Witness Name: Jonathan Marron

Statement No: 2

Exhibits: [JM2/01 – JM2/11] Dated:

UK COVID-19 INQUIRY

DEPARTMENT OF HEALTH AND SOCIAL CARE

Module 7: Witness Statement of Jonathan Marron

1. I, Jonathan Marron, Director General of Primary Care and Prevention at the Department of Health and Social Care (DHSC), 39 Victoria Street, London, SW1H OEU, will say as follows:

2. I make this statement in response to a request dated 5 February 2025. Where I have not directly responded to a matter raised in the Rule 9, I would refer the Inquiry to the corporate statement drafted on behalf of DHSC which I have had sight of.

3. I have worked in DHSC, its Arm's-Length Bodies, and the NHS for 30 years. In the period leading up to the pandemic, I was Director General for Prevention, Community and Social Care, a role I was appointed to in June 2017. As Director General, I was responsible for policy work in primary care, medicines, community services, mental health, social care and technology transformation. In 2019, I took on responsibility for policy on health improvement and the formal

sponsorship of Public Health England (PHE) and gave up responsibility for

technology transformation as part of internal reorganisations.

4. My role as Director General was to support ministers in the formulation of government policy and to ensure delivery of that policy, through the activities of my own teams and our work with others, for example, the NHS and Local Authorities (LAs).

5. As preparations for a COVID-19 pandemic increased from January 2020 to March 2020, my group's work switched to supporting the preparations, including the readiness of social care and primary care, and the Department's role in developing the shielding policy.

6. In March 2020, I became more closely engaged with the effort to secure and distribute PPE. My formal responsibilities were changed on 27 April 2020, when I formally became Director General for PPE and Prevention, a role I held until 1 October 2021, and my former responsibilities were distributed to other DHSC Director Generals.

7. My responsibilities as Director General PPE and Prevention involved NHS Test and Trace (NHS T&T) in three ways. From July 2020, I was responsible for the reorganisation of the public health system that led to the merger of NHS T&T with the health protection teams of PHE and the establishment of the UK Health Security Agency (UKHSA).

8. The reorganisation of the public health system followed the decision in July 2020 to abolish PHE and merge the health protection functions of PHE with NHS T&T and the Joint Biosecurity centre. This would form a new single health protection agency, initially to be known as the National Institute for Health Protection, which was established in April 2021 and became UKHSA. Interim arrangements were put in place to establish a single management team and allow NHS T&T and PHE to operate as single team ahead of the formal establishment of the UKHSA. I was also responsible for the restructuring of PHE's health improvement functions, which after public consultation were

transferred to NHS England (NHSE) or merged with the DHSC's public health policy functions in the new Office for Health Improvement in October 2021.

9. From September 2022, I was the DHSC lead Director General for Self-Isolation policy and then Senior Responsible Officer (SRO) for Compliance and Enforcement from February to July 2021. I took on responsibility as lead DHSC Director General for self-isolation policy in September 2020. I have consulted my diary and my first meetings in this role took place on the 21 September. I later took on the function as SRO for Compliance and Enforcement, which I held from 5 February 2021 to 26 July 2021, at which point Scott McPherson took on this responsibility.

10. I took on the role of DHSC Senior Sponsor for NHS T&T from David Williams when he left the Department in April 2021. As DHSC Senior Sponsor I attended the NHS T&T weekly Executive Committee, my role was to represent DHSC's interests and ensure the NHS T&T Executive team had the support they needed from the wider Department. In April 2021 I became the SRO until NHS T&T transitioned to UKHSA in October 2021. I was also appointed the SRO for compliance and enforcement on 5 February 2021 until this transferred to Scott McPherson on 26 July 2021.

11. The aim of NHS T&T was to reduce the rate of transmission of COVID-19, breaking chains of transmission through testing, contract tracing and self isolation. Throughout this period the NHS T&T Executive Team led: a. the scale up of the provision of PCR and then LFD tests;

    b. the establishment of a testing service to allow access to PCR tests, and then LFDs and driving up the operational performance of this new system;

    c. the establishment of a contract tracing service able to carry out contract tracing for the large numbers of people with positive test results; and d. work with LAs to tailor testing and contracting services to local needs and to improve take up testing and compliance with self-isolation.

