



House of Commons  
Public Accounts Committee

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# COVID-19: Test, track and trace (part 1)

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2019–21

*Report, together with formal minutes relating  
to the report*

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## Summary

A well-functioning test and trace programme is key to our success in the fight against the COVID-19 virus. Since May 2020, the NHS Test and Trace Service (NHST&T) has led the national programme for testing and tracing in England, aiming to help break chains of transmission and enable people to return to a normal way of life.

The scale of NHST&T's activities is striking, particularly given its short life. Between May 2020 and January 2021, daily UK testing capacity for COVID-19 increased from around 100,000 to over 800,000 tests. NHST&T had also contacted over 2.5 million people testing positive for COVID-19 in England and advised more than 4.5 million of their associated contacts to self-isolate.

NHST&T, however, still has work to do to ensure it meets its critical targets and objectives in a timely and cost-efficient manner. We appreciate that NHST&T had to be set up and staffed at incredible speed, but in particular it now needs to wean itself off its persistent reliance on consultants and temporary staff. Up to November 2020, NHST&T had spent £5.7 billion, although it has been allocated far more (£37 billion over two years). The Department of Health & Social Care justified the scale of investment, in part, on the basis that an effective test and trace system would help avoid a second national lockdown; but since its creation we have had two more lockdowns. There is still no clear evidence to judge NHST&T's overall effectiveness. It is unclear whether its specific contribution to reducing infection levels, as opposed to the other measures introduced to tackle the pandemic has justified its costs.

A major focus for NHST&T in early 2021 was the mass roll-out of rapid testing in different community settings, but there have been particular setbacks for the roll-out to schools. Both the Department and NHST&T must learn lessons from this about their role in engaging stakeholders and setting out how rapid tests can be used. The Department must also remain one step ahead in setting the future strategy for the national test and trace service, including how to secure long-term benefits from the vast expenditure it will have incurred.

This is our first examination of NHST&T and its performance. We intend to follow up on progress on the test and trace programme later in the year.

## Introduction

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Test and trace programmes are a core public health response in epidemics. The basic principles of test and trace are identifying infected individuals, or groups of individuals, through testing, and tracing their contacts as early as possible. Potentially infectious contacts are then encouraged or obliged to reduce interactions with other people (to self-isolate), thereby reducing the spread of disease. On 28 May 2020, the government launched the new NHS Test and Trace Service (NHST&T), to lead the national test and trace programme, working in conjunction with Public Health England (PHE) and English local authorities. The ‘isolate’ part of the COVID-19 strategy is not part of the scope of the Test and Trace programme, but is key to successfully controlling the disease.

NHST&T is part of the Department of Health & Social Care (the Department), which has overall responsibility for testing and tracing. Throughout the pandemic, the Secretary of State for Health has had ministerial accountability for the test and trace programme. Up to December 2020, NHST&T had an unusual accountability relationship with the Department: it was subject to the Department’s financial, information and staffing controls, but its head, the executive chair, reported directly to the Prime Minister and the Cabinet Secretary. The Department told us this relationship changed on 3 December 2020, with the executive chair now reporting to the Secretary of State for Health. PHE is England’s expert public health agency, with responsibilities for public health advice, analysis and support, and for responding to public health emergencies. Local authorities employ directors of public health who have a statutory duty to control local COVID-19 outbreaks.

## Conclusions and recommendations

1. **NHST&T publishes a lot of performance data but these do not demonstrate how effective test and trace is at reducing transmission of COVID-19.** For NHST&T to be effective in breaking chains of COVID-19 transmission, it must identify as many people as possible who are infected with or exposed to the virus, as quickly as possible. SAGE, the Government’s Scientific Advisory Group for Emergencies, advised that contacts should be reached within 48–72 hours of the original case developing symptoms, i.e. from ‘cough to contact’. NHST&T’s effectiveness also relies on people self-isolating in line with requirements. NHST&T quotes findings from an “independent verified analysis”, which suggested that its activities in October 2020 may have contributed to a reduction in the “R number” (the number of other people a person with COVID-19 infects) by 0.3 to 0.6, provided that people with the virus start self-isolating once they develop symptoms, i.e. before even engaging with the test and trace system. Most of the reduction arises from the assumption that people self-isolate as required, in particular between developing symptoms and receiving their test results. In reality full compliance with self-isolation rules can be low. NHST&T also has plans to increase the proportion of cases identified through the mass testing of people without symptoms. However, the interim report on the Liverpool mass testing pilot did not find clear evidence that the pilot reduced positive COVID-19 cases or hospital admissions. Professional bodies, such as SAGE and BMA, have raised concerns about the effectiveness of the programme in reducing transmission. NHST&T publishes weekly performance data, but these do not provide an overview of the speed of the process from beginning to end (“cough to contact”) and thus do not allow readers to understand the overall effectiveness of the programme.

