'satellite' test centres

b. From May 2020, the Department worked closely with the Royal National Institute of Blind People (RNIB) to mitigate barriers experienced by people with visual impairments and to create a more accessible testing service

c. When the NHS T&T service was launched on 28 May 2020, communications emphasised that tests could be booked either online or over the phone by calling 119, thereby ensuring that people without internet access or who lacked confidence in using the internet could easily book a test.

d. To mitigate the impact of technology access, the department ensured multiple routes to engage with the contact tracing system. From 28 May 2020, people who tested positive for COVID-19 could share information about their recent contacts, either via a web-based portal, or by speaking over the phone to a clinical contact tracer to maximise accessibility.

e. On 26 June 2020, the Secretary of State announced that specialised translation services would be offered across a range of 68 drive-through testing sites to support people who did not speak English as their first language.

f. The Department mitigated the risk to those without a fixed address by collaborating with local outreach organisations, shelters, prisons and community centres to deliver mobile testing units to vulnerable populations.

g. The NHS COVID-19 app and communication materials were as user friendly as possible by ensuring they could be read by those with reduced literacy skills.

h. The Department ensured that the app was translated into multiple languages

45. EIAs carried out in relation to self-isolation indicated that, for some people, self-isolation was likely to have an adverse impact in respect to loss of income, concern about job security, loneliness, prevalence of domestic abuse, difficulty accessing food and separation from families and friends. Population groups identified as most vulnerable to these potential impacts included: those living alone or in multiple-occupancy households; the homeless; new or single parents; those with caring responsibilities; those from black and minority ethnic backgrounds; people suffering domestic abuse or living in hostile home environments; those with English as a second language; and those with a learning disability, mental illness or dementia. The support developed for self-isolation was designed to help mitigate these impacts.

46. Misinformation and disinformation about testing, contact tracing and self-isolation was an equality issue, as some groups were more likely to be exposed to, or vulnerable to being influenced by, false or misleading information than others. Combatting these harmful narratives took a cross-government approach. The Cabinet Office set up a Rapid Response Unit, made up of experts across government and the technology sector, which led the effort to tackle COVID-19 misinformation and disinformation. When false narratives were identified, the Rapid Response Unit coordinated with departments across government to deploy the appropriate response. This included direct rebuttals on social media, working with platforms to remove harmful content and ensuring public health campaigns were promoted through reliable sources. The Department has acknowledged the need to combat misinformation and disinformation in previous statements to this Inquiry, in particular regarding vaccines. The Department is committed to reducing harmful, online health content and the government's introduction of the Online Safety Act aims to do this.

CONCLUSIONS

47. The Department has sought to set out the lessons learned in the body of these opening submissions. The single most important source of information that we have available, when reflecting on lessons learned is the Technical Report on the COVID-19 pandemic in the UK published on 1 December 2022. Key lessons learned within the scope of Module 7 include:

a. The importance of having knowledge, systems and partnerships in place that allow testing and contact tracing capacity – and support for self-isolation – to

be scaled up rapidly at the outset of a pandemic. Because the nature of a future virus will not be known in advance, it is not possible to have capacity stood ready, but the COVID-19 pandemic reinforces the vital importance of having plans in place so that steps can be taken to build capacity quickly. Just as with other modules, the Department reiterates the need to invest in research and development (so that there are experts able to create tests and identify how pandemics spread) and to invest in public health in between pandemics so the structures and organisations are in place to scale up.

b. Providing accessible testing, contact tracing and self-isolation support services and engaging with the public to promote participation in testing, contact tracing and self-isolation relies on strong and effective partnerships between national and local government and in turn strong engagement with local communities. Services like testing, contact tracing and self-isolation support are always likely to require a strong degree of national infrastructure, but this should be developed in a way that allows local authorities and their community partners to deploy and target services in ways that reflect local needs and circumstances.

c. Messaging needs to be consistent, clear and easy to understand. The Department recognises that guidance changed frequently: in part that was inevitable as knowledge grew about the virus and its spread, as new technologies and interventions became available, and as a combination of non-pharmaceutical interventions, testing, therapeutics and vaccination enabled restrictions to be eased in support of social and economic recovery. In any future pandemic, there are likely to be advantages in keeping guidance as simple and consistent as possible to promote adherence.

48. The Department is incredibly grateful to all those who helped support the country's response: NHS and PHE/UKHSA and local authority staff, care workers, volunteers, the military and, of course, the public for their willingness to come forward for testing, to participate in contact tracing and to self-isolate when asked or instructed to do so.