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Summary

NHS Test and Trace has been one of the most expensive health programmes delivered in the pandemic with an allocated an eye watering £37bn over two years, although it underspent by £8.7 billion in its first year. It has focused on delivering programmes but its outcomes have been muddled and a number of its professed aims have been overstated or not achieved. For the vast sums of money set aside for the programme, equal to nearly 20% of the 2020–21 NHS England budget, we need to see a proper long-term strategy and legacy as it moves into the new UK Health Security Agency (UKHSA.)

In March this year, we reported NHS Test and Trace Service's (NHST&T) failure to deliver on its central promise of averting another lockdown. Since then, however there have been some improvements. From November 2020 It has significantly increased the number of tests available and reduced the time it takes to provide results. It also increased the proportion of people who have tested positive and their contacts that it reaches, and the speed with which it reaches them, as well as developing the UK's capacity for genomic sequencing. Despite this, NHST&T has further to go particularly when its architecture and leadership is changing. Urgent improvements are needed regarding public outreach with over 60% of people who experience COVID-19 symptoms reporting that have not been tested, and certain groups such as older people, men, and certain ethnic minorities less likely to engage with the service. When under pressure, as it was over Christmas 2020 and more recently in April, performance deteriorates, with only 17% of people receiving tests within 24 hours in December 2020. In addition, most of the testing and contact tracing capacity that NHST&T paid for has not been used, and despite previous commitments to reduce dependency on consultants, it employed more in April 2021 than in December 2020.If NHST&T is to control spending on consultants it must produce a plan with targets.

NHST&T's overall goal is to help break the chains of COVID-19 transmission and enable people to return to a more normal way of life, but there have been two national lockdowns since October 2020 and at the time of our evidence session cases were increasing again. It is hard to assess how much of this should be laid at the door of NHST&T, because it has not set out what it specifically needed to do to achieve this objective, and what would be achieved by other policy tools, such as social distancing or temporarily closing parts of the economy.

Finally, NHST&T's collaboration with local authorities has improved and we were encouraged to hear how local stakeholders are being involved in designing the operating model for the UKHSA, into which NHST&T will be subsumed later this year. The UKHSA will need to get to grips with the issues raised in our report and put in place a sustainable delivery model that makes the best use of national scale and local expertise.

Introduction

NHS Test and Trace Service (NHST&T) was set up in May 2020 as part of the Department of Health and Social Care (the Department). It provides: COVID-19 polymerase chain reaction (PCR) testing, where results are processed in laboratories, primarily for people with symptoms; and lateral flow device (LFD) testing, which give results in around 30 minutes and are used to identify people with COVID-19 who are not showing symptoms. Working with local authorities, it contacts people who have tested positive and their recent contacts to advise them to self-isolate, as well as providing telephone monitoring and support during the self-isolation period. It also supports the UK's work on genomic sequencing of some PCR tests to track variant forms of COVID-19 and carries out other research and data analysis through the Joint Biosecurity Centre. NHST&T estimates that it spent £13.5 billion in 2020–21, an underspend of £8.7 billion against its budget. By the end of May 2021, it had sent out 691 million lateral flow tests, but results had been registered for only 96 million (14%) of them. On 24 March 2021, the government announced that NHST&T would form part of the newly created UK Health Security Agency (UKHSA). This transition is due to be complete by the end of October 2021.

Conclusions and recommendations

1. **NHST&T has not achieved its main objective to help break chains of COVID-19 transmission and enable people to return towards a more normal way of life.** NHST&T's main objective is to help break chains of COVID-19 transmission and enable people to return towards a more normal way of life. Yet since the end of October 2020 the country has had two national lockdowns and case numbers have risen dramatically. It is not clear how much of this should be laid at the door of NHST&T because it did not set out what it specifically needed to do to achieve this objective, and what contribution would be made by other policy tools such as social distancing and closing parts of the economy. It may never have been an achievable goal for a testing and tracing service, but it was a goal set by NHST&T in its own business case. The Delta variant became the dominant strain in the UK within four weeks of being identified as a variant of concern and, even with the benefit of hindsight, the Chief Executive of the UKHSA cannot identify anything NHST&T could have done to prevent this. We have previously found that gaps in data meant NHST&T was unable to demonstrate how effective it was at reducing the transmission of COVID-19. Continuing gaps in NHST&T's data collection means it still does not have a full picture of its performance. It only routinely monitors in-person PCR tests but lacks targets for PCR tests taken at home or in care homes, which make up the majority of these tests. NHST&T has not been able to monitor the proportion of all COVID-19 cases that it identifies through testing, a key measure of its success, since November 2020 because the ONS stopped publishing the data it used to calculate it.