**Recommendation:** *NHST&T should improve the data it publishes so people get a better sense of its effectiveness. In future, its weekly statistics should include the total time taken to reach contacts after an initial person develops symptoms (the “cough to contact” metric), how many actual days NHST&T asks people to self-isolate for, as well as the latest indicators of people’s compliance with self-isolation. NHST&T should also publish periodic evaluations of its impact on infection levels.*

2. **NHST&T still struggles to consistently match supply and demand for its test and trace services, resulting in either sub-standard performance or surplus capacity.** We accept the need to build surplus capacity into test and trace services to handle unexpected, sometimes exponential, surges in infections. However, the percentage of total laboratory testing capacity used in November and December has remained under 65%, at the lower end of what NHST&T states is best practice (between 60% and 85%). Even with spare capacity, NHST&T has never met the target to turn around all tests (in face-to-face settings) in 24 hours. In September 2020, NHST&T significantly underestimated the increase in demand for testing when schools and universities returned, resulting in poor performance. When the demand for tests surged again over Christmas, NHST&T feels it managed access to tests better, but there were still dips in turnaround times despite apparent spare laboratory capacity. For tracing, the Department accepts that, with hindsight, it did not need to scale

up central tracing services for May as much as it did. While it has sought to reduce capacity and increase flexibility since then, low utilisation rates—well below the target of 50%—persisted into October.

**Recommendation:** *For all aspects of its testing and tracing operations, NHST&T should identify opportunities to make better use of the capacity it has paid to create. Where it retains surplus capacity, this should be for a clear and explicit purpose. It needs to strike a better balance between meeting surges in demand, maintaining timely services, having eligibility criteria that allow it to identify as many people with the virus as possible, and not paying unnecessarily for surplus capacity.*

3. **Although it had to act quickly to scale up the service, NHST&T is still overly reliant on expensive contractors and temporary staff.** To scale up the test and trace service rapidly, the Department and NHST&T worked with a wide range of public and private sector partners, including consultants. By the end of December 2020, the Department had signed over 600 contracts for NHST&T-related services. At the beginning of November 2020, a ministerial announcement said there were 2,300 consultants and contractors working on NHST&T. When we took evidence in mid-January the Department estimated that from Deloitte alone there were still around 900 contractors on the books. In early February NHST&T said it was still employing around 2,500 consultants, at an estimated average daily rate of around £1,100, with the highest daily rate paid of £6,624. It is concerning that the DHSC is still paying such amounts—which it considers to be “very competitive rates”—to so many consultants.

**Recommendation:** *NHST&T should put in place a clear workforce plan and recruitment strategy which aim to reduce significantly, month by month, its reliance on costly consultants and temporary staff. NHST&T would benefit from learning lessons on how other NHS bodies manage the need for additional personnel, for example, through staff banks and should explore incorporating these into its approach.*

4. **The introduction of rapid-results testing was supposed to be a ‘gamechanger’ but confusion persists over why and how it should be used in different community settings.** Around one-third of people who have coronavirus are asymptomatic. There is now a widespread roll-out of rapid tests (primarily lateral flow device (LFD) tests, which give results in 30 minutes) for local authority use and in other community settings, such as schools and workplaces. To support this roll-out, the government allocated a further £7 billion to NHST&T in December 2020 on top of £3 billion already budgeted. The Department had already purchased 384 million LFD test kits. However, a number of reports have raised concerns about the effectiveness and risks of mass testing using LFD tests, given their lower accuracy compared to laboratory-processed tests, particularly the higher risk of ‘false negatives’ (people who actually have the virus getting a negative result). NHS T&T told the committee that a negative test result means that an individual is around 77% likely to be negative for Covid-19. Initial NHST&T and PHE guidance for schools suggested that they could use LFD tests for daily tests as an alternative to self-isolation, but this advice has now been withdrawn. On 21 January, PHE announced that it would pause or scale back the roll-out of mass testing in schools, with further evaluation needed because

of the emergence of the new, more transmissible variant of the virus. Following the Prime Minister's announcement on 22 February, schools will test students and staff regularly using LFD tests, but guidance on rapid testing in schools is yet to be updated.

**Recommendation:** *The Department and NHST&T should set out clearly how and why mass rapid testing should be used in each of the settings where roll-out is planned, alongside clear targets and updates on progress in the various sectors. Any plans should take account of the approved purpose and accuracy of rapid tests, and how to manage the risks associated with false assurances the tests may provide. If LFD testing is not suitable in some circumstances, NHST&T should urgently bring forward other plans for identifying more asymptomatic carriers of COVID-19.*

5. **NHST&T claims to be a learning organisation, but since last May many important stakeholders have at times felt ignored by it.** NHST&T emphasises to us that it is “constantly learning what works and what does not” and that it is critical to develop “an integrated team of all the different organisations, institutions and individuals in the country”. However, a range of stakeholders have queried why local authorities and NHS primary care bodies were not more directly involved in testing and tracing activities at the outset, given their existing networks, experience and expertise. Local authorities have subsequently become much more involved, for example undertaking contact tracing for people who are hard to reach. We are also concerned by a lack of engagement with school heads and education stakeholders in the roll-out of rapid testing, and the lack of general public health expertise at senior levels of NHST&T. NHST&T will need to focus more on engagement and collaboration with other sectors if the rapid testing expands to cover an increasing range of settings.

