

From the Permanent Secretary/Chief Executive of UKHSA  
Sir Chris Wormald/Jenny Harries



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of Health &  
Social Care



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04 August 2021

Dear Chair,

Following our appearance at your Committee on 8 July 2021 on Covid-19: Test, Track and Trace, Part 2, we committed to writing to you on several points raised during the hearing. These are addressed below.

- 1. In response to a query from Greg Clark, Sir Chris Wormald agreed to return to the Committee on who commissioned the PHE study on the data link between hospital infections and care home outbreaks? And why it was decided to pool all the data together instead of splitting into smaller time gaps.**

Following PAC's 14<sup>th</sup> report of session 2019-21 entitled *Readying the NHS and social care for the COVID-19* on 22 June, the Committee requested that the Department and NHS England and Improvement review which care homes received discharged patients and how many subsequently had outbreaks (Recommendation 3).

At the request of DHSC and SAGE Social care Working Group (SCWG) subgroup, PHE was asked to investigate care homes that received COVID-19 positive patients discharged from hospital, and subsequently experienced an outbreak.

PHE's report looked at care home outbreaks from 30 January to 12 October 2020, the date on which the report was produced. PHE included as much data as was available at the time in the report. The original commission to PHE did not include any specific timeframe for collation of relevant data and therefore maximum quantitative content was used for the first study.

This PHE investigation on discharge from hospital found that from 30 January to 12 October 2020, 1.6% (n=97) of outbreaks were identified as potentially seeded from hospital associated COVID-19 infection. You will also have seen the letter that I sent to you with PHE's analysis on specific time points as requested by the Committee. This revised assessment over a pre-

and post-time point evaluation period has been provided to the Committee and the associated analysis does not materially change the reported findings of the initial commission

**2. In response to a query from Greg Clark, Dr Jenny Harries agreed to provide a confirmation that the PHE study conclusion was peer reviewed and who the researchers that were involved with this were.**

The methods and results of the PHE paper were reviewed on several occasions by the Scientific Advisory Group for Emergencies SCWG sub-group, which includes a number of leading academics in modelling (including members of SPI-M), public health and care of the elderly (including a member from National Care Forum)<sup>1</sup>. The methodology was also discussed in meetings with authors of analysis from Scotland and Wales and also with NHSE colleagues.

A symposium was held on the 21 September 2020 to enable SCWG to review intelligence from microbiology studies from across the UK in order to assess this alongside other epidemiological and qualitative evidence. The outcomes of this symposium formed a major part of the paper presented to SAGE on 23 September 2020. The paper can be viewed here: <https://www.gov.uk/government/publications/scwg-covid-19-and-care-homes-update-paper-23-september-2020> .

The report was also reviewed internally at PHE, as part of PHE's Quality Assurance process. This report is being prepared for submission to a peer-reviewed medical journal and will be externally peer-reviewed in this process.

**3. Sir Chris Wormald agreed to confirm to the Committee what additional data is available that was produced/obtained as part of the PHE report and to provide any data.**

PHE is able to allow access to de-personalised hospital-linked data subject to PHE's governance processes and any third-party permissions. In order to initiate such access and comply with governance all requests from researchers should be clearly formulated and sent to: [ODR@phe.gov.uk](mailto:ODR@phe.gov.uk).

The Office for Data Release (ODR) is responsible for approving requests from external organisations to access personally identifiable or de-personalised data controlled by PHE. This includes requests to process data for:

- ethically-approved medical research
- surveillance
- health service planning
- evaluation or commissioning
- local and national clinical audits

ODR Approval must be in place before PHE data can be shared. This is to make sure that we comply with the legal and ethical provisions of:

- the common law duty of confidentiality
- data protection legislation, including the Data Protection Act 2018 and UK General Data Protection Regulation (GDPR)

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<sup>1</sup> Membership of the SCWG is published online at: <https://www.gov.uk/government/publications/scientific-advisory-group-for-emergencies-sage-coronavirus-covid-19-response-membership/list-of-participants-of-sage-and-related-sub-groups#social-care-working-group-schwg>

- Eight Caldicott principles
- the Information Commissioner's statutory data sharing code of practice
- the national data opt-out programme.