   Recommendation: ***UKHSA should set out in detail its objectives and the impacts it aims to secure, and publish, by the end of December 2021, a performance management framework which:***

   - ***supports delivery of a comprehensive plan of activities to deliver its overall objectives;***
   - ***includes specific published targets and metrics for each major area of activity; and***
   - ***captures speed, reach and compliance measures across the whole test and trace process from experiencing symptoms to complying with requirements to self-isolate.***

2. **Uptake of NHST&T's services by the public is variable, and some vulnerable groups are currently much less likely to engage with it.** Only a minority of people experiencing COVID-19 symptoms get a test. Between 18% and 33% of people who experience COVID-19 symptoms report getting a test. Some groups, such as older people, men, and certain ethnic minorities, are much less likely to request tests. While it recognises that some groups of people are underrepresented in the testing programme, NHST&T's test and trace data is not sufficiently robust to establish a baseline against which progress can be measured. The UKHSA is planning to establish a baseline data set against which the new organisation will prioritise its work and assess its impact in all areas of health protection. The NHS Covid-19 app has had some success in identifying and contacting those who need to self-isolate

and sharing information. But there is a risk that people delete or switch it off to avoid self-isolating, reducing how effective it can be. The NAO reported that in late April around 16 million people had the app fully or partially enabled on their phone, but the Department is not able to provide us with more recent figures. Around 16% of people who have tested positive for COVID-19, and around 20% of their contacts, do not fully meet self-isolation requirements. The Department is working to improve the percentage of people who comply with self-isolation, including how it communicates that it is still important to get a test if someone has COVID-19 symptoms and removing the physical barriers to getting tested or to self-isolation. The Department has appointed a cross-government senior officer responsible for compliance with self-isolation.

Recommendation: ***The Department and UKHSA should write to the Committee, by the end of November, setting out which groups are most underrepresented in its testing programme and what plans it has to drive up public engagement with NHST&T, with a particular focus on these groups.***

3. **NHST&T has focussed on getting programmes up and running and paid less attention to ensuring these programmes delivered the benefits they promised.** NHST&T has distributed 691 million lateral flow device (LFD) tests but only 96 million of these have been registered. This represents only 14% of the total so it is not clear what benefit the remaining 595 million tests have secured. LFDs have been distributed since October 2020, but NHST&T has only recently started work in June 2021 to understand why test registrations was so low. In the business case for the funding it received in November 2020, one of the benefits NHST&T committed to deliver was that a £150 million investment in the laboratory network would provide NHS England with a legacy in terms of diagnostics capacity for future emergencies and for certain diseases such as cancer. But it has only recently began having detailed discussions with NHS England about these potential legacy opportunities and NHS England was unaware of this commitment at the time it was made. In the same business case NHST&T committed to drawing up a detailed benefits realisation strategy by December 2020, but this has still not been done.

Recommendation: ***UKHSA should clearly set out how it plans to deliver the benefits expected from the funding it receives from the forthcoming spending review. This should be informed by an evidence-based understanding of the actual benefits delivered by its major areas of spending to date, as measured against the intended outcomes.***

4. **NHST&T's approach to laboratory and contact centre usage is still not flexible enough to meet changing demand and risks wasting public money.** In 2020–21, NHST&T paid £3.1bn to secure the laboratory capacity to process PCR tests and £911 million for contact tracing, primarily on contact centres. However, NHST&T used only a minority of the laboratory and contact centre capacity it paid for. Between November 2020 and April 2021, the average utilisation of its laboratories was 45%. In December 2020, the Department said 85% of laboratory capacity could safely be used. In June it said this figure was 80% and in July UKHSA said that it may actually be closer to 70%. NHST&T does not have a target utilisation rate for its laboratories, but at 45%, the utilisation rate is well below the threshold of laboratory capacity that is available. NHST&T has a 50% target utilisation rate for its contact

centre staff, but the highest reached was 49% at the beginning of January 2021 and this had fallen to 11% by the end of February 2021. Over Christmas 2020, when there appeared to be spare laboratory capacity and COVID-19 cases were rising, performance declined and it took longer to provide test results, with only 17% of people receiving test results within 24 hours in December 2020. NHST&T plans to move to a more flexible approach for both laboratories and contact centres, so there should be less need in future to hold unused capacity.

Recommendation: ***UKHSA should establish and monitor clear utilisation targets for both the laboratory and contact centre capacity it pays for. In January 2022, it should write to the committee to provide an update for laboratory and contact centre utilisation for the first 9 months of 2021–22.***

5. **NHST&T's continued over-reliance on consultants is likely to cost taxpayers hundreds of millions of pounds.** Our previous report found that NHST&T was overly reliant on expensive contractors and temporary staff and recommended that it needed to reduce this. Despite NHST&T committing to reduce the number of consultants it employed, the number of consultants employed was higher in April 2021 (2,239) than in December 2020 (2,164). The Department pays consultants an average of £1,100 per day but some are paid more. NHST&T does not have a firm grip on its overall spending on consultants. It estimates that it will spend a total of £195 million on consultancy in 2021–22, but at the same time, indicated it would be spending £300 million on its top ten consultancy suppliers alone. The skills that NHST&T is currently using consultants to fill are in short supply across the civil service. Over a third of the 523 recruitment campaigns run by NHST&T up to the end of May 2021 failed to appoint anyone. The Department asserts that it has detailed plans in place to reduce the number of consultants it employs and that it expects this to be lower by the end of March 2022.