Modelling & Data

12. Statement B outlines decisions taken by the Department on data and modelling. As set out in that statement, the Department was provided with data

by bodies such as PHE and NHSE and had no role in collecting data directly.

13. The Department used the product of the modelling work conducted by others throughout the pandemic, as set out in the Witness Statement of Christopher Mullin, dated 25 August 2023 (**JM2/01 - INQ000252722**). The Inquiry has already received detailed evidence for Module 2 concerning the decisions that were taken during the pandemic; those decisions were, as previously set out, guided by the science, which included the modelling evidence.

Challenges

14. I am asked to explain the most significant challenges I encountered or managed in respect of Test, Trace and Isolate (TTI).

15. Statement B sets out the challenge of a system which initially had limited diagnostic capacity and had to rapidly expand to accommodate PCR testing. By the time I assumed my role these early challenges had long since been dealt with.

16. It was important to be able to encourage people to come forward for testing. The aim of compliance and adherence was to encourage testing and self isolation. The Office for National Statistics (ONS) background survey was carried out during this period, this found a higher statistic rate than the TTI figures suggested. This could have been representative of under-utilising testing prior to the introduction of lateral flow tests. This is also representative of there being a high number of asymptomatic people.

17. The essential challenge was to identify people with COVID-19 and for them to self-isolate to break the onwards chains of transmission.

18. The first challenge was identifying individuals with COVID-19. Symptoms for COVID-19 were similar to many very common conditions, or indeed individuals

may have had, and transmitted, COVID-19 without any symptoms. In the early stages of the pandemic, before the widespread availability of testing, self isolation guidance was based on symptoms and would therefore apply to large numbers of people who did not have COVID-19.

19. The availability of widespread testing, first for symptomatic patients, provided a clear COVID-19 diagnosis. This had two impacts. First, the overwhelming majority of symptomatic people tested did not have COVID-19 and these people could be released to carry on with their normal lives. I do not recall seeing a positivity rate (i.e. the % symptomatic people tested who did have COVID-19) higher than 10%. Second, those that had a positive COVID-19 diagnosis could make decisions on self-isolation knowing they had COVID-19 and the importance of them self-isolating. Cabinet Office data on compliance with self isolation suggested as few as 20% of people with symptoms were self-isolating. However, NHS T&T surveys of self-isolation for people who had tested positive for COVID-19 showed 80% compliance with self-isolation. Getting more people to test and start the NHS T&T journey was key to the effectiveness of breaking chains of transmission.

20. The ability of people to self-isolate when they had COVID-19 was a further challenge. The costs and practical challenge of self-isolation were significant and we were concerned that everyone should be able to self-isolate. We did not want concern over ability to self-isolate to discourage people from coming forward for testing or from supplying contacts when tested positive.

21. The operational challenges to scaling up testing and contract tracing were immense. Building laboratory capacity, securing the materials for the tests themselves, establishing testing centres across the country and then rolling out LFD tests, in addition to establishing a contract tracing service able to work at scale. The focus on operational delivery improvements to speed up the delivery cycle from test to result. The work of Dido Harding and her Executive Team to deliver and continuously improve the NHS T&T service made widespread testing possible and allowed people to self-isolate when they had COVID-19. Ben Dyson provides a full account in his witness statement of the testing and tracing capacity in the early phase of the pandemic and steps taken by NHS T&T to establish effective at scale testing and contact tracing.

Public Communications

22. From the onset of the pandemic, it quickly became clear that the departmental communications response would need to be agile to keep pace with rapidly

changing developments and with the evolving understanding of the virus and how it spread.

23. Statement D outlines the communications response in the early stages of the pandemic and how public communications around testing, contact tracing and self-isolation developed. I have nothing to add in my personal capacity to departmental evidence on those points.

