



UK Health
Security
Agency

Rt Hon Greg Clarke MP and Steve Brine MP
Chairs, Science and Technology Committee
and Health and Social Care Committee Social
House of Commons
London
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Sent via email

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Dear Chairs,

COVID-19 LESSONS LEARNT JOINT INQUIRY

Thank you for the opportunity to discuss the lessons learnt to date from the Covid-19 pandemic response at the Joint Committees session on 30 November 2022. . During the session I made commitments to provide further detail on the following issues.

Mass testing

UKHSA has extensive plans for implementing a contingency response in the event that a variant or resurgence of Covid-19 requires greater interventions than are currently in place. Unlike at the start of the pandemic we are able to use both PCR and lateral flow device (LFD) testing as appropriate for the clinical and public health interventional requirement.

Under the Living with Covid strategy, we are delivering testing to targeted, vulnerable cohorts who are most at risk of severe disease from Covid-19. As a result, our operational capability requirements to rapidly deliver mass testing for COVID-19 in a similar way to pre-April 2022 has been significantly reduced. However, we continue to maintain a minimum stock holding of 84.5m Lateral Flow Tests (LFTs) in packs of seven that can be deployed rapidly should the situation require it. The stock holding is maintained on a rolling basis, with tests deployed for ongoing use cases and replenished through ongoing procurement to ensure sufficient shelf-life, so the actual holding at any given time could be in excess of this volume.

From a distribution capacity perspective, we would be able within two weeks to deliver up to 2.6m tests per day directly to the homes of individuals in addition to retaining the capability to deliver up to 2.2m tests per day directly to settings such as care homes and

workplaces. There would be further capability to deliver up to 7.35m tests per day to individual's homes after four weeks, meaning in total, our current contingency capability would allow us to send tests to up to 1.36m recipients per day after four weeks.

On a continued basis, use of this capacity would be reliant on the procurement of additional Lateral Flow Tests. We have commercial frameworks ready in place that would allow us to bring in further stock in three to four weeks once all approvals have been granted to procure. This distribution capability will be reviewed in the new year as part of routine fiscal and epidemiological analysis control processes.

The current risk from a Variant of Concern severely impacting the performance of all of our Lateral Flow Tests to the point that performance is below the required thresholds is assessed to be low and, as such, our contingency plans utilise Lateral Flow Tests in the first instance. We maintain a diverse stockpile of different Lateral Flow devices to help mitigate this risk.

Additionally, we also currently hold a standing capacity for 58,000 PCR tests per day at the UKHSA-operated Rosalind Franklin Laboratory. We also hold contracts with two laboratories that are capable of supporting with further capacity at Plymouth and Brants Bridge. Currently, these two laboratories would be able to provide another 20,000 PCR tests in two weeks taking the capacity at that stage to 78,000 PCR tests per day.

Funding for surveillance

Definitions of disease surveillance can vary in terms of what is in and out of scope. Taking the World Health Organisation's (WHO) definition, it includes "the continuous, systematic collection, analysis and interpretation of health-related data needed for the planning, implementation, and evaluation of public health practice." With this definition in mind, surveillance covers a vast proportion of our work across the organisation. This includes but is not limited to:

- Epidemiologists who survey a range of diseases to detect outbreaks, undertake international horizon scanning, and monitor the success of our preventative measures.
- Microbiologists and virologists in our labs analysing pathogens.
- Specialist services which monitor the environment, vectors and animals, whether in UKHSA directly or in partner agencies such as the Department for Environment, Food and Rural Affairs and Animal and Plant Health Agency and Defence, Science and Technology Laboratory.
- Data specialists who design, build and manage the digital and data infrastructure to bring this data into the organisation in a useable format.

- Analysts and topic specialists who interpret the data for use by public health and policy advisors.
- Surveillance data are reported by collaborative teams of these specialists and the resulting multidisciplinary reports are used by health professionals and governments around the world.

There will also be work that could be deemed surveillance one day, and incident response the next, if the disease reaches an exceedance level that means this intervention is necessary. We therefore do not account for surveillance as a discrete cost, but recognise that a significant portion of UKHSA's budget delivers against surveillance outcomes. For FY22/23 there is a COVID-19 specific budget currently operational (£2.4bn) as indicated in the Committee session which is shared across the health family response to the pandemic (including testing in the NHS in England. UKHSA receives some of this funding specifically to support COVID-19 response, including surveillance whilst all routine surveillance programmes are costed from the UKHSA core budget.

Disease surveillance is an ever evolving landscape and we continually strive to ensure we are resourced to respond to emerging health threats. For example, our work in partnership with others on studies such as the SARS-CoV-2 Immunity & Reinfection Evaluation (SIREN), the ONS Covid-19 Infection Survey and VIVALDI study provided us with insights to formulate policy interventions. Our commitment to ensure we are prepared and able to respond has led to the development of the Centre for Pandemic Preparedness (CPP). The CPP is working with cross government colleagues and international partners to articulate requirements needed to effectively respond to future pandemics. Lastly, we are placing data at the heart of the decision making process by investing in our infrastructure and modernising systems.

If the Committees would like more specific information on any particular surveillance activities that are of interest, we would be happy to oblige.

I hope that this further information is helpful to the Committees' inquiry.

Yours sincerely



Prof Dame Jenny Harries
Chief Executive, UK Health Security Agency