Recommendation: ***UKHSA should write to the Committee by the end of November 2021 detailing how it will reduce its dependency on consultants and write to us again in March 2022 and June 2022 setting out its progress against this.***

6. **UKHSA has still not set out how it would like to work with local authorities, leaving them little time to plan for the new approach.** The UKHSA was announced in March 2021 and is expected to be in place by the end of October 2021. However, NHST&T has still not finalised the operating model for the new organisation, meaning local authorities will have less than three months to plan for new arrangements. Local authorities play a vital and crucial role in public health, including in the response to COVID-19. We have previously criticised NHST&T for not properly engaging with important stakeholders, including local bodies. NHST&T has made progress in its relationship with local authorities and the UKHSA has committed to co-designing its new operating model with local stakeholders. At present, tracing often falls to the staff of local bodies and the additional time and effort this requires puts a strain on already stretched resources and may not be sustainable longer term. Our report earlier this year, on COVID-19 local government finance, highlighted how the pandemic had caused sudden and severe drops in local authorities' income, whilst at the same time creating additional financial pressures from the need to deliver new services and increased costs and demand for existing services.

Recommendation: ***The Department and UKHSA must urgently provide clarity to local government and other stakeholders about the future operating model. As part of this, it should ensure local authorities and other stakeholders have the resources to deliver their parts of the process. It should write to the Committee to provide an update on progress by the end of November 2021.***

1 Breaking the chains of COVID-19 transmission

1. On the basis of a report by the Comptroller and Auditor General, we took evidence from the Department of Health and Social Care (the Department), the former Head of the NHS Test and Trace Service (NHST&T), and the Chief Executive of the newly formed UK Health Security Agency (UKHSA) about the Test and Trace Service in England.[1]

2. Test and trace programmes are a core public health response during pandemics. They work by identifying infected individuals or groups of individuals through testing, tracing these individuals and their contacts, and instructing those testing positive and their contacts to self-isolate thereby reducing the spread of disease.[2]

3. NHST&T was launched on 28 May 2020 as a part of the Department to lead on the government's test, trace and contain approach in response to the COVID-19 pandemic. It works with Public Health England (PHE), local authorities and a range of academic and commercial organisations to provide tests and testing services, laboratories to process test results, tracing services, support for people self-isolating, and analysis and insight to aid decision-making at local and national levels.[3] NHST&T had a budget of £22 billion in 2020–21 and estimates that it spent £13.5 billion of that, an underspend of 39%.[4]

4. This is the second of our reports on government's approach to test and trace services in England and follows our first report in March 2021. In our previous report, we found that the scale of NHST&T's activities was striking, having increased the daily UK testing capacity for COVID-19 tests from 100,000 tests in May 2020 to over 800,000 tests in January 2021. But our report also found NHST&T still had work to do to ensure it met critical targets and objectives in a timely and cost-efficient manner. It struggled to consistently match supply of its services with demand and we were also strongly critical of its reliance at the time on expensive contractors and temporary staff.[5]

5. Since October 2020, NHST&T has increased levels of activity and improved some aspects of its performance. From October onwards, it began reaching more people testing positive, and their contacts, and reduced the time it took to reach these individuals.[6] NHST&T has also made well-regarded contributions to global efforts to understand and track new forms of COVID-19 through carrying out genomic sequencing of new variants and sharing these with the international community. Around 30% of the global sequencing of the virus and its variants has come from the UK, which is the single largest contributor to these efforts.[7] On 24 March 2021, the government announced that NHST&T would form part of the newly created UK Health Security Agency. This transition is due to be complete by the end of October 2021.[8]

1 C&AG's Report, *Test and Trace in England – Progress Update*, Session 2021–22, HC 295, 25 June 2021
2 C&AG's Report, para 1.2
3 C&AG's Report, para 1.3–1.6
4 Q 54
5 Committee of Public Accounts, COVID-19: Test, track and trace (part 1), Forty-Seventh report of Session 2019–21, HC 932, 10 March 2021
6 C&AG's Report, para 3.8, 3.10, 3.11
7 C&AG's Report, para 9, 1.20, 1.21
8 Q 91

Providing an effective testing and tracing service

6. NHST&T's overarching objective, as stated in its business case, is to "help break chains of COVID-19 transmission and enable people to return to a more normal way of life.": However, between the start of the pandemic and the end of April 2021 there have been over 4 million confirmed inflections and 131,600 deaths involving COVID-19 in England. Since October 2020 there have also been two national lockdowns and at the time of our evidence session case numbers were rising again.[9] On 8 July, the day that we took evidence, 33,278 people tested positive for COVID-19, compared to no more than 4,000 each day during April and May.[10]

7. We asked our witnesses whether these figures meant that NHST&T had been given an unrealistic objective at the outset. The former head of NHST&T told us that it alone could not prevent a lockdown and that it was one of four main tools the Government used to tackle COVID-19. They explained that the other tools available were non-pharmaceutical interventions such as restrictions on movements and social interactions, the government's vaccine programme, and therapeutic treatments for people with the disease. They also asserted that NHST&T was "never set up to be the single solution to COVID".[11] We therefore asked whether this meant that other tools had failed in their objectives. The Department explained that the balance between these tools had shifted throughout the pandemic and that its focus going forwards would be more towards vaccines and therapeutic treatments. It told us that NHST&T did not have a specific role as this had evolved over the course of the pandemic.[12]

