



Department of Health & Social Care

Rt Hon Greg Clark MP
Chair, Science and Technology Committee
By email: scitechcom@parliament.uk

*From the Rt Hon Matt Hancock MP
Secretary of State for Health and Social Care*

*39 Victoria Street
London
SW1H 0EU*

020 7210 4850

15 July 2020

Dear Greg

Many thanks for your letter asking about our plans for COVID-19 testing of health and care workers and for your correspondence to the Prime Minister of the 18 May on novel coronavirus.

Novel Coronavirus

From the beginning of the outbreak, our policies have been guided by the advice of the Government Chief Scientific Adviser (GCSA) and the Chief Medical Officer (CMO) for England. They are in turn advised by SAGE. SAGE has participants rather than members, and only the GCSA and the CMO can talk on behalf of SAGE. There are roughly 20 scientists at each meeting but there will not be the same people at every meeting. Expert participation varies depending on the subjects being discussed. We estimate that up to 100 people have been involved in SAGE and its subgroups so far. The GCSA and the CMO decide whose expertise is needed, in discussion with other participants and relevant experts. We are reforming how the process works.

Other SAGE participants include Public Health England (PHE), the Office for National Statistics (ONS), the NHS, the Food Standards Agency, the Health and Safety Executive, and Chief Scientific Advisers of Government departments relevant to specific meetings, such as from the Department for International Development, the Home Office and the Ministry of Defence.

SAGE is activated by a Cabinet Office Briefing Room (COBR), and is responsible for ensuring that timely, coordinated scientific advice is available to support decision-making. SAGE advice is fed into decision-makers in Government, alongside advice on social, economic, operational and policy considerations. To enable SAGE to both review and validate the wide range of research related to the COVID-19 response and undertake new assessments, analysis and modelling, it has been necessary to draw upon expert groups. Multiple subgroups feed into SAGE, covering areas such as modelling, behavioural sciences, clinical science, serology, environment and children. SAGE expert groups consider the scientific evidence and provide their consensus conclusions to SAGE.

The Government is committed to the open sharing of the scientific advice guiding our response to COVID-19 where possible. The Government's approach to publishing evidence from SAGE has been adapted from previous emergencies, such as the 2009 H1N1 influenza pandemic, where papers were published only at the end of the emergency. By contrast, due to the volume of evidence being reviewed by SAGE, the Government has increased the rate of publishing evidence compared to previous emergencies; we have already published documents discussed at SAGE and its sub-

committees since the outbreak began. This will continue throughout the COVID-19 emergency.

Turning to the concerns raised about a coordinated response with the devolved nations, the four UK governments' CMOs continue to advise the health and social care systems across the UK, and government agencies in all parts of the UK involved in responding to this outbreak. System-wide response plans for pandemic influenza, focused on the continuity of public and critical services and the stability of the economy, have been adapted for COVID-19, based on the best available scientific evidence and advice. Although the responses of the devolved nations have been widely in line with each other, the exact response to COVID-19 will be tailored to the nature, scale and location of the threat in the UK.

With regard to testing, this is a key part of the UK's response to COVID-19 and capacity has rapidly expanded. Anyone in England who has symptoms of COVID-19, whatever their age, can now be tested for the virus. Further information can be found at www.gov.uk by searching for 'coronavirus (COVID-19): getting tested'.

Professor John Newton, the Director of Health Improvement at PHE, was appointed in April to co-ordinate delivery of the testing strategy and to bring together industry, universities, the NHS, PHE and the Government to deliver on our ambitious targets and improve testing capacity. Moreover, as part of her unpaid role, Baroness Dido Harding is leading on contact tracing, swab and antibody testing, national surveillance and immunity certification.

I wanted to make the process of accessing a test faster and simpler. This is why we set up a new online portal for booking a test, opened 150 regional testing sites across the UK and introduced a home-testing solution, which is now providing tests to thousands of people every day, completely free of charge. Home tests are couriered directly to one of the Government's labs for analysis and results are sent directly to the individual's mobile phone, as well as being added to their NHS patient record.

We have already built relationships with commercial partners, including Amazon, Boots, Thermo Fisher Scientific and Randox. We are continuing to build new relationships with national and international businesses in life sciences and other industries to turn their resources to creating and rolling out mass testing at scale. We will also support anyone across the UK with a scalable scientific idea or innovation to start a business.

We continue to review the tests on the market, from both domestic and international suppliers, and are backing efforts to develop a 'homegrown' test. The UK Rapid Test Consortium, which includes Oxford University, Abingdon Health, BBI Solutions and CIGA Healthcare, has been launched in order to design and develop a new antibody test that will determine whether people have had the virus.

We have also been working to better understand where the virus is and how it is progressing in the UK. I asked the ONS to undertake a world-leading study to understand the prevalence of the virus. In addition, we are partnering with a world-class team of scientists, clinicians and researchers at Imperial College London, alongside colleagues at Imperial College Healthcare NHS Trust and Ipsos MORI. The findings from the ONS are

published weekly and the results inform both the short-and long-term plans to tackle the virus.

By working together, a truly national response has been delivered. UK testing capacity is now 300,000 tests a day. The rapid expansion of testing capabilities has led to the largest network of diagnostic testing facilities in British history.

On 18 June, I announced that we had started the next phase of development in building an app that supports the end-to-end NHS Test and Trace service.

The rigorous testing that NHSX carried out found that there were issues with its app, but it also identified issues with the Google and Apple API. We are now bringing together the work done on the NHSX COVID-19 App with the Google and Apple framework.

It is worth noting that the Isle of Wight trial provided us with valuable learnings that we are now incorporating in our new development.

We are also proactively working with other countries to exchange ideas and learnings.