Self-Isolation and Adherence

24. I am asked to discuss adherence to TTI and my role in improving it. I am also asked what data on adherence was available to me and how this informed my decision making. I was asked to be the DHSC policy lead on self-isolation, working with colleagues in NHS T&T and colleagues across Whitehall, in September 2020 attending my first internal and cross-Whitehall meetings on the 21st and 22nd of that month.

25. Self-isolation had been integral to the approach to reduce the transmission rates of COVID-19 from the beginning of the pandemic. Policies for self isolation for people with COVID-19 symptoms and their household contacts were introduced in March 2020.

26. The Departmental position on such matters is discussed extensively in Statement C. As stated therein, the Government kept under review the factors influencing public adherence to guidance and regulations on self-isolation, including communications to help people understand the guidance and rules and to understand the importance of self-isolation and its benefits for society.

27. It was understood that the most critical factors influencing people's willingness and ability to self-isolate – and, in turn, their willingness to come forward for testing in the first place – were the potential financial or employment impacts of not being able to work if they had to stay at home. Adherence to self-isolation could also be affected by practical issues, such as access to food or medicines or the need to provide informal care for other people. Statement C contains

discussion of the Government's evolving policies for helping address those financial and practical support needs, with the aim of helping improve both adherence to self-isolation and take-up of testing.

28. Decisions on who should self-isolate, on the basis of symptoms; test results; or contact with other cases, and on the nature and length of self-isolation were taken on the basis of clinical advice and the evolving scientific understanding of COVID-19 and its transmissibility. Ben Dyson provides a full account of this advice in his witness statement.

29. The need to ensure as many people as possible followed the self-isolation guidance, and that they had the means and the practical support to do so were the focus of Government throughout the pandemic. The approach to ensuring adherence and supporting people to do so developed over the course of the pandemic.

30. Changes to the qualifying period for Statutory Sick Pay (SSP) were made in March 2020 so that those self-isolating could access SSP from day 1, rather than the usual day 4 of an illness. In May 2020 ministers received advice on whether to adopt voluntary or mandatory self-isolation. At this stage, a voluntary approach was preferred due to the perceived risks of a mandatory scheme reducing the willingness of people to come forward for a test, or to share their close contacts. The Government continued to pursue "nudges" to encourage people to comply with the self-isolation guidance and kept the option of mandatory self-isolation under review. In June 2020, COVID-O considered further measures to improve adherence with self-isolation. These were; marketing and awareness, a trail of contact tracers calling people who were self-isolating, a trail of text messages to people who were self-isolating, support

for those needing to self-isolate outside their home, and the provision of financial support to those self-isolating.

31. In September 2020 ministers received further advice on improving compliance with self-isolation. They agreed to introduce a legal duty to self-isolate, penalties for employers who forced employees to leave self-isolation, and an Isolation Support Payment for low paid individuals. The legal duty to self-isolate applied

to people who had tested positive for COVID-19 or had been notified to self-isolate by NHS T&T or an LA. They were also required to provide details of where they would stay for their self-isolation. This duty came into force on 28 September 2020.

32. Following the introduction of the legal duty NHS T&T colleagues worked with the Police and the Crown Prosecution Service (CPS) to ensure they had the information and evidence they need to enforce the legal duty, while protecting individuals' healthcare information.

33. NHS T&T agreed a Memorandum of Understanding (MoU) with the National Police Chiefs Council to set out how information would be shared with the Police for the purposes of enforcing the duty to self-isolate. The MoU came into force on 14 October 2020.

34. We continued to work with the Police and the CPS to address concerns they raised over the information available to them, and whether it would meet the evidential requirements needed to allow enforcement action through the courts. On 25 January, we provided advice to ministers on amendments to the self isolation regulations to allow additional information to be shared with the Police to meet their concerns, and to support the successful issuing of Fixed Penalty Notices to those in breach of the self-isolation regulations. On 28 January, a Written Ministerial Statement was laid explaining the amendments and the rationale for the changes **(JM2/02 - INQ000592789).**

35. Data collected by the ONS was made available to me. Data collected from 1 February to 13 February 2021 (**JM2/03 - INQ000565626**) (the first release for

positive cases) and from 1 March to 6 March 2021 (**JM2/04 - INQ000565627**) (the first release for contacts of positive cases) indicated that the majority of respondents – 86% for positive cases and 90% for contacts – reported being fully adherent to self-isolation requirements throughout their self-isolation period.