8. In April 2021, the Department identified the Delta form of COVID-19 as a variant of concern and within four weeks it had become dominant in the UK, accounting for 99% of positive cases.[13] The Chief Executive of the UKHSA told us that even with the benefit of hindsight they could not identify anything NHST&T could have done to stop the spread of the new variant. They noted that while there had been isolated local successes in containing pockets of variants, such as in Sefton and Bolton, the transmissibility of the Delta variant made controlling it particularly difficult. They told us that there had been over 4,000 mutations of the virus and the combination of the sheer number of virus mutations and the time taken to understand whether a variant was of significance or concern, created difficulties in managing them effectively. This meant that, despite NHST&T's significant and internationally well-regarded efforts to sequence the genomes of variants, the Delta form of COVID-19 was able to spread rapidly once it arrived in the UK.[14]

9. In our March 2021 report, we concluded that NHST&T published a lot of performance data but that this did not demonstrate how effective test and trace was at reducing transmission of COVID-19. We recommended that NHST&T should improve the data it published so that people were able to get a better sense of its effectiveness, as well as

9 Qq 34–35, 113; C&AG's report para 2
10 Department of Health and Social Care, Coronavirus (COVID-19) cases in the UK data tables
11 Qq 34, 120
12 Qq 34–35, 120
13 Q 51, Department of Health and Social Care, Confirmed cases of COVID-19 variants identified in UK
14 Qq 51, 52

periodic evaluations of its impact on infection levels.[15] The NAO found that NHST&T had worked to model the impact of its activities, which was an inherently challenging task, but that there were some uncertainties in these estimates.[16]

10. The Scientific Advisory Group for Emergencies (SAGE) recommends that, for a test and trace system to be effective, no more than 48 hours should elapse between identifying an original case and their contacts self-isolating. NHST&T routinely monitors the speed with which it provides results for PCR tests carried out in person and met its target to reach 80% of these within 72 hours from January 2021 onwards. The NAO found that NHST&T did not routinely monitor performance for other types of PCR tests, such as those taken in peoples' homes or in care homes which make up the majority of PCR tests.[17] However, the former Head of NHST&T was able to provide this data at our evidence session and it showed significantly worse performance for all PCR tests than for in-person PCR tests. They told us that, by mid-January 2021, 73% of results for in-person tests were returned within 48 hours and 91% were completed within 72 hours. For all PCR tests 54% of results were provided within 48 hours and 75% of results were provided in 72 hours. They accepted that NHST&T had more work to do on home testing, and highlighted how it was working with Royal Mail to make it easier for people who could not get to a physical test site to get their home test quickly.[18] One of NHST&T's main targets was to identify 60% of COVID-19 cases through its testing. However, it had not, since November 2020, been able to monitor this because of changes to the methodology used by the Office for National Statistics to calculate new infections, a key input to this metric.[19]

Engagement with test and trace

11. Academics and experts have consistently noted that the effectiveness of test and trace systems rests on adherence to their requirements and high levels of compliance by members of the public, but these are still low for NHST&T. Of those people experiencing symptoms of COVID-19, only 18% to 33% get a test and only 43% fully comply with requirements to self-isolate, though the figure is higher for those who have received a positive test result, at 82–86%. Around 16% of people testing positive, and around 20% of their contacts, do not fully meet isolation requirements. NHST&T is responsible for improving public compliance but currently has no target relating to compliance with self-isolation.[20]

12. We asked our witnesses what progress had been made across government to improve self-isolation rates since we last examined the programme. The Department asserted that it has done significant work, including appointing a cross-government senior officer with responsibility for compliance with self-isolation. It explained that it was focussing on three areas: communications so people understand the importance of getting a test when they have symptoms; removing physical barriers to testing; and providing financial and practical support for people that are self-isolating, such as through hardship payments and medicine deliveries. It told us that it now had over 1,000 testing sites and 35,000 post-boxes to receive tests, as well as home testing and pharmacies that could give out tests. It

15 Committee of Public Accounts, COVID-19: Test, track and trace (part 1), Forty-Seventh report of Session 2019–21, HC 932, 10 March 2021, para 1
16 C&AG's Report, para 17, 3.24–3.28
17 C&AG's Report, para 15
18 Qq 42–43
19 C&AG's Report, para 3.18, 3.19
20 C&AG's Report, paras 16, 3.21–3.23

similarly explained that it had made £176 million available to support those who need to self-isolate, including £73 million to pay for the Test and Trace support payment, which provided £500 to anyone who needed to self-isolate and was on qualifying benefits, and £75 million for discretionary hardship payments.[21]

13. We asked our witnesses about the role of the NHS COVID-19 app in ensuring that people self-isolate if they need to, particularly given suggestions that some people might delete the app or stop it being enabled in order to avoid having to self-isolate. The Chief Executive of the UKHSA told us that they were aware that some people were choosing not to use the app, but stressed that it continued to be important in alerting people they needed to self-isolate, and in passing information to large numbers of people quickly.[22] The NAO reported that in late April 2021 around 16 million people had the app fully or partially enabled.[23] In its letter to us after our evidence session, the Department and the Chief Executive of the UKHSA told us that the app had been downloaded over 27.1 million time since it was launched, but that they were unable to estimate the number of people who had the app enabled at any one time and therefore unable to provide us with more recent figures.[24]