With regard to vaccines, we are working with the Vaccines Taskforce at the Department for Business, Enterprise and Industrial Strategy to support efforts to develop a vaccine as quickly as possible, and ensure that we are ready to administer the vaccine to people who need it as soon as one becomes available. Great progress has already been made, with clinical trials in humans underway at both the University of Oxford and Imperial College, London, following Government investment of over £130 million at these institutions. We have also announced a further £93 million to accelerate the building of the new Vaccines Manufacturing and Innovation Centre so it can open in summer 2021, a year ahead of schedule.

Whilst the Taskforce is leading on engagement with the pharmaceutical companies on research and development, clinical trials and supporting manufacturing capacity in the UK, across the health family we are focusing on making sure we are ready and able to deploy a vaccine at pace and at scale. This includes a range of activities such as ensuring we have the necessary workforce, and procuring essential cold storage and distribution, and the necessary consumables and personal protective equipment. We are also working with the Joint Committee on Vaccinations and Immunisations to identify those cohorts who should be offered the vaccine as a priority, such as frontline health and care workers, taking into account evidence of efficacy.

Internationally, we recognise that we have the best chance of defeating this virus by working together globally to develop and mass produce a vaccine. So, in addition to domestic efforts, we have committed to support equitable and affordable access to new coronavirus vaccines and treatments around the world. The UK has committed £250m to the Coalition for Epidemic preparedness Innovations (CEPI) to support the global efforts to develop a COVID-19 vaccine and recently pledged £1.65bn over the next five years to Gavi, the vaccine alliance, to ensure that, if a coronavirus vaccine is found, Gavi will play a role in distributing it in developing countries.

The scientific community has been working at pace to research the factors that place individuals at greater risk of developing serious COVID-19 symptoms. This new work will help us to better understand the multiple factors that carry the greatest risk, and has the

potential to enable us to develop a clinical risk tool to support more targeted advice and support for individuals.

The Minister for Equalities will consider where and how the collection and quality of data into the disparities highlighted can be improved on - and taking action to do so, working with the Equality Hub, government departments and their agencies.

To complement the wider disparity review, a research call by the National Institute for Health Research (NIHR) and UK Research and Innovation (UKRI) has jointly called for research proposals to investigate emerging evidence of an association between ethnicity and COVID-19 incidence and adverse health outcomes.

Testing of health and care workers

I updated the house on the NHS's current plans for staff testing in the form of a Written Ministerial Statement ([HCWS312](#)) on 24 June. This was laid to accompany a letter from Ruth May, Chief Nursing Officer, Steve Powis, National Medical Director, Prerana Issar, Chief People Officer and Pauline Phillip, National Director of Urgent and Emergency to the Chief Executives, Chief Nurses and Medical Directors and HR Directors of all NHS Trusts and Foundation Trusts in England. The Letter outlines the current approach being taken by the NHS and the importance of the SIREN study for informing future approaches. It can be read [here](#).

Testing of all symptomatic NHS and care home staff remains an utmost priority, as does testing of NHS and care staff without symptoms where appropriate.

At the end of last month, the NHS set out its guidance that NHS staff without symptoms should be tested where there is an incident, outbreak or high prevalence. An incident, for example, could be when an asymptomatic staff member is treating, and is exposed to, a patient who unexpectedly tests positive for COVID-19, and so testing of the staff member will help to reduce the spread of infection.

The CMO's view is that regular testing of asymptomatic NHS staff is best done through surveillance studies – these help us to continually, closely monitor risk and identify areas of high prevalence where wider, regular asymptomatic staff testing is needed to limit the spread of infection. Public Health England's study, **SIREN**, is doing exactly that. It is a prospective longitudinal study over 2 years, which will help to monitor prevalence in healthcare staff and will also look to determine if prior infection in health care workers confers future immunity to re-infection.

A risk-based approach to focus testing in high prevalence areas is essential over mass asymptomatic testing in areas of low prevalence, as when prevalence is low, the risk of misleading results is higher and can undermine the value of testing. Mass-swab testing people with no symptoms is not an effective way of reducing transmission if there is low prevalence.

Regarding testing in care homes, we announced on 3 July that from 6 July we will start to roll out weekly re-testing of staff and monthly (every 28 days) re-testing of residents to prevent the spread of coronavirus in care homes. This is in addition to intensive testing in

any care home facing an outbreak, or at increased risk of an outbreak (such as in an area where there is a community outbreak).

The new testing approach comes following the latest advice from SAGE, the evidence from the initial round of whole home testing and the recent **Vivaldi 1** surveillance study, published last Friday. The study indicates a higher prevalence in care homes and highlighted the importance of frequent testing in care homes, and particularly frequent testing of care home staff.

Over the next 4 weeks, re-testing will be rolled out to all care homes for over 65s and those with dementia who have registered to receive re-testing. Repeat testing will be extended to include all care homes for working age adults in August. We will review this strategy in September, taking into account prevalence levels in the community and local settings and the latest evidence. Based on this, the frequency of testing may be adjusted. Our approach is set out in detail in the attached letter to Directors of Public Health and Directors of Adult Social Care from Ros Roughton, Director General for Adult Social Care.

We also launched the [Vivaldi 2 surveillance study](#) at the end of June to monitor prevalence in care homes. Approximately 10,000 people in 100 care homes will be given repeat testing to understand more about the virus's spread in these settings: swab tests (to test if a person currently has the virus) and antibody tests (to test if a person has previously had the virus) for all consenting staff and residents over the next year. It forms part of pillar 4 of the government's COVID-19 testing strategy to conduct UK-wide surveillance testing to learn more about the spread of the virus.

We will continue to keep our approach under review in relation to clinical and scientific advice, as it evolves.

Thank you again for your letter and I look forward to meeting with you and the Committee on 16th July.

Yours ever,



MATT HANCOCK