36. I understood that these were experimental statistics, based on a sample of

respondents and with a risk that those who did not respond to the survey were less adherent than those who did. The statistics nonetheless suggested a relatively high level of adherence among positive cases and their contacts – and significantly higher than reported levels of adherence for people who had symptoms of COVID-19.

37. I was SRO for compliance. We were most concerned about whether individuals could afford to isolate and so we worked to ensure that this could be achieved.

38. I am asked what barriers to adherence were identified and how they were mitigated. I was not directly involved in any such work, and this is discussed in the corporate statements. This sets out that the Department produced a paper dated 19 January 2021 for COVID-O meeting on 'Removing Barriers to Self Isolation and Improving Adherence', (**JM2/05 - INQ000119872; JM2/06 - INQ000565574**). This paper sought to assess the level of support given to people self-isolating and improve their ability to comply with the legal requirement. It proposed working with LAs to provide a more consistent, visible and accessible framework of practical, social and emotional support for people self-isolating, modelled on the shielding support framework and expanding the medicines delivery service to cover people self-isolating.

39. I also understand that increasing compliance with self-isolation was discussed at a COVID-O meeting on 22 January 2021 (**JM2/07 - INQ000054522**).

40. The overall compliance in my view was positive, we were concerned about those who would not be able to comply and so worked where we could to put

support in place. The Department carried out the work and HM Treasury provided the funds to put it in place.

41. In recognition of the financial and practical challenges some people faced in complying with the duty to self-isolate the Government introduced a range of support, these areas are explored in more detail in the corporate statements:
    a. The Test and Trace Support Payment Scheme. Launched on 28

September this scheme applied across the country and LAs were expected to have arrangements in place to operate the scheme by 14 October. The scheme provides for a £500 support payment for low income individuals who would lose income through self-isolating and who had been contacted by NHS T&T and told to self-isolate. Those entitled to the payment would be in receipt of at least one of seven benefits payments;

b. The Local Authority Support Fund provided LAs with financial support to allow them to provide practical, social or emotional support to those who had to self-isolate;

c. Medicines Delivery Scheme. Launched in March 2021 and ran to March 2022. The Government provided £3.2m a month to provide a free delivery service for prescription medicines for those self-isolating. NHSE made arrangements with participating pharmacies and dispensing doctors to provide the service.

42. The Government and NHS T&T continued to explore further ways to increase adherence with self-isolation and to remove the barriers to compliance. In March 2021 NHS T&T initiated a programme of self-isolation pilots to explore additional approaches to support self-isolation. By May 7 pilots had been established with LA partners looking at a range of additional support including buddying systems, daily contact testing, community owned communications approaches, and temporary accommodation.

43. The ONS published experimental statistics on self-reported compliance with self-isolation. Data first collected in February for positive cases and in March for contacts showed 86% and 90% full compliance respectively. Although this

data has limitations, it does suggest relatively high levels of compliance were being achieved.

44. A review of the self-isolation support payments undertaken in May 2021 found that only a third of eligible people were accessing the self-isolation support package. The reasons for not taking up support included being unaware of the schemes, being unsure if they qualified for support, time spent waiting for a

payment, concern that £500 would not cover loss of earnings, and concern over longer term implications of absence of work for those in insecure employment.

45. I am asked to explain any pilots that were undertaken to support adherence with TTI requirements. As set out in Statement C, NHS T&T introduced self isolation pilots, run by LAs. The Department encouraged LAs to use the full flexibility available to them to adapt the Test and Trace Support Payment Scheme (TTSP Scheme) to their local circumstances and identify potentially better ways to provide financial support.