**Recommendation:** *NHST&T should review how it engages with and draws expertise from the wider public health establishment and other sectors that are especially dependent on its work. This should include, but is not limited to, local government, the schools sector and the hospitality industry.*

6. **As we hope for longer-term and sustained reductions in infection levels, the Department needs to think about the future shape of national test and trace services, and how it will secure lasting benefits from its spending.** NHST&T will be part of the newly formed National Institute for Health Protection (NIHP). However, the Department has not set out the details or timetable for the establishment of NIHP, scheduled for April 2021. In allocating additional funds to NHST&T, the 2020 Spending Review outlined that this funding will be subject to review as the vaccine programme is rolled out. The Government is now accelerating the roll-out of vaccines across the country, but we have not seen a future strategy for test and trace in response. NHST&T anticipates a continuing need for large-scale testing and tracing alongside the vaccine programme and the Department says it still needs to think through how best to wind down capacity at the appropriate time. The Department and NHST&T talk about leaving a legacy for the NHS through the vast investment in testing capacity, but they have not articulated even at a high level what this will be. We challenged NHST&T whether large testing centres were

the best way forward for the NHS, compared to having more testing capacity in local hospitals. NHST&T explained “there is not a single model” and that it is yet to “work through how it should evolve in a post-COVID world”.

**Recommendation:** *Within the next six to nine months, the Department should outline publicly its future strategy for testing and tracing services in England, including:*

- *its timetable for transitioning to the new National Institute for Health Protection,*
- *its exit strategy when infection levels reduce, including downscaling, mothballing and reallocating national and local capacity;*
- *how it will cost-effectively maintain a degree of readiness for future surges of COVID-19 and other influenza-like infections; and*
- *how it will work with the NHS, public health and local government bodies to secure continued benefit from the assets and infrastructure it has created.*

# 1 Operational performance

1. On the basis of a report by the Comptroller and Auditor General, we took evidence from the Department of Health & Social Care (the Department), including the NHS Test and Trace Service (NHST&T).<sup>1</sup>
2. Test and trace programmes are a core public health response in epidemics. The basic principles of test and trace are identifying infected individuals, or groups of individuals, through testing, and tracing their contacts as early as possible. Potentially infectious contacts are then encouraged or obliged to reduce interactions with other people (to self-isolate), thereby reducing the spread of disease.<sup>2</sup>
3. On 28 May 2020, the government launched the new NHS Test and Trace Service (NHST&T), which brought together test and trace services into a national programme, working in conjunction with Public Health England (PHE) and English local authorities.<sup>3</sup> The government has committed £22 billion funding to the programme for 2020–21 and £15 billion for 2021–22.<sup>4</sup> Up to November 2020, spending to date by NHST&T totalled £5.7 billion.<sup>5</sup> Between May 2020 and January 2021, NHST&T rapidly expanded UK testing capacity for COVID-19 from around 100,000 to over 800,000 a day.<sup>6</sup> It has also contacted 2.4 million people testing positive for COVID-19 in England and advised more than four million of their associated contacts to self-isolate.<sup>7</sup>
4. NHST&T leads on the national programme in England. Its overall aim is to help break chains of transmission and enable people to return to a normal way of life. PHE is England’s expert public health agency, with responsibilities for public health advice, analysis and support, and for responding to public health emergencies. Local authorities employ directors of public health who have a statutory duty to control local COVID-19 outbreaks.<sup>8</sup> NHST&T is part of the Department of Health & Social Care (the Department), which has overall responsibility for testing and tracing. Throughout the pandemic, the Secretary of State for Health has had ministerial accountability for the test and trace programme. Up to December 2020, NHST&T had an unusual accountability relationship with the Department: it was subject to the Department’s financial, information and staffing controls, but its head, the executive chair, reported directly to the Prime Minister and the Cabinet Secretary. The Department told us this relationship changed on 3 December 2020, with the executive chair now reporting to the Secretary of State for Health.<sup>9</sup>

## Breaking chains of COVID-19 transmission

5. The scale of NHST&T’s activities is striking, particularly given its short life. NHST&T estimated that, around the time of our evidence session, it was administering around

1 C&AG’s Report, The government’s approach to test and trace in England – interim report, Session 2019–21, HC 1070, 11 December 2020

2 C&AG’s Report, para 1

3 C&AG’s Report, paras 2–4, Figure 4

4 Q 31; C&AG’s Report, para 1.28

5 Q 107

6 Qq 6, 8, 41, 108, 112

7 Department of Health and Social Care, [NHS Test and Trace statistics, 28 May 2020 to 13 January 2021: data tables](#)

8 Q 4; C&AG’s Report, paras 4, 1.19, Figure 4

9 Qq 53–54; C&AG’s Report, paras 4, 1.19–1.21

965 swab tests a minute, processing 365 tests and tracing 198 people.<sup>10</sup> However, for the test and trace programme to be effective in breaking the chains of transmission, it must both identify as many people as possible who have been infected with or exposed to the virus, and also do so as quickly as possible.<sup>11</sup> SAGE, the government’s Scientific Advisory Group for Emergencies, advised that “any delay beyond 48–72 hours total before isolation of contacts” from the original case developing symptoms, i.e. from “cough to contact”, will have a significant impact on the transmission rate.<sup>12</sup> To understand NHST&T’s effectiveness, it is important to know both the number of people tested and contacted, and at what stage of infection, or exposure to infection, people are asked to self-isolate.