**4. Nick Smith requested that Jonathan Marron provide the Committee with information on how DHSC are looking to recycle out-of-date visors into food trays as well as the wider steps being taken to reuse and recycle all forms of PPE.**

Over the course of the pandemic it became apparent that a proportion of stock would need to be recycled. Clipper, our logistics partner, identified a route to trial for recycling which could be set up under a clause in the existing contract.

As part of this trial in June, we recycled 22 million tiger eyewear products to make plastic containers, which can be used to store foods. These products were part of the original Pandemic Influenza Preparedness Programme (PIPP) stock but were date-expired, which meant that they could not be used hence were in the our 'do not supply' category. Clipper co-ordinated the recycling of these products using an extrusion process that enabled the product to be broken down and converted into food containers using thermo-formers. These trays will also be recyclable once they have been used.

We have also been working to repurpose the material from other items of PPE that are surplus to our requirements. Surplus items might be recycled for other purposes, and some might be broken back down to the raw material and potentially sold on. We have identified almost 69,000 pallets for recycling, with eye protectors, gowns and coveralls making up approximately 90 per cent of this stock and, importantly, we are able to gather other intelligence, such as pallet disposal rates. We will continue the trial to gather learnings, after which a formal tender will be run for the recycling of remaining products. We are expecting to have a contract in place for this by the end of August.

The effort to repurpose items is one of the approaches that we are taking to manage the excess stock associated with the programme. As we set out in our letter of 22 June, we are also working to redistribute items. We have donated items to other countries, including Lebanon and Nepal, and we are working with the World Health Organization to build demand for products that we can donate to countries such as Africa where there is a need. Domestically, we have supported the reopening of society by providing PPE to other government departments for the services that they oversee.

**5. Nick Smith requested that, in addition to the next quarterly PPE update, Jonathan Marron provide an assessment of how much money NHS T&T are looking to save by renegotiating contracts.**

As at the start of June 2021, the Department had negotiated the cancellation or variation of contracts in order to reduce the original supply of PPE by 1 billion items, with an associated taxpayer saving of £475 million.

Meanwhile, we are undertaking commercial discussions (potentially leading to litigation) in relation to 40 contracts. These contracts are valued at £1.2 billion covering 1.7 billion items of PPE.

According to our current forecast, we expect to have completed accounts by November. Alongside the regular cycle for reporting to the Committee, we will provide an updated position on the contractual status of these agreements and validated amounts that have been

recovered, those that we are confident will be recovered, and the total sums that we believe to be unrecoverable. We will also set out our methodology for assessing the associated risk.

**6. The Committee was interested in how the efforts to increase UK-based production of PPE enable us to provide price-competitive mass-produced PPE. On a related note, Jonathan Marron also agreed to provide details of the individual companies that the Department is working with, which are well placed to provide price-competitive PPE.**

We have invested considerable effort in working with manufacturers in the UK to scale up domestic PPE production and with that reduce our reliance on other countries. The Department has signed contracts with over 30 UK-based companies for 3.9 billion units, 2.5 billion of which have been successfully delivered.

We believe that UK companies are now competitive in the production of masks, aprons, clinical waste bags and eye protectors. We do not currently manufacture gloves although several UK companies are considering glove manufacture.

The principal reason UK manufacturers are competitive is because they have invested heavily in world-class automated production lines. For instance, automated machines have increased the capacity for the production of masks from 100 per minute to 1000. Now, only one operative is required to load the raw material where it would have previously been 10 people.

UK manufacturers also now have ready access to raw materials, reducing their input costs. 250 tonnes of MeltBlown (a key material for the production of FFP3 and Type IIR masks) is now produced in the UK each month, enough to manufacture 250 million Type IIR masks.

Automation and access to raw materials are enabling UK firms to be competitive, but it is also worth noting that firms are innovating to add more value to products. Through the Innovation Hub, we have brought together thinking and specifications on transparent masks, which has led to at least two UK-based companies designing a regulatory compliant product. For example, companies have been collaborating with Alder Hey Hospital, have reached the procurement phase and we expect that the new product will be available to the frontline later this year. Such masks will have a global market.

You asked for details of the individual companies that the Department is working with, which are well placed to provide price-competitive PPE. We are providing a full list of the manufacturers and products they make at *Annex 1*. It would be commercially sensitive for us to comment on which companies are best placed to be price competitive.

**7. Jonathan Marron agreed to update the Committee by the end of Summer 2021 on what the stock of medically unusable PPE is.**

In the letter we sent to the Committee on 22 June, we committed to providing a quarterly update on the amount of stock that has been categorised as 'do not supply'.

