**People’s Covid Inquiry February-June 2021**

**Witness statement  
Janet Harris**

**Session 3 24 March 2021  
DID THE GOVERNMENT ADOPT THE RIGHT PUBLIC HEALTH STRATEGY?**

**STATEMENT**

I (name) Janet Harris

Job title/ role/ occupation retired public health professional  
  
will say as follows:

1. I make this statement for the purposes of the People’s Covid Inquiry, which is to be held on 24 March.
2. I am able/unable to attend and give evidence. If unable to attend, I agree to my statement being considered by the Inquiry.
3. What is your job/ role/ occupation – how long doing this for/ brief summary of background/ experience - if possible, attach CV to statement

I was a public health commissioner working in communicable disease control in the United States for 10 years. After returning to England in 2001, I shifted into academia, running the MSc and DPhil in Evidence Based Health at University of Oxford for 10 years, followed by 3 years in Norway to establish postgraduate programmes for their Centre for Evidence Based Practice. For the past 13 years, I have worked at the School of Health & Related Research, University of Sheffield teaching Public Health Management and doing community based participatory research. I completed a NIHR Fellowship in Knowledge Mobilisation in 2019, which focused on building an evidence based for the effectiveness of communities in mobilising health and wellbeing.

1. What is your connection/ interest/ background/ experience relevant to the pandemic in England?

I am a volunteer working with the Sheffield Community Contact Tracers. In this role, I work with communities across Sheffield to mobilise knowledge and responses to the covid pandemic via a programme called “Covid Confidence”. Sheffield Community Contact Tracers (SCCT) is a volunteer-led project sitting within a local charity, Heeley Trust. SCCT helps to identify gaps in systems relating to COVID-19 and raise awareness on these issues. SCCT also conduct studies and demonstration projects to show possible solutions to these problems; through supporting communities to become more confident and resilient on this topic and to amplify seldom heard voices by giving them a platform to share their experiences.

SCCT was established in March 2020 with the [initial pilot project](https://www.communitycontacttracers.com/evaluation/) of setting up a contact tracing initiative for residents of Sheffield before the government had a national scheme in place. Since conducting this study, SCCT has grown and expanded its work, now providing vaccine and COVID confidence training workshops to communities across the city, hosting regular updates on Sheffield’s management of the virus and volunteering to support the national vaccination programme.

1. How are you able to assist the Inquiry – what is your expertise/ knowledge/ specialism?

I have prior experience of directing seroprevalence and surveillance programmes which included establishing community contact tracing programmes. I have directed the linking of top down, regional and national responses to epidemics with local initiatives to communicate effectively across different BAMER groups during epidemics. I have 30 years of experience in community organisation and management, using participatory approaches to promote public health.

1. What in your view were the original vision and principles underpinning the NHS?

The original vision was to provide high quality health care, that met the needs of patients, which was free for all at the point of delivery. Universal access on the basis of need, ensuring that regardless of race, class, ethnicity, everyone was entitled to the same standard of care.

**Please briefly outline your testimony below or attach or reference an article which will provide the panel with relevant information.**

It is not too late to establish local public health approaches to contact tracing and isolating with support, but success of local initiatives is dependent on a number of elements.

Our pilot study in Sheffield exploring the feasibility of local test and trace implementation found that [people had concerns](https://www.communitycontacttracers.com/wp-content/uploads/2020/08/CCT-%20%20%20%20%20Volunteer-Evaluation-TW-Final.docx.pdf) about secure data access and storage. We know that reluctance to be tested is related to poverty, a lack of digital skills, misinformation and a mistrust of the government. [NHSTT fails to detect](https://blogs.bmj.com/bmj/2020/11/10/we-must-stop-being-polite-about-test-and-trace-there-comes-a-point-where-it-becomes-culpable/) reach those who are asymptomatic and people who are unwilling or unable to be tested. We followed our evaluation, which was completed last May, by setting up Covid-19 Updates and sessions to promote Covid Confidence. Since September 2020, SCCT has provided 9 Updates and 13 Covid Confidence sessions. Attendance ranges from 27-41 people at the larger sessions, with smaller neighbourhoods consistently represented by 8-10 organisations. Participants come from all sectors, with at least 50% participation by the Voluntary, Community and Faith (VCF) sectors. Repeat attendance (both within neighbourhoods and across neighbourhoods) has created an interdisciplinary network that actively engages people in discussions about how to mobilise to manage the pandemic. Alongside the quantitative data from our evaluation, and the qualitative information and activity data provided by people in Sheffield, we have sought out models of contact tracing that have been effective in other countries. The elements of success reported elsewhere support the Sheffield experience. We therefore believe that a [contact tracing system could be effectively organised](https://blogs.bmj.com/bmj/2020/09/08/best-practice-in-contact-tracing-how-should-an-effective-system-be-organised/) if the following points are considered.