6. We are pleased that the Department and NHST&T regularly publish data on testing and tracing performance, but these data do not in themselves demonstrate how effective NHST&T is at reducing new infections. The published data include a daily dashboard and weekly statistics on a range of performance indicators including, for example, the number of tests carried out and people contacted, and turnaround times for tests in different settings.<sup>13</sup> These indicators cover individual stages of the test and trace process but do not provide information across the test and trace process from beginning to end (“cough to contact”). For example, they do not show the total time from someone developing symptoms to being advised to self-isolate following a positive test; nor the time from someone being in close contact to a person with the virus and being advised to self-isolate.<sup>14</sup> In its review of these data, the Office for Statistics Regulation noted that they do not yet allow people to judge “the impact the programme has on reducing the spread of COVID-19”.<sup>15</sup> Internal data, reviewed by the National Audit Office, showed that at the end of October the median time taken between an original case presenting symptoms and their contacts being traced and advised to self-isolate was 119 hours. After our evidence session the Department and NHST&T provided updated information for the beginning of February that this now stood at 78 hours, still a little short of the internal target of 48–72 hours. They highlighted improvements in the speed of testing and contact tracing, although we note the reduction may also partly reflect changes in counting when and how quickly household contacts are reached.<sup>16 17</sup>

7. NHST&T’s effectiveness also relies on people complying with its processes, from coming forward to take a test when they have symptoms, to self-isolating in line with requirements. NHST&T noted that the single most important part of the process was people coming forward for testing.<sup>18</sup> The National Audit Office also highlighted the low compliance with self-isolation rules, with estimates of the proportion of people fully complying with requirements ranging from 10% to 59%. We are concerned that lack of

10 Qq 13, 43

11 C&AG’s Report, para 1.13

12 Scientific Advisory Group for Emergencies, [Thirty-second SAGE meeting on Covid-19, 1 May 2020](#)

13 Department of Health and Social Care, [Weekly statistics for NHS Test and Trace](#); Department of Health and Social care, [The COVID-19 dashboard](#); Office for Statistics Regulation, [Ed Humpherson to Stephen Balchin; NHS Test and Trace statistics \(England\)](#)

14 Qq 27–30; [Weekly statistics for NHS Test and Trace](#); Department of Health and Social care

15 Office for Statistics Regulation, [Ed Humpherson to Stephen Balchin; NHS Test and Trace statistics \(England\)](#).

16 Department of Health & Social Care submission point 2; C&AG’s report, para 3.17 From November 2020, NHST&T no longer contacts household contacts individually; instead the person testing positive is asked to inform their household contacts that they need to self-isolate. This change was intended to “optimise... productivity... by minimising the number of calls made”. In terms of performance metrics, it increases the total proportion of contacts counted as reached, and the proportion reached within 24 hours. See also: <https://www.gov.uk/government/publications/nhs-test-and-trace-statistics-england-methodology>.

17 Department of Health & Social Care submission point 2; C&AG’s report, para 3.17

18 Qq 15, 16, 96

compliance is undermining the effectiveness of the test and trace programme.<sup>19</sup> When challenged, NHST&T acknowledged more could be done but contended that its actions, such as follow-up calls with people asked to self-isolate, had helped to improve compliance since the programme began. It stressed it was “really difficult” for individuals to self-isolate and it was working with local government and broader society to support people in this. NHST&T noted the difficulty of accurately assessing how well people are complying, and that it was working with the Office of National Statistics to improve its survey-based measures of compliance.<sup>20</sup>

8. In September 2020, SAGE concluded that “test and trace was having only a marginal impact on transmission”. NHST&T said that the situation had improved, and highlighted that it was now meeting all its operational performance targets for contact tracing.<sup>21 22</sup> It also quoted findings from an “independent verified analysis” which suggested that, NHST&T activities in October 2020, may have contributed to a reduction in the ‘R number’ (the number of other people a person with COVID-19 infects) by 0.3 to 0.6 (18–33% of the estimated ‘R number’ in October).<sup>23</sup> However, as set out in the analysis published by NHST&T the biggest part of this estimated impact arises from the assumption that people self-isolate for the period between developing COVID symptoms and receiving their test results, i.e. before even engaging with the test and trace system. NHST&T’s model also suggested that only around 10% of the total reduction in the “R number” could be attributed to NHST&T’s contact tracing activities.<sup>24</sup> We are also aware that the interim report on the Liverpool mass testing pilot did not find clear evidence that the pilot reduced positive COVID-19 cases or hospital admissions.<sup>25</sup>