14. University College London found that older people, men, and people in lower-income households were consistently less likely to request a test following symptoms.[25] We asked our witnesses how the test and trace system could be improved to reach those who were not currently being reached. The previous Head of NHST&T recognised that one of the most important lessons over the last year had been the importance of targeting and tailoring services to work for those who needed them most. The Chief Executive of the UKHSA agreed that the test and trace service needed to know who it had to reach, and told us it now had really good data to enable this. They explained that data available through Test and Trace was routinely reviewed and that age group, ethnicity, working group and locality were all considered as part of this. They also told us that it matched testing data and immunisation data, as often the communities or groups which were not coming forward for vaccination were also not coming forward for testing.[26] We asked whether they were now confident they had the data and baselines needed to identify and target under-represented groups. The Chief Executive of the UKHSA explained that it was "monitoring a lot of these areas far more than we could ever have done to start with, and we will continue to do so".[27] They committed to providing us with baseline data about the under-represented groups that NHST&T intended to focus on, so that they could later inform us exactly what changes had taken place within these groups.[28] However, NHST&T was subsequently unable to provide this information. In their letter to us after our evidence session, the Department and the Chief Executive of the UKHSA told us when NHST&T compared test and trace data to the national picture, it could see that some groups of people were underrepresented in the testing programme and that it was focusing on how best to provide services to those in these "disproportionately impacted and underserved groups". But they explained that variability in the current test and trace

21 Q 49
22 Qq 109, 110
23 C&AG's Report, para 1.30
24 Letter from Sir Chris Wormald, Department for Health and Social Care, and Dr Jenny Harries, UK Health Security Agency, to Rt Hon Meg Hillier MP, Chair of Public Accounts Committee, 4 August 2021
25 C&AG's Report, para 3.23
26 Qq 44–45
27 Q 47
28 Q 48

data meant NHST&T was not able to establish a robust baseline against which it could measure progress. They told us that the UKHSA was planning to establish a baseline data set against which the new organisation will prioritise its work and assess its impact in all areas of health protection.[29]

29 Letter from Sir Chris Wormald, Department for Health and Social Care, and Dr Jenny Harries, UK Health Security Agency, to Rt Hon Meg Hillier MP, Chair of Public Accounts Committee, 4 August 2021

2 Protecting taxpayers' money

Laboratory and call centre utilisation

15. In 2020–21, NHST&T paid £3.1 billion to secure the laboratory capacity to process PCR tests and £911 million for contact tracing, primarily for contact centres.[30] In our March 2021 report, we found that NHST&T struggled to consistently match supply and demand for its test and trace services, resulting in either sub-standard performance or surplus capacity. We recommended that NHST&T needed to make better use of the capacity it had paid to create and strike a better balance between meeting surges in demand and maintaining timely services.[31] However, NHST&T only used a minority of the laboratory and contact centre capacity that it paid for in 2020–21. In December 2020, the NAO found that, for its laboratories, NHST&T set a threshold utilisation rate of 85%, beyond which it felt they could not operate safely or reliably. By June 2021, this figure had been revised to 80%. However, the Chief Executive of the UKHSA told us that the figure was actually closer to 70%. The percentage of laboratory capacity that has been used is well below this. Between November 2020 and April 2021, the average utilisation of NHST&T's laboratories was 45% and it does not have a target for their utilisation. Over Christmas 2020, when there appeared to be spare laboratory capacity as highlighted in the NAO report, some aspects of NHST&T's performance nevertheless dipped as cases rose. For example, it provided only 17% of in-person PCR test results within 24 hours in December compared to 38% at the end of October. While NHST&T does have a 50% average utilisation target for its contact centre staff, the highest achieved was 49% at the beginning of January 2021 and this had declined to 11% by the end of February.[32]

16. The Chief Executive of the UKHSA told us that it was "extremely difficult" to predict how much NHST&T would spend on laboratory and contact centre capacity or what demand would be for these services. Witnesses assured us that arrangements had been put in place for a more flexible approach for both laboratories and contact centres.[33] Between September and November 2020, NHST&T set up a cross-government team with commercial and contracting expertise to strengthen contract and operational management. The NAO found that since November, NHST&T had built more flexibility into its contact centre contract to allow it to adjust capacity.[34] The former Head of NHST&T told us that NHST&T was working to renegotiate contracts so that it could increase and decrease the number of contract tracers within its national teams far quicker. They told us that, for example, for its call centre staff NHST&T could now flex up to 50% up or down over a four-week period, and up to 100% up or down over an eight-week period.[35]

Benefits realisation

17. NHST&T does not yet know how it will secure the promised benefits from the laboratory infrastructure it has established. NHST&T's November 2020 business case for a £10 billion expansion of its testing capability stated that a £150 million investment