1. We need to build trust. Now that the national system has been widely recognised as a failure, some damage control is going to be needed to build trust. [Meaningful community involvement](https://blogs.bmj.com/bmj/2020/10/29/it-is-not-too-late-for-local-authorities-to-start-leading-contact-tracing/) working with “ear to the ground” organisations.
2. Counteracting negative experiences is going to take some social marketing, done by local people who understand the reluctance to participate in a contact tracing system. Sheffield is implementing a local system. This systems will need to be publicised via community anchor organisations. Getting information about the service from trusted local people and local networks via word of mouth increases the chances that people will be willing to engage. Further, stories about positive contact tracing experiences need to be shared, using Covid Champions in each area. This local endorsement increases chances that people will answer the phone, and name their contacts.
3. Digital tracking should enhance tracing – not the other way around. There is a low level of trust in digital apps for some of the reasons listed above. They should be a part of a contact tracing system, to supplement what one of your previous witnesses described as ‘good old fashioned shoe leather’.
4. We need to critically review the existing public health and government messages. Although these have been translated in to a number of languages, groups across Sheffield note that this is not adequate. Some languages are still not included. Publishing written material marginalises people with low literacy, and who have learning disabilities. Further, government and NHS ‘branding’ is often seen as being told what to do by people in positions of power and control. Localities need to consider which forms of messaging are trusted by different groups, who may prefer different types of social media. Co-producing local messages increases relevance and ownership.
5. Develop targeted communication strategies that are grounded in understanding of barriers experienced by diverse communities/groups. Enlist the support of people with local credibility, to develop alternative forms of communication to the written word.

It is important to also note that delivering a ‘message’ is different from having a conversation. Our local Covid Confidence sessions have confirmed the value of sharing information informally, via locally known people, to help people make informed decisions about getting tested and self-isolating. Be aware that often more than one conversation is needed, in order to counteract the misinformation that people get from other sources.

1. Promote partnership working to ensure responsiveness to local outbreaks. Effective communication strategies may have to be tweaked when local outbreaks occur, collaborate with local community organisations to increase targeted publicity whenever there is a local outbreak.
2. Local delivery means training local people. Our pilot demonstrated that local people without prior experience can be trained, as long as they are supported by public health experts. Enrolling workers to do contact tracing who have knowledge of and are already working with local groups increases the chances that interactions during contact tracing are sensitive to different cultures, and reflect local circumstances.
3. Build in support for the contact tracing workforce. Using paid workers who have specific training, with volunteers who have local expertise reassures local people that they are developing a good skill set. In Sheffield, community organisations have already mobilised to support FTTIS, but this has been very under-resourced. Workers report that they are trying to support local people while [dealing with illness and bereavement in their own families](https://www.communitycontacttracers.com/shc/). This is doing to be a long-term, workforce management issue, so adequate resources need to be identified to provide support for workers.
4. Establish local call centres. And be aware that the structure for call centres may differ by locality, depending on local issues. Local call centres could be run by the local health/public health services, staffed by trained workers from voluntary sector organisations, and/or collaborating with a call centre company that has a track record in working with the health service. This type of locally-connected call centre is one of the key elements contributing to success of the [Massachusetts Community Tracing Collaborative Support Centr](https://www.mass.gov/info-details/covid-19-community-tracing-collaborative-support-center-implementation)e, which had a [92% success rate](https://www.masslive.com/coronavirus/2020/08/more-than-2100-contact-tracers-working-to-track-covid-19-in-mass-have-achieved-a-92-success-rate-moving-metric-to-positive-trend-for-the-state.html)as of August 2020.
5. Pave the way so that people are responsive to local authority intervention. We know that using local health officers and health protection teams is essential, in order to investigate workplaces, nursing homes, schools and other institutions when there is an outbreak. How this statutory authority is exercised, however, can either promote cooperation or increase mistrust. Bringing mobile testing vans into a community does not ensure that people will visit them. Community based organisations are key to facilitating access, increasing uptake and cooperation.
6. Contact tracing needs to be implemented in hospital settings, our most recent [feasibility study](https://blogs.bmj.com/bmj/2021/02/21/contact-tracing-of-in-patients-with-covid-19-the-use-of-volunteers-to-enhance-nhs-test-and-trace/) indicates that NHSTT [fails to engage](https://www.medrxiv.org/content/10.1101/2021.01.28.21250096v1) nearly two thirds of Covid-19 in patients and fails to advise two thirds of their close contacts to self isolate.
7. Use funding to promote cross-sector integration. Funding going to Local Authority Public Health Departments needs to be supplemented with funding to Primary Care, in order to ramp up the capacity to diagnose patients ahead of testing and notify local contact tracers, in tandem with ordering and conducting the test.
8. Get people to associate contact tracing with support. At present, contact tracing is associated with ‘naming’ and ‘telling people what to do’. It needs to be rebranded as a package of support. Covid Champions, who are locally known and trusted people, can not only increase trust in contact tracing, but crucially can pick up people who need to self-isolate and ensure that the support they get is based on knowledge of their individual circumstances. This linking and bridging role is very similar to what is currently done under Social Prescribing, and drawing upon the experience of Social Prescribers can facilitate rapid referral to needed services across different systems.
9. Identify local quarantine facilities, that can be accessed on short notice. Develop local, backup plans to restrict travel that can be implemented and make sure that staff are trained to respond to local and national travel restriction queries when they arise.
10. Train local people in all aspects of contact tracing and support. In future, it is likely that the number of cases will fluctuate and there could be a corresponding threat of prematurely reduced funding, leading to loss of a trained workforce. If people are trained across different aspects of FTTIS, we can create a flexible workforce that can shift roles in responses to changes in case rates.

**I confirm that the opinions I have expressed represent my true and complete professional opinions on the matters to which they refer.**

 **19 March 2021**

**SIGNED DATE**

**Please return to** [**Inquiry@keepournhspublic.com**](mailto:Inquiry@keepournhspublic.com)

**Thank you**

**Olivia O’Sullivan**

**Secretary to the panel**

**The People’s Covid Inquiry**