## Managing supply and demand

9. We found that NHST&T was still struggling to consistently match supply and demand for its test and trace services. In September 2020, NHST&T significantly underestimated the increase in demand for testing, when schools and universities returned.<sup>26</sup> Laboratories processing community swab tests were unable to keep up with demand, leading to large backlogs, limits on the number of tests available, longer turnaround times and some people having to travel hundreds of miles to get a test.<sup>27</sup> At other times, the issue has been the large amounts of reported capacity, both for testing and tracing, not being used.<sup>28</sup>

10. The Department and NHST&T emphasised to us the importance of maintaining excess capacity in the test and trace system, due to the difficulty of predicting the pace and direction of COVID-19.<sup>29</sup> While we accept the need to build in surplus capacity to handle surges in infections, we remain concerned that significant mismatches in supply

19 Qq 96–102; C&AG’s report, para 25

20 Qq 25–26, 96–100

21 Q 14

22 See footnote 17 for details of changes in how NHST&T reaches household contacts and the associated performance metrics.

23 Qq 13,25

24 Department of Health & Social Care, The Rùm Model Technical Annex – assessing the impact of test, trace and isolate parameters on COVID-19 transmission in an October-like environment, 11 February 2021.

25 <https://www.liverpool.ac.uk/research/news/articles/covid-19-liverpool-community-testing-pilot-interim-findings-published/>; <https://www.bmj.com/content/371/bmj.m4690>

26 Qq 83–85

27 C&AG’s Report, para 17

28 C&AG’s Report, paras 15, 22

29 Qq 46, 89–90, 95

and demand do lead to some capacity being persistently under-used. To take the example of laboratory capacity for swab testing, NHST&T intentionally runs this at less than 100%, noting that best practice is to run at between 60% and 85%.<sup>30</sup> However, throughout November and December 2020, the weekly percentage of total laboratory testing capacity used (for swab tests administered in community and hospital settings) remained below 65%.<sup>31</sup> And even with this apparent spare capacity, NHST&T has never met its target to turn around tests taken face-to-face within 24 hours.<sup>32</sup> NHST&T told us its target was to turn these tests around as quickly as possible, with a particular interest in whether people get results the day after they take a test.<sup>33</sup> As demand for tests surged over Christmas 2020, NHST&T felt it managed access better than it had in September, but the increase in volumes still led to increased turnaround times, despite apparent spare laboratory capacity.<sup>34</sup> One member of the Committee also highlighted an issue of very low numbers of tests being done in his local drive-through testing with site in Cwm.<sup>35</sup> The Department noted that the site has a maximum monthly capacity of 26,880, while between October and December 2020, the monthly number of tests taken there ranged from 6,026 to 16,934.<sup>36</sup>

11. For tracing, the Department accepted that, with hindsight, it did not need to scale up central tracing services for May 2020 as quickly as it did. It highlighted the very uncertain environment in April and May and the limited basis it had for estimating the numbers of people it would need to contact and trace.<sup>37</sup> For example, the Department initially assumed that on average each person would have 10–30 contacts to trace, but by June the actual average was 2.4.<sup>38</sup> The Department did not have any flexibility to change the level of tracing staff for the first three months, but did include break and review points in the contracts. Following this, from August, it built more flexibility into the contracts and reduced the levels of central call handlers it had contracted for. However, even through to October 2020, utilisation rates of central call handlers remained well below the target utilisation rate of 50%, and as low as 1% in August.<sup>39</sup>

## Use of contractors and consultants

12. NHST&T relies on contractors for many of its supplies, services and infrastructure. The Department stated that, to scale up NHST&T so rapidly, it had used a “blended mix” of civil servants, military support, contractors and consultancy support.<sup>40</sup> By the end of October 2020, NHST&T had signed 407 contracts worth £7 billion with 217 public and private organisations, of which 121 (or 70% of the contract value) were assigned as direct awards without competition under emergency measures.<sup>41</sup> The Department told us that,

30 Qq 45–46

31 Q 46; <https://www.gov.uk/government/publications/nhs-test-and-trace-england-statistics-31-december-2020-to-6-january-2021>. The weekly utilisation rate is calculated from the published statistics on available capacity and number of tests processed.

32 C&AG’s Report para 16; <https://www.gov.uk/government/publications/nhs-test-and-trace-england-statistics-31-december-2020-to-6-january-2021>

33 Qq 128–134

34 Qq 134–143; <https://www.gov.uk/government/publications/nhs-test-and-trace-england-statistics-31-december-2020-to-6-january-2021>

35 Qq 38–39

36 Department of Health & Social Care submission point 4

37 Qq 88–89

38 Q 88; C&AG’s Report, para 3.30

39 Q 89; C&AG’s Report para 22, 3.30–32, Figure 22

40 Q 32; C&AG’s Report para 9

41 C&AG’s Report para 9, 1.34

in November and December, it had awarded a further 207 contracts worth £1.3 billion, of which around 30 were direct awards under emergency regulations. It anticipated further reductions in the use of these regulations in favour of competitions and tendering exercises in future.<sup>42</sup>