30 C&AG's report, Figure 6
31 Committee of Public Accounts, COVID-19: Test, track and trace (part 1), Forty-Seventh report of Session 2019–21, HC 932, 10 March 2021, para 2
32 Qq 64, 87; C&AG's Report, paras 7, 12, 14, 2.15, 2.17 and Figure 12
33 Qq 87, 97–100
34 C&AG's Report, para 2.11
35 Qq 97–100

in laboratory infrastructure would leave a lasting 'legacy' for NHS England, in terms of preparedness for future disease emergencies and early diagnostic capabilities for cancer and cardiovascular and metabolic diseases. However, the NAO found that NHS England and NHS Improvement had not been informed of this commitment at the time it was made and only recently began having discussions with NHST&T about potential legacy opportunities. We asked our witnesses how this had happened. The previous Head of NHST&T told us that they were surprised by the statement in the NAO report as they had ongoing discussions with NHS England and NHS Improvement about the importance of ensuring that better diagnostic capability was in place rather than having to be built from scratch. We noted that both the Department and NHS England signed off the account in the C&AG's report as factually accurate.[36] The November business case also committed to drawing up a detailed benefits realisation strategy by December 2020 setting out how benefits would be achieved from the £10 billion funding that NHST&T was requesting. However, the Department accepted that this was not yet in place. Without this, it is not clear what benefits are expected from this funding, who is responsible for delivering them or whether there are risks that need to be managed.[37]

18. Since October 2020, NHST&T has introduced lateral flow device (LFD) tests to detect infections in people without symptoms. NHST&T distributed around 691 million LFD tests between October 2020 and May 2021 as part of its plans to roll out regular asymptomatic testing. These were initially targeted at specific high-risk groups, such as care home residents, before being made available to other groups and then the wider population. By 26 May 2021, of the 691 million tests distributed by NHST&T, 96 million had been registered as used, representing only 14% of the total.[38] We questioned our witnesses about this low number. The Chief Executive of UKHSA explained that if tests believed to be in storage or transit were discounted the percentage of tests which had been registered rises to 20%. However, they also noted that, beyond that, it was difficult to identify what had been done with the rest. The NAO report found that there was no system in place to monitor LFD results and ensure they are reported.[39] We were told that around 40% of people were using tests and not reporting the results. LFD tests have been distributed since October 2020, but the NAO report in June 2021 found that NHST&T had only recently started work to understand why LFD registrations were so low.[40] We were also told that as a third of cases of COVID-19 were asymptomatic, lateral flow tests were an important way of identifying positive cases, particularly when used by people who do not have symptoms who would otherwise be unlikely to get a test.[41] The 96 million test results registered by the end of May identified 223,000 positive cases.[42]

Reliance on consultants

19. Our first report on NHST&T concluded that it was overly reliant on expensive contractors and temporary staff. We found that by October 2020, it had signed 407 contracts worth £7 billion with 217 public and private organisations. By the end of December 2020, this had risen to over 600 contracts. We recommended that NHST&T should put

36 Qq 170–174, 178 ; C&AG's Report, para 21
37 Qq 172–173, C&AG's Report, para 21, 4.18
38 Q 154; C&AG;s Report para 8, 1.13–1.14
39 Q 119; C&AG's report para 2.19
40 Qq 119, 154, C&AG's Report, para 8, 1.13, 1.14
41 Q 40
42 Q 154

in place a clear workforce plan and recruitment strategy which aimed to significantly reduce its reliance on consultants and temporary staff. As part of our previous inquiry, the Department assured us that it had plans in place to reduce NHST&T's use of external consultants, but that this was dependent on the availability of civil service recruits to fill posts and on future demand for test and trace services.[43] Despite this, NHST&T employed more consultants in April 2021 (2,239) than in December 2020 (2,164). As of April 2021, consultants accounted for nearly half of all NHST&T's central staff.[44]

20. We therefore asked our witnesses why NHST&T's use of consultants continued to be so high. The previous Head of NHST&T explained that up to the end of May 2021, 196 (37%) of the 523 recruitment campaigns run by NHST&T failed to appoint anyone. They told us that this was because the skills NHST&T was trying to recruit for, in data, digital, and operational and project delivery roles, were in short supply in the civil service. They explained that as part of reducing the number of consultants, it would be important to ensure that there were permanent civil servants in the total, which had been difficult to do.[45] They also acknowledged that plans to reduce consultants need to be managed in a staged manner, to ensure skills are transferred into permanent roles. The Department assured us that detailed plans were in place to reduce consultants and that it expects their numbers to be lower by March 2022.[46]

21. We again challenged the Department and NHST&T on the value for money of their spend on consultants. The Department told us the average day rate for consultants was £1,100 but that some would have "undoubtedly" earned more than that. They were unable to tell us what NHST&T's highest paid individual consultants received during our evidence session and committed to providing us with further detail.[47] However, in their letter to us after our evidence session, the Department and the Chief Executive of the UKHSA subsequently informed us that they were not able to provide any further information as NHST&T did not hold data on the pay of individual consultants.[48]

22. At the time of the NAO's report, NHST&T provisionally estimated that it had spent £372 million on agency and contractor staff and £195 million on consultancy fees, compared with £52 million on permanent and seconded staff in 2020–21. It had not yet completed its year-end checks, and anticipated that the amount recorded as consultancy spend would increase. However, the NAO's own enquiry on contract spend indicated that NHST&T was expected to spend £300 million on the top 10 consultancies with the highest contract values.[49] We were concerned that NHST&T's consultancy expenditure may have gotten out of hand. The previous Head of NHST&T explained that the nature of the pandemic had meant that NHST&T had needed to bring in contingent, short-term labour from all parts of society, including the Army, civil servants, volunteer contracts, unpaid staff, as well as consultants. They explained that NHST&T needed to rely on consultants in part because some of the skills it needed did not exist in the civil service, and partly because the nature of the pandemic response meant the roles available were temporary rather than

