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Written Evidence submitted by The Health Foundation

About the Health Foundation

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.

Summary

At the Health Foundation, we have written about the development of NHS Test and Trace through to September 2020, documenting the challenges it faced and lessons learnt.[1] We also provided detailed input to the National Audit Office's interim report on NHS Test and Trace published in December 2020.[2] This submission summarises our current view of some of the challenges faced by NHS Test and Trace from January 2021 onwards.

Key points and recommendations:

- NHS Test & Trace must do all it can to avoid widening the inequalities that have already been exacerbated by COVID-19
- Measures to address inequalities need to be in place beyond vaccine rollout
- People must be supported to isolate at home and be confident that they will be no worse off for having to do so
- Any rollout of asymptomatic testing initiatives in the community needs to be closely evaluated for their impact on inequalities and involve local government Directors of Public Health in both their design and implementation.

COVID-19 is exposing and exacerbating inequalities throughout society.[3] It is imperative that NHS Test and Trace does everything it can to ensure that these inequalities are not widened further. In this submission, we focus on three areas where NHS Test and Trace can help to break chains of transmission: being tested,

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[1] https://www.health.org.uk/publications/long-reads/nhs-test-and-trace-the-journey-so-far
[2] https://www.nao.org.uk/report/the-governments-approach-to-test-and-trace-in-england-interim-report/
[3] https://www.gov.uk/government/publications/covid-19-review-of-disparities-in-risks-and-outcomes. NB: differences for those who were self-employed or more deprived did not remain after the results were adjusted for a range of demographic and socioeconomic factors.

contact tracing, and isolation. Each of these areas will remain important throughout the coming year. Even beyond the vaccine rollout, it will remain critical to test for vaccine evasive disease and repeat infections, with contact tracing and isolation of those testing positive.

Getting a test

Firstly, for symptomatic individuals in the community to be tested, this requires the recognition of symptoms, being able to take time away from caring responsibilities or work, and having access to a testing site or kit. Survey data from the CORSAIR study collected between March and August showed that people from more socioeconomically deprived backgrounds were less able to identify symptoms of COVID-19.[4] As testing availability fell in September,[5] difficulties in accessing test appointments and increases in the distance needed to travel are likely to have had a disproportionate impact on those who don't own a vehicle or are less able to take time away from work, including the self-employed.

Similarly, the CORSAIR study found that people from deprived areas are less likely to fully comply with isolation guidance when they have symptoms of COVID (but before having a test result), and so too are people who have a dependent child or are self-employed.[3] Increased delays in people receiving test results in December means that people from more deprived areas or with a dependent child may have been less likely to isolate whilst awaiting test results, therefore potentially further exacerbating inequalities.

Contact tracing

Secondly, our analysis of contact tracing data (up to 18 November) suggests that fewer cases and contacts are reached by NHS Test and Trace in more deprived local authorities. Updating this analysis through to the end of December found similar differences of around 3% for the proportion of cases reached between local authorities in the most and least deprived deprivation quintiles, and a widening of the gap from 6% to 11% for the proportion of contacts reached.[6] There are likely to be a number of reasons for this, ranging from differences in demographic profile between areas, through to more structural issues such as the national approach to contact tracing or how quickly areas were able to establish local contact tracing systems.

Support to isolate

Thirdly, people need to be supported to isolate at home and be confident that they will be no worse off for having to do so. It is clear that isolation compliance is higher where people have access to social, practical, and economic support.[7]

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[4] https://www.medrxiv.org/content/10.1101/2020.09.15.20191957v1
[5] https://www.gov.uk/government/collections/nhs-test-and-trace-statistics-england-weekly-reports
[6] https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)32593-9/fulltext
[7] https://www.sciencedirect.com/science/article/pii/S0033350620300718;

A key route for NHS Test and Trace to improve isolation support (when people are symptomatic, accessing a test, awaiting a test result, and when identified as a case or contact) will be to ensure that people can get the help they need to isolate without fear of the impact on their work, income, or people they care for. Economic support is a key part of this and given the expenditure on COVID response so far, it may be a useful exercise to model the economic impact of increased isolation support (for example, adopting the model of jury service) versus the subsequent case management resulting from people not isolating. Additional support options should also be explored, such as the proactive offering of food supplies and essential goods, and the provision of hotel rooms for those in multiple occupancy or multi-generational households where isolation is difficult (as provided in various other countries[8]).

The role of asymptomatic testing

Finally, the use of rapid antigen testing through lateral flow devices (LFDs) for people who are asymptomatic is currently being trialled in a range of settings, such as schools and workplaces.[9] LFDs have the potential to be a hugely valuable way of identifying cases that would otherwise not be known about. For example, their use in daily testing of contacts as a route for case finding may also be very helpful for early identification of contacts and ensuring they go on to isolate, with the additional benefit of allowing people to continue their day-to-day activities if testing negative. However, these tests require training to deliver (sensitivity varies depending on who conducts the test[10]), they would need to be conducted on multiple - often consecutive - days, and are likely to require a confirmatory test, such as PCR, should the LFD result be positive.

The more complicated an intervention, the more likely it is to lead to a widening rather than narrowing of social inequalities.[11] [12] Therefore, any rollout of mass testing using LFDs either in particular settings (e.g. schools and workplaces) or in the community needs to be closely evaluated for their impact on inequalities, for example by socioeconomic group and by ethnicity. This will ensure that any differences in either use or impact are identified early and mitigated. Local authorities are likely to have a role in supporting people in their local populations to use and benefit from rapid testing and mass testing, particularly in more deprived communities. Therefore, Directors of Public Health in local government should be closely involved in the development of asymptomatic testing policy and have sufficient resource to support effective and equitable rollout.

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https://www.medrxiv.org/content/10.1101/2020.09.15.20191957v1;
https://www.sciencedirect.com/science/article/pii/S003335062030319X

[8] https://www.nychealthandhospitals.org/test-and-trace/take-care/

[9] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/947799/schools_and_colleges_testing_handbook.pdf

[10] https://www.ox.ac.uk/sites/files/oxford/media_wysiwyg/UK%20evaluation_PHE%20Porton%20Down%20%20University%20of%20Oxford_final.pdf

[11] Adams J et al. Why Are Some Population Interventions for Diet and Obesity More Equitable and Effective Than Others? The Role of Individual Agency. PLoS Med. 2016;13(4):e1001990

[12] Rose G. The strategy of preventive medicine. Guildford: Oxford University Press; 1992.

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