13. The response to a parliamentary question confirmed that, at the beginning of November 2020, there were 2,300 consultants and contractors working for 73 different suppliers in NHST&T, with a total consultancy cost of approximately £375 million up to that point.<sup>43</sup> However, when giving evidence to the Science and Technology Committee on 3 February, NHST&T said that it was still employing around 2,500 consultants.<sup>44</sup> When we took evidence in mid-January, the Department estimated around 900 contractors from Deloitte alone were still on NHST&T's books.<sup>45</sup> The Department reported to us that the average cost per consultant was about £1,100 a day, up to a maximum of £6,624 for some consultancy staff.<sup>46</sup> It also said it had plans to reduce NHST&T's reliance on external consultants, although this was dependent on the availability of civil service recruits to fill posts and future demand for test and trace services.<sup>47</sup>

14. We challenged the Department and NHST&T on the value for money and their scrutiny of these consultancy contracts and associated spend. On day rates, the Department felt it had mitigations in place, including specifying within contracts that services are to be obtained from staff at an appropriate grade, rather than directors and partners by default. It also noted that some consultancies had dropped their normal public sector rates for COVID-19 work.<sup>48</sup> The Department felt it had mitigated the risk of profiteering through its approvals and contract management processes, and the way it structured its contracts, e.g. by not committing to fixed levels of volume. It also told us it had "beefed up" NHST&T's commercial function.<sup>49</sup> The Department said that it was as confident as it could be, based on monitoring information, that there was no profiteering, and that it did not have, and had not had, any "red flags" on contractors or contracts linked to NHST&T.<sup>50</sup>

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42 Qq 58–59

43 <https://questions-statements.parliament.uk/written-questions/detail/2020-10-14/103454>

44 Select Committee on Science and Technology, [Oral evidence: UK science, research and technology capability and influence in global disease outbreaks](#), HC 136, Wednesday 3 February 2021, Qq 1928, 1931

45 Q 47–48

46 Qq 33–35; Department of Health & Social Care, point 3

47 Qq 32, 47; Department of Health & Social Care, point 3

48 Qq 33, 36

49 Q 49; C&AG's Report para 1.35

50 Qq 50–52

## 2 Learning lessons for the future

### Rollout of rapid testing

15. In December 2020, the Department announced that it would roll out mass Lateral Flow Device (LFD) testing for schools and colleges in the New Year, building on its earlier use at universities.<sup>51</sup> LFD tests give results within 20–30 minutes, compared with the standard PCR swab tests, which must be sent to a laboratory for processing. NHST&T confirmed it was also rolling out LFD tests for key workers, such as in care homes or food processing plants, and for community testing, for people without COVID-19 symptoms.<sup>52</sup> To support the roll-out of mass testing, as well as the continued increase in testing capacity, the government allocated a further £7 billion to NHST&T in November in addition to the £3 billion already made available for mass testing for 2020–21.<sup>53</sup> The Department informed us that it had already purchased and taken delivery of 384 million LFD test kits, with a further 239 million to be delivered in February. It was in the process of tendering for up to a further 200 million LFD tests by early March.<sup>54</sup>

16. A number of significant commentators, including the British Medical Association and British Medical Journal, have raised concerns about the effectiveness and risks of mass testing with LFD tests.<sup>55</sup> A particular issue raised is the relative accuracy of LFD tests compared to PCR tests and the higher risk of false negatives.<sup>56</sup> Published evidence indicates that LFD tests had a sensitivity of only 77% (broadly, if 100 people with the infection take the test, only 77 of them will return a positive result). NHST&T considers LFD tests a “very useful addition to our overall testing toolkit”.<sup>57</sup> But the interim evaluation of the Liverpool mass testing pilot found that, when self-administered, LFD tests overall only detected 40% of positive cases detected by PCR tests. In the evaluation, LFD tests did detect a higher proportion of positive PCR tests—around two thirds—when individuals had a higher “viral load” and were more “substantially infectious”.<sup>58</sup> While the authors of the Liverpool evaluation pointed out the benefits of LFD tests in identifying many infectious asymptomatic cases who would otherwise go undetected, they also stressed the need to communicate clearly that when people test negative, it does not provide assurance that they are not infectious.<sup>59</sup>

17. We are aware that the Medicines and Healthcare products Regulatory Agency (MHRA), the government’s regulatory body which approves medical devices, approved

51 <https://www.gov.uk/government/news/staggered-rollout-of-coronavirus-testing-for-secondary-schools-and-colleges>; <https://www.gov.uk/government/publications/coronavirus-covid-19-asymptomatic-testing-in-schools-and-colleges/coronavirus-covid-19-asymptomatic-testing-in-schools-and-colleges>; <https://www.gov.uk/government/news/all-students-offered-testing-on-return-to-university>

52 Q 13, 16–17, 118

53 C&AG’s Report paras 1.28–1.29

54 Q 117

55 For example: <https://www.bma.org.uk/news-and-opinion/the-implications-of-rapid-testing-for-nhs-workers>; <https://www.bmj.com/content/371/bmj.m4436>