43 Committee of Public Accounts, COVID-19: Test, track and trace (part 1), Forty-Seventh report of Session 2019–21, HC 932, 10 March 2021, para 3
44 Q 129, C&AG's Report, para 13
45 Q 135
46 Qq 136, 141
47 Qq 132–133
48 Letter from Sir Chris Wormald, Department for Health and Social Care, and Dr Jenny Harries, UK Health Security Agency, to Rt Hon Meg Hillier MP, Chair of Public Accounts Committee, 4 August 2021
49 Qq 129, 138; C&AG's Report para 2.20

permanent. The Chief Executive of the UK Health Security Agency confirmed that it had a "very detailed ramp-down plan" to reduce the number of consultants by the end of March 2022.[50] In their subsequent letter to us, the Department and the future Chief Executive of UKHSA told us that NHST&T had reduced the number of consultants from a peak of 2,504 to 1,864 over the previous four months. They committed to reducing the number of consultants, "balanced with the delivery of national priorities, ensuring the sustainable handover of critical knowledge, and managing recruitment into high-skill roles".[51]

50 Qq 138–140

51 Letter from Sir Chris Wormald, Department for Health and Social Care, and Dr Jenny Harries, UK Health Security Agency, to Rt Hon Meg Hillier MP, Chair of Public Accounts Committee, 4 August 2021

3 Developing an effective operating model

Transition to the UK Health Security Agency

23. Local authorities and public health experts play a vital role in protecting the health of the population. Our previous report on test, track and trace, concluded that many important stakeholders had at times felt ignored by NHST&T. We found that a range of stakeholders had queried why local authorities and NHS primary care bodies were not more directly involved with testing and tracing activities at NHST&T's outset given their existing networks, experience and expertise. We recommended that NHST&T review how it engaged with, and draws expertise from, the wider public health and other sectors, including local government.[52] We challenged the UKHSA and the Department about how they will ensure UKHSA makes the best use of local expertise. The Department acknowledged the importance of getting this balance right, and told us it was trying to identify what was best delivered nationally to a common set of national standards and securing economies of scale, and which parts should best be delivered locally making use of local knowledge and expertise. It explained that, for example, laboratory capacity and data tracking systems such as barcodes might best be organised nationally, whereas setting up testing centres might best be done locally, drawing on local expertise about how to reach vulnerable communities.[53]

24. Our report in March 2021 on local government finance highlighted how the pandemic had caused sudden and severe drops in local authorities' income, whilst at the same time creating additional financial pressures from the need to deliver new services and the increased costs of delivering existing services.[54] In 2020–21, NHST&T paid a total of £2.2 billion to local authorities out of its overall budget of £22 billion and actual spend of £13.5 billion. This included: £1.7 billion for 'contain' activities to identify local COVID-19 outbreaks and support local responses to the pandemic; £176 million for test and trace support payments; and £13 million for practical support for self-isolation.[55] Local authorities' involvement in testing and tracing increased significantly during the course of the pandemic. The Chief Executive of the UKHSA explained that some local authorities had taken responsibility for contact tracing through the Local Zero programme. However, as cases have increased NHST&T had taken some of this back because local authorities did not have the capacity to do it.[56] The NAO report noted that some tracing often fell to staff of local bodies, and the additional time and effort required put a strain on resources, which may not be sustainable in the long term. It also found that funding for local responses to the pandemic was one of only three areas where NHST&T had budgeted less than it eventually needed to spend.[57] We questioned whether, given the involvement and responsibilities of organisations at a local level, too much money was being held centrally. The Chief Executive of the UKHSA told us that it was committed to learning the lessons

52 Q 145; Committee of Public Accounts, COVID-19: Test, track and trace (part 1), Forth report of Session 2021–22, HC 239, 4 June 2021, para 18
53 Qq 143–145, 147–151
54 Committee of Public Accounts, COVID-19: Local government finance, Forty-Seventh report of Session 2019–21, HC 932, 10 March 2021, para 3–8
55 Q 143; C&AG's Report, para 2.4
56 Q 151; C&AG's Report, para 10
57 C&AG's report, para 1.16, Figure 6

from Test and Trace in how it balanced the national, regional and local. They confirmed that it would develop a full business case for funding in the forthcoming spending review, and it would consider what funding to provide to local authorities as part of that.[58]

25. From 1 October, NHST&T will become part of the newly created UKHSA. We asked witnesses how they were involving local authorities and other stakeholders in designing the model for this new organisation.[59] The Department acknowledged that it had not always got the balance between local and national delivery right. It committed to co-creating the model for the new organisation with local authorities. The Chief Executive of the UKHSA acknowledged that the way it worked with local authorities, the NHS and other stakeholders will be critical and that it had sessions organised to work through this.[60]

58 Qq 143–144
59 Qq 91–96
60 Qq 151, 160

Formal minutes

Thursday 21 October 2021

Members present:

Dame Meg Hillier, in the Chair

Sir Geoffrey Clifton-Brown

Peter Grant

Mr Richard Holden

James Wild

Test and Trace update

Draft Report (*Test and Trace update*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 25 read and agreed to.