We will provide this information alongside the regular reporting cycle in the Autumn.

**8. Barry Gardiner asked Dr Jenny Harries to send the Committee a range of baseline figures of the demographics in society who the NHS Test and Trace system is less able to reach but is focused on, so that in a few months' time a new set of figures can be provided which the Committee can use to compare and analyse.**

We are focusing on groups in society who are disproportionately impacted by Covid and underserved by national programmes. Disproportionately impacted groups are those in which people are more likely to be infected with, made seriously ill by, and/or likely to transmit the COVID-19 virus. Characteristics can overlap making exact demographic numbers hard to define – an example of this can be, someone from an ‘at risk’ minority ethnic group who also happens to live in an area of socio-economic deprivation, and works in a ‘high exposure risk’ role.

We also consider the groups of people who are frequently ‘under-served’ by national programmes and are less likely to be willing, confident and/or able to engage. When we compare Test and Trace data to the national picture, we can see that some groups of people are underrepresented in the testing programme. These groups share many of the characteristics of PHE’s health inclusion groups.

We are focussing on how best to provide services to people in these disproportionately impacted and underserved groups. For example:

- Provision of services via 119, which means that services are accessible to those without access to the internet. This translates into 11.9m people in the UK who despite lacking digital skills or access to the internet, are still able to use Test and Trace services.
- Increasing accessibility of testing services for people with disabilities, including physical accessibility measures, assisted testing, and work to support people who are blind or partially sighted to test themselves at home.
- Provision of translation and interpretation services in more than 200 languages via 119, which have been accessed tens of thousands of times to date.
- Work with and supporting Directors of Public Health to deliver targeted community testing to reach priority group. This includes jointly making best possible use of data to identify priorities and inform both the approach as well as innovative delivery models to reach people.
- Work with communities most affected by COVID-19 to develop guidance and communications materials that most meet their needs. For example, training Community Champions in collaboration with MHCLG, PHE and local authorities.
- Work with community leaders, and through trusted voluntary and community service groups such as: rehabilitation centres, refuges, formal and informal community centres, homeless hostels, and places of worship.
- Piloting different models to support people to self-isolate, including trialling different models of financial and practical support for self-isolation.

Current T&T data for many characteristics of populations with enduring transmission does not form a robust baseline given the variability of reported content. We work routinely with the Joint Biosecurity Centre, Public Health England, Directors of Public Health and ONS to use wider additional methodologies and datasets (including the index of multiple deprivation, routine ONS reports, research studies (e.g. SIREN and VIVALD (and *ad hoc* questionnaires) to enable a shared quality and effective baseline statistical framework on which to base new interventions. New programmes of work introduced from June onwards will routinely include evaluation frameworks with a requirement for assessment by some social factors. An example is the externally commissioned review of interventions for supported isolation payments. We are happy to share these with the committee when completed.

Health protection equity is an acknowledged key strategic priority for the new UK Health Security Agency. We are currently planning a baseline data set against which the new

organisation will prioritise its work and assess its impact in all areas of health protection. This will become a key driver for performance management and service delivery.

- 9. Baroness Dido Harding and Shona Dunn agreed to write to the Committee with more detail on why the 'Pillar One' rate of NHS Swabbing was almost 50% less than what the original budget purported would be necessary.**

A provisional budget of £841m was set by NHS Test and Trace for Pillar 1 testing within the NHS; the actual expenditure in 2020/21 was £424m.

The budget was set during a time of uncertainty about the future of testing needed for NHS staff and for non-Covid patients using hospital and other NHS sites. The scale and impact of the pandemic were difficult to predict at that point. There were several lockdowns during the financial year and this directly impacted on hospital admissions/visits which in turn reduced demand for testing during these periods.

The amount claimed by NHS trusts from the Pillar 1 budget represented their actual costs for testing patients and staff. The decision to test was a clinical decision and not a financial one.

- 10. In response to a question from Nick Smith on how many consultants will have earned over £200,000 since March 2020, the Chair asked Shona Dunn for a reading room approach to the release to the Committee of information around payments to consultants.**

- 11. Nick Smith requested Shona Dunn to write to the Committee with detail on how many people have earned over the brackets of £150,000/£200,000/£250,000 over the last year.**

The earnings of individual consultants are subject to the employment contract between the consultancies and their employees. NHS Test and Trace has no access to the data owned by consultancies in this respect. The contract values with each consultancy is a matter of public record held within Contracts Finder.