56 See, for example, <https://www.bmj.com/content/371/bmj.m4916>

57 Q 116; <https://www.gov.uk/government/publications/evidence-on-the-accuracy-of-lateral-flow-device-testing/evidence-summary-for-lateral-flow-devices-lfd-in-relation-to-care-homes>

58 <https://www.liverpool.ac.uk/research/news/articles/covid-19-liverpool-community-testing-pilot-interim-findings-published/>

59 [Microsoft Word - Deeks Response 210114.docx \(liverpool.ac.uk\)](https://www.liverpool.ac.uk/research/news/articles/covid-19-liverpool-community-testing-pilot-interim-findings-published/)

the LFD test in December 2020.<sup>60</sup> However, we are concerned at media reports that it had advised the Department against using LFD tests in schools for daily testing of contacts of people with COVID-19 (as an alternative to self-isolation), because of the false assurance it may give to those testing negative.<sup>61</sup> NHST&T contended that it had worked closely with MHRA on “all the rolling out of different testing protocols”, including piloting and rolling out LFD tests in schools. It confirmed that it was continuing with the process of rolling out LFD tests for people returning to school and for weekly testing of school staff, and that by the time of our session “up to 250,000 lateral flow tests were registered by schools”.<sup>62</sup> Despite this, on 21 January, three days after our evidence session, NHST&T and PHE announced that they would pause the roll-out of LFD tests for daily contact testing, in light of the emergence of the new variant of the virus and to undertake further evaluation.<sup>63</sup> Following the Prime Minister’s announcement on 22 February, schools will test students and staff regularly using LFD tests, but guidance on rapid testing in schools is yet to be updated.<sup>64</sup>

## Partnership working

18. NHST&T told us the biggest lesson it had learnt from the last year was that “you can only deliver this sort of service as an integrated team of all the different organisations, institutions and individuals in the country”. It said it had learned a lot about “how to build this coalition between local government and national Government, the NHS, the broader public sector and the private sector—and, ultimately, with the general public as a whole”.<sup>65</sup> However, a range of stakeholders have queried why local authorities and NHS primary care bodies were not more directly involved in the government’s approach to test and trace from the outset, given their existing networks, experience and expertise.<sup>66</sup> For example, the Local Government Association felt that a lack of consultation with local areas had led to test centres being set up in places that many people had difficulty getting to. Since July, local authorities have assumed a bigger tracing role, setting up their own locally run contact tracing schemes to cover the minority of cases that the national service cannot reach, working in conjunction with NHST&T.<sup>67</sup>

19. The Department acknowledged that it took the decision to build up tracing capacity centrally at the beginning because of the need to do this quickly, but it maintained that there had been “a series of conversations” with local authorities and directors of public health. NHST&T stressed that it had always engaged with and had senior representations from local authorities at a national level.<sup>68</sup> As of October 2020, the National Audit Office noted that NHST&T’s Executive Committee included one member from a local authority

60 MHRA, <https://www.gov.uk/government/news/mhra-issues-exceptional-use-authorisation-for-nhs-test-and-trace-covid-19-self-test-device>

61 Q 10; Guardian, [https://www.theguardian.com/world/2021/jan/14/regulator-refuses-to-approve-mass-covid-testing-schools-in-england?CMP=Share\\_iOSApp\\_Other](https://www.theguardian.com/world/2021/jan/14/regulator-refuses-to-approve-mass-covid-testing-schools-in-england?CMP=Share_iOSApp_Other)

62 Q 10

63 <https://www.gov.uk/government/publications/daily-contact-testing-in-schools-statement-from-phe-and-nhs-tt-about-next-steps/position-statement-regarding-daily-contact-testing-in-schools-from-phe-and-nhs-test-and-trace>

64 <https://www.gov.uk/guidance/asymptomatic-testing-in-schools-and-colleges>

65 Q 5

66 Qq 86–87; [Local Government Association submission para 3](#); [British Medical Association submission paras 1.1–1.8](#); [We Own It submission paras 3–5](#); C&AG’s report, para 7

67 C&AG’s Report, para 19, 1.24

68 Qq 86–88

(out of 15 members).<sup>69</sup> NHST&T told us that it had increasingly involved local authorities in its test and trace programme, for example through rolling out community testing.<sup>70</sup> It has also established contact tracing partnerships with nearly 300 local authorities, and has plans to increase local support for ‘extended’ contact tracing (when tracers seek to identify where an individual was infected, not just their close contacts).<sup>71</sup> However, both the National Audit Office report and evidence submitted by the Local Government Association highlighted a lack of clarity about whether and how much funding was available to local authorities.<sup>72</sup> The Department told us that it had provided a total of £925 million to local authorities since early summer, but we remain concerned that local authorities are hampered by limited funding and resources, and continuing uncertainties around funding levels, in carrying out their share of testing and contact tracing activities effectively.<sup>73</sup>

20. While we welcome NHST&T’s increasing collaboration with local authorities, we see a need for it to expand its collaboration with a range of other sectors, reflecting the wider scope of the roll-out of rapid testing. In our local constituencies, we heard of lack of engagement with school heads in the roll-out of mass testing for schools, although NHST&T told us there were joint working teams with the Department for Education for activity within schools and universities.<sup>74</sup> We also remain concerned at the lack of clinical public health expertise at senior levels within NHST&T.<sup>75</sup> Without cross-working processes at different levels, linking well to regions and local areas, and rooted in sound clinical and practical public health considerations, it will be difficult to develop effective collaborations across different sectors on a consistent basis. NHST&T is not just a large-scale customer service organisation; it is a vital public health intervention.