Summary agreed to.

Introduction agreed to.

Conclusions and recommendations agreed to.

Resolved, That the Report be the Twenty-third of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

Adjournment

[Adjourned till Monday 25 October at 3:30pm

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the inquiry publications page of the Committee's website.

Thursday 8 July 2021

Gareth Davies, Comptroller and Auditor General, **Robert White**, Director, National Audit Office, and **Marius Gallaher**, Alternate Treasury Officer of Accounts, HM Treasury	Q1–178

Published written evidence

The following written evidence was received and can be viewed on the inquiry publications page of the Committee's website.

TT2 numbers are generated by the evidence processing system and so may not be complete.

1 Local Government Association's (LGA) (TT20001)

List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the publications page of the Committee's website.

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2nd	BBC strategic financial management	HC 187
3rd	COVID-19: Support for children's education	HC 240
4th	COVID-19: Local government finance	HC 239
5th	COVID-19: Government Support for Charities	HC 250
6th	Public Sector Pensions	HC 289
7th	Adult Social Care Markets	HC 252
8th	COVID 19: Culture Recovery Fund	HC 340
9th	Fraud and Error	HC 253
10th	Overview of the English rail system	HC 170
11th	Local auditor reporting on local government in England	HC 171
12th	COVID 19: Cost Tracker Update	HC 173
13th	Initial lessons from the government's response to the COVID-19 pandemic	HC 175
14th	Windrush Compensation Scheme	HC 174
15th	DWP Employment support	HC 177
16th	Principles of effective regulation	HC 176
17th	High Speed 2: Progress at Summer 2021	HC 329
18th	Government's delivery through arm's-length bodies	HC 181
19th	Protecting consumers from unsafe products	HC 180
20th	Optimising the defence estate	HC 179
21st	School Funding	HC 183
1st Special Report	Fifth Annual Report of the Chair of the Committee of Public Accounts	HC 222

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2nd	Defence Nuclear Infrastructure	HC 86

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3rd	High Speed 2: Spring 2020 Update	HC 84
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5th	University technical colleges	HC 87
6th	Excess votes 2018–19	HC 243
7th	Gambling regulation: problem gambling and protecting vulnerable people	HC 134
8th	NHS capital expenditure and financial management	HC 344
9th	Water supply and demand management	HC 378
10th	Defence capability and the Equipment Plan	HC 247
11th	Local authority investment in commercial property	HC 312
12th	Management of tax reliefs	HC 379
13th	Whole of Government Response to COVID-19	HC 404
14th	Readying the NHS and social care for the COVID-19 peak	HC 405
15th	Improving the prison estate	HC 244
16th	Progress in remediating dangerous cladding	HC 406
17th	Immigration enforcement	HC 407
18th	NHS nursing workforce	HC 408
19th	Restoration and renewal of the Palace of Westminster	HC 549
20th	Tackling the tax gap	HC 650
21st	Government support for UK exporters	HC 679
22nd	Digital transformation in the NHS	HC 680
23rd	Delivering carrier strike	HC 684
24th	Selecting towns for the Towns Fund	HC 651
25th	Asylum accommodation and support transformation programme	HC 683
26th	Department of Work and Pensions Accounts 2019–20	HC 681
27th	Covid-19: Supply of ventilators	HC 685
28th	The Nuclear Decommissioning Authority's management of the Magnox contract	HC 653
29th	Whitehall preparations for EU Exit	HC 682
30th	The production and distribution of cash	HC 654
31st	Starter Homes	HC 88
32nd	Specialist Skills in the civil service	HC 686
33rd	Covid-19: Bounce Back Loan Scheme	HC 687
34th	Covid-19: Support for jobs	HC 920
35th	Improving Broadband	HC 688
36th	HMRC performance 2019–20	HC 690

Number	Title	Reference
37th	Whole of Government Accounts 2018–19	HC 655
38th	Managing colleges' financial sustainability	HC 692
39th	Lessons from major projects and programmes	HC 694
40th	Achieving government's long-term environmental goals	HC 927
41st	COVID 19: the free school meals voucher scheme	HC 689
42nd	COVID-19: Government procurement and supply of Personal Protective Equipment	HC 928
43rd	COVID-19: Planning for a vaccine Part 1	HC 930
44th	Excess Votes 2019–20	HC 1205
45th	Managing flood risk	HC 931
46th	Achieving Net Zero	HC 935
47th	COVID-19: Test, track and trace (part 1)	HC 932
48th	Digital Services at the Border	HC 936
49th	COVID-19: housing people sleeping rough	HC 934
50th	Defence Equipment Plan 2020–2030	HC 693
51st	Managing the expiry of PFI contracts	HC 1114
52nd	Key challenges facing the Ministry of Justice	HC 1190
53rd	Covid 19: supporting the vulnerable during lockdown	HC 938
54th	Improving single living accommodation for service personnel	HC 940
55th	Environmental tax measures	HC 937
56th	Industrial Strategy Challenge Fund	HC 941