46. Pilot schemes to provide financial support for people self-isolating were introduced in three areas with high levels of COVID-19, Blackburn and Darwen; Pendle; and Oldham, from 1 September 2020.

47. Further, in March 2021, NHS T&T initiated a programme of pilot interventions for communities disproportionately impacted by COVID-19 and in areas of enduring transmission and variant of concern outbreaks to improve adherence to self-isolation requirements and engagement with the NHS T&T service (**JM2/08 - INQ000595354**).

48. The pilots involved initiatives designed and delivered by participating LAs to reflect local needs and generate national learning. The aim was to improve the evidence base for successful interventions by encouraging, testing, evaluating and sharing innovative approaches.

49. Paragraphs 300 – 313 of Statement C set out the detail of the pilots that were running by May 2021. I worked on these on behalf of the Department.

Inequalities

50. I am asked to explain, in respect of all my evidence, what inequalities were identified and in which groups, how these were mitigated in general, and how they could be mitigated in future pandemics.

51. The Department's approach to such matters is discussed extensively in Statement D.

52. This sets out that equalities advice was provided by the Department at all key stages, for example, by providing advice on 17 May 2020, ahead of increased eligibility for testing being announced. The Department advised that overall, expanding eligibility would be a positive step for promoting equal access to testing, and greatly increase the diversity of those able to get tested (**JM2/09 - INQ000562650**).

53. The Department identified equality issues, such as barriers to 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. The Department noted the overlap between groups facing access issues and those at most risk from COVID-19. The Department also noted that those on the lowest incomes, including homeless people, were least likely to have reliable internet access, and that there were some differences in digital exclusion in terms of race, ethnicity and sex. Digital literacy was also flagged as a barrier, which was a particular issue for some older people (**JM2/10 - INQ000565911**).

54. The Department referenced several mitigations, covered in more detail in Statement B, which were already in place, including home testing (launched on 23 April 2020 in partnership with Royal Mail and Amazon as an alternative to having to visit a testing site), mobile testing units (introduced in late April 2020, originally targeted at essential workers and people in vulnerable settings to reduce the distances that people had to travel to a testing site), telephone test booking (as an alternative to online booking), the intuitive design of the digital

test booking system, and instruction products. However, it was acknowledged that increased eligibility would expose any weaknesses in these existing access arrangements.

55. The Department continued to work to identify equality issues at every stage. I adopt the evidence set out in the corporate statements and have nothing to personally add to the position set out therein.

Lessons Learned

56. I note the lessons learned section in Corporate Statement D and adopt the evidence therein. I agree that the Technical Report (**JM2/11 - INQ000203933**), published on 1 December 2022, is a particularly useful tool. Ben Dyson in his witness statement has provided a comprehensive view of the lessons learnt by the Department. I wholly endorse Mr Dyson's conclusions, and from my personal perspective would emphasise the following key lessons:

    a. Communication with the public is vitally important so that people fully understand the changes to their daily lives that society as a whole needs them to make to reduce the impact of the pandemic. Understanding the risks, exactly what is expected of them, and the impact of public health interventions they are being asked to undertake is crucial.

    b. There is great value in self-isolation and contact tracing for breaking the chains of transmission and slowing down the transmission of the pandemic.

    c. The value of testing cannot be understated. Both for identifying individuals who are both symptomatic and asymptomatic, in the case of the pandemic with COVID-19, so they are clear on the need to self isolate, and for releasing symptomatic individuals who have not caught the virus. As a result of the shared symptoms with many minor conditions, many individuals would have self-isolated on the basis of conditions alone if it were not for the benefit of testing. One of the economic benefits of NHS T&T is that it enabled those who had symptoms but were not COVID-19 positive to return to work if they were fit to return. The impact of this was heightened as a result the individual not having to self-isolate for a period of up to 14 days;

    d. The public must be supported practically and financially so that they can self-isolate. It is important that as many people as possible self-isolate, support needs to be provided to allow this to be possible.

    e. The main central operational challenge is providing test, trace and contact services at scale. It is important to have the right capabilities in place that these can be built on in response to any future pandemic.

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: 19/06/2025