## The National Institute for Health Protection and long-term strategy

21. On 18 August, government announced that a new body, the National Institute for Health Protection (NIHP), would subsume NHST&T, the health protection functions of PHE and the Joint Biosecurity Centre. The executive chair of NHST&T is also acting as interim executive chair for NIHP. The establishment of NIHP is due to take effect from 1 April 2021.<sup>76</sup> However, to date, there have been no further details published on the transition arrangements to the new body.

22. The 2020 Spending Review allocated £15 billion to NHST&T for 2021–22, to be kept under review as the vaccine programme rolled out.<sup>77</sup> The government is now accelerating the roll-out of vaccines across the country, but we are yet to see a future strategy for test and trace in response. NHST&T anticipates a continuing need for large-scale testing and tracing alongside the vaccine programme, emphasising that vaccines and test and trace are not “either/or” strategies. The Department noted that there were still many unknowns about the vaccine, and that it still needed to think through how best to wind down test

69 C&AG’s Report, para 1.24

70 Qq 16, 24, 37, 120, 145–146,

71 Qs 24, 37, 93, 120

72 C&AG report, para 19; LGA submission

73 Qq 93–95

74 Qq 77–81

75 C&AG’s Report, para 1.24

76 C&AG’s report, para 1.21; <https://www.gov.uk/government/news/government-creates-new-national-institute-for-health-protection>

77 <https://www.gov.uk/government/publications/spending-review-2020-documents/spending-review-2020>

and trace capacity at the appropriate time, and what kind, and level, of capacity would be required in the longer-term.<sup>78</sup> If the country does reach a situation where outbreaks of COVID-19 are more localised and sporadic, exhaustive and prompt testing and tracing in those areas will be essential, as outlined in World Health Organisation guidance.<sup>79</sup>

23. Both the Department and NHST&T signalled the opportunity to generate a long-term legacy from the vast public investment in, and expansion of, diagnostic capacity.<sup>80</sup> However, they have not yet articulated how this is going to happen: NHST&T told us it was still working through how laboratory infrastructure should “evolve in a post-COVID world”. It explained, “there is not a single model” for the laboratories it has set up, which range from entirely private facilities to partnerships between the NHS and private or university laboratories.<sup>81</sup> We challenged NHST&T specifically on whether large testing centres were the best way forward in terms of an NHS legacy compared with having more capacity within local hospitals. Its view was that a combination of public and private approaches was preferable, given the different types of testing each undertakes.<sup>82</sup>

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78 Q 111

79 <https://www.who.int/publications/i/item/contact-tracing-in-the-context-of-covid-19>

80 Qq 44, 111

81 Q 113

82 Qq 41–44,126

## Formal minutes

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**Thursday 4 March 2021**

Virtual meeting

Members present:

Meg Hillier, in the Chair

Olivia Blake

Sir Bernard Jenkin

Sir Geoffrey Clifton-Brown

Nick Smith

Mr Richard Holden

Draft Report (*COVID-19: Test, track and trace (part 1)*), proposed by the Chair, brought up and read.

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

Paragraphs 1 to 23 read and agreed to.

Summary agreed to.

Introduction agreed to.

Conclusions and recommendations agreed to.

*Resolved*, That the Report be the Forty-seventh 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.

[Adjourned till Monday 8 March at 1:45pm]

# Witnesses

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

## Monday 18 January 2021

**Baroness Dido Harding**, Executive Chair, NHS Test and Trace and Chair of NHS Improvement, NHS Improvement; **Sir Chris Wormald**, Permanent Secretary, Department of Health and Social Care; **David Williams**, Second Permanent Secretary, Department of Health and Social Care; **Jonathon Marron**, Director General, Public Health England

[Q1-158](#)

## Published written evidence

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

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

- 1 Local Government Association ([CTT0003](#))
- 2 The Health Foundation ([CTT0004](#))
- 3 We Own It ([CTT0006](#))
- 4 British Medical Association ([CTT0007](#))

# List of Reports from the Committee during the current Parliament

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All publications from the Committee are available on the [publications page](#) of the Committee's website.

## Session 2019–21

Number	Title	Reference
1st	Support for children with special educational needs and disabilities	HC 85
2nd	Defence Nuclear Infrastructure	HC 86
3rd	High Speed 2: Spring 2020 Update	HC 84
4th	EU Exit: Get ready for Brexit Campaign	HC 131
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

<b>Number</b>	<b>Title</b>	<b>Reference</b>
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
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