Consultant salaries are a reflection of their skills and experience. The sum charged within the contract between a consultancy and NHS Test and Trace is not the sum an individual consultant will receive as a salary. NHS Test and Trace does not hold data on how many individual consultants have been paid more than £150,000, £200,000 and £250,000. That is data that is held only between the contracted consultancy and their employee.

NHS Test and Trace was set up at great speed, needed huge flexibility in response and has operated with significant uncertainty during the pandemic. Recruitment has been a recurring challenge, a point that has been recognised by, amongst others, the Prime Minister, Secretary of State, Cabinet Secretary and Chief People Officer of the Civil Service. This context has necessitated the use of consultants who have been instrumental in ensuring the programme meets the stretching targets it has been set. Their specialist skills have enhanced the strategic, policy and operational capacity of NHS Test and Trace, ensuring that chains of transmission were broken faster.

Looking ahead to the UK Health Security Agency (UKHSA), a ramp down plan has been produced to reduce the number of consultants over the next 12 months. This has been signed off by DHSC ministers, Cabinet Office and Her Majesty's Treasury. Reducing the number of

consultants is balanced with the delivery of national priorities, ensuring the sustainable handover of critical knowledge, and managing recruitment into high-skill roles.

NHS Test and Trace has reduced the number of consultants from a peak of 2,504 to 1,864 in the past four months while continuing to provide a consistently high quality and universally available service, in addition to the scaling of new services such as workplace testing and the universal testing offer.

Where roles are enduring and long-term in UKHSA, civil servants have been recruited. Where civil service resource is not available, or the nature or duration of the role makes it unsuitable for a civil servant to fill, NHS Test and Trace has used contingent and short term labour appropriate to the role, providing much needed flexibility at great speed and at reduced cost.

**12. In response to a question from Sarah Olney regarding data collection from asymptomatic testing, Dr Jenny Harries agreed to provide data on how many positive cases have been detected from various channel/area.**

The following table sets out the total number of LFD tests reported for each main channel/area and the number of positive, negative and unknown/void results reported.

*England, 28 May 2020 - 07 July 2021*

Use case	Total Tests	Positive Tests	Negative Tests	Unknown/Void
General public testing, including community testing	24,207,666	188,306	23,985,604	33,756
NHS	18,019,036	53,131	17,920,969	44,936
Nurseries, primary schools, secondary schools, and colleges	65,119,949	99,115	64,936,115	84,719
Higher education				
Adult social care	13,848,157	26,854	13,817,016	4,287
Private sector employers	3,073,955	5,380	3,065,48	3,145
Public sector employers	1,126,383	1,564	11,22,761	2,058

Source:

[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/1002465/tests\\_conducted\\_2021\\_07\\_15.ods](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1002465/tests_conducted_2021_07_15.ods)

**13. In response to a question from Greg Clark, Dr Harries agreed to write to the committee with a note setting out the latest figures for app downloads and those who have enabled the app.**

Since the NHS COVID-19 app launched in September it has been downloaded over 27.1 million times.

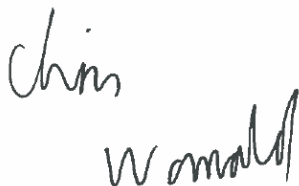
There is no single definition or established measure of a user who has enabled the app. Some people may pause contact tracing temporarily as there are several situations in which we advise pausing contact tracing temporarily, including if the user is a healthcare worker working in a healthcare building such as a hospital, or if someone works behind a Perspex screen and is fully protected from others.

Due to these limitations and privacy-preserving design of the app, it is not possible to make a reliable and consistent calculation of the number of people with the app enabled at any one time.

Thank you again for giving us the opportunity to provide evidence at the Committee meeting. I hope you find the supplementary responses in this letter helpful.

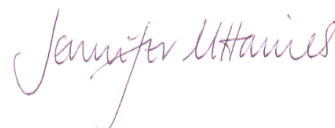
Yours sincerely,

**Sir Chris Wormald**



Department of Health and Social Care

**Jenny Harries**



UK Health Security Agency

**Annex 1**

List of PPE manufacturers and their products



