UK COVID-19 INQUIRY

MODULE 2 CLOSING STATEMENT ON BEHALF OF THE UK HEALTH SECURITY AGENCY

Introduction

1. The UK Health Security Agency ("UKHSA") is an executive agency of the Department for Health and Social Care ("DHSC") and carries out certain statutory functions on behalf of the Secretary of State for Health and Social Care. Fully operational from 1 October 2021, UKHSA's role is to protect the public from infectious diseases as well as external hazards including biological, nuclear and environmental threats. It brings together expertise from predecessor organisations including Public Health England ("PHE"), NHS Test and Trace ("NHSTT"), the Joint Biosecurity Centre ("JBC") and the Vaccine Task Force[1].

2. UKHSA is focused on establishing itself as a world leader in health security by using and developing its public health, scientific, data, operational and policy capabilities so that all four nations of the UK can better respond to and prepare for a range of health hazards including a future pandemic or major epidemic[2]. UKHSA's ongoing work will be informed by the important work of this Inquiry in identifying the lessons to be learned for the future. To assist the Chair on issues that may bear on such matters, this statement addresses four topics which arose during the Module 2 hearings:

   (a) The relationship between UKHSA and partner agencies in the Devolved Nations.

   (b) The collating and sharing of Data.

   (c) Delivering Health Equity.

   (d) UKHSA's Centre for Pandemic Preparedness.

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[1] For further detail as to the establishment of UKHSA, see the Third Witness Statement of Professor Dame Jenny Harries at §§26 to 33 [INQ000251906/7]-[INQ000251906/9].

[2] UKHSA strategic plan 2023-2026 [INQ000235221].

The relationship between UKHSA and partner agencies in the Devolved Nations

3. Professor Ailsa Henderson observed that, despite its title, UKHSA had a predominantly English focus during the pandemic[3]. That UKHSA's responsibilities, insofar as public health is concerned, are limited to England is a consequence of the constitutional and legislative arrangements which, as Professor Henderson explains, provide for most health protection functions to be a devolved matter for each of the four nations[4]. UKHSA does play a role in those specific health protection functions where the UK Government retains responsibility, such as technical and response support for protecting the public from radiation. Further, the UK government retains responsibility for global health security matters and oversight of the UK's compliance with, and support to relevant international agreements. UKHSA works with and through DHSC and other government Departments to fulfil this role. For example, UKHSA provides the member state focal point for the UK for reporting notifiable diseases under the International Health Regulations[5] and works with the World Health Organisation on behalf of the UK[6] at global, regional and specialist technical levels.

4. The relevant public health agencies in the devolved nations (Public Health Scotland, Public Health Wales and the Public Health Agency in Northern Ireland) have a similar remit in relation to domestic health protection matters to that carried out previously by Public Health England and now by UKHSA but with acknowledged reliance on areas of specialist expertise from England. Even before the pandemic, the four public health agencies worked together routinely both in preparing for and responding to incidents and continue to do so.

5. Infectious diseases do not respect borders. Collaboration between the four nations deepened during the pandemic reflecting the agreed view that there was a need for close working. As Professor Harries explained: representatives of the devolved public health agencies met with PHE colleagues on a regular (at times daily) basis[7]; NHSTT delivered

[3] Report of Professor Alisa Henderson at §§141-142 [INQ000269372/47].
[4] Report of Professor Alisa Henderson at §§1, 26 and table 2 [INQ000269372/4]; [INQ000269372/11-12].
[5] First Witness Statement of Professor Dame Jenny Harries at p§33 [INQ000148429/9].
[6] UKHSA strategic plan 2023-2026 p.33 [INQ000235221].
[7] Third Witness Statement of Professor Dame Jenny Harries at §44 [INQ000251906/11] and §142-145, [INQ000251906/37].

the testing programme in greater part on a four nations basis further to a joint agreement between the four CMOs as to allocation of testing capacity with scope for additional support beyond that allocation[8]; and the JBC was set up to operate on a four nations basis[9]. These collaborations continued following UKHSA becoming operational.

6. Ensuring that the public health agencies in the four nations continue to build upon and strengthen the arrangements already in place so as to work together in the most effective way possible is vital for pandemic preparedness. The Common Framework on Public Health Protection and Health Security was jointly developed and agreed by the UK government, the Welsh Government, the Scottish Government, the Northern Ireland executive and the four UK public health agencies following the United Kingdom's exit from the European Union. It sets out a governance structure for collaboration between the constituent parts of the UK on health security and protection matters. That structure has a legislative component in the form of the Health Security (EU Exit) Regulations 2021 and a non-legislative component in the form of a memorandum of understanding between the four administrations [10].

7. To supplement the framework UKHSA has established the UKHSA-DG board which brings together representatives of UKHSA, the devolved administrations and their public health agencies. This builds on arrangements which evolved during the pandemic[11] and provides a forum for all concerned to continue to discuss means of working effectively together including in relation to future pandemic preparedness[12].

8. On an operational level, UKHSA already provides support to the other nations in various ways. For example, UKHSA is the only public health agency that has laboratories that can operate at containment level four[13],the work of which provides benefits to all four UK nations. Similarly, UKHSA has several specialist laboratories which can deliver work as necessary for the other nations. The response to the 2022 outbreak of Monkeypox (Mpox) is a recent example of collaborative working between the UK's four public health

[8] Ibid at §§146-153 [[INQ000251906/38-39].
[9] Ibid at §68 [INQ000251906/18] and §§155-159 [INQ000251906/40].
[10] Public health protection and health security: provisional common framework; Third witness of statement of Professor Dame Jenny Harries at §161 [INQ000251906/41].
[11] Third Witness Statement of Professor Dame Jenny Harries at §160 [INQ000251906/40].
[12] Third Witness Statement of Professor Dame Jenny Harries at §161 [INQ000251906/40].
[13] First Witness Statement of Professor Dame Jenny Harries at §206 [INQ000148429/56]; Professor Dame Jenny Harries – oral evidence on 26 June 2023 [Day9/150/7].

agencies where, by agreement, UKHSA took a lead role on the procurement of vaccines and therapeutics on behalf of the other nations[14].

The collating and sharing of Data

9. A question was posed in Module 2 as to the extent to which data systems set up during the pandemic have been maintained and whether they can meet any future exigency. Access to good data is essential to health security. Historic low infrastructure investment into general infrastructure and current funding levels however, mean that it is neither possible nor proportionate for UKHSA to maintain the scale of standing surveillance and data capability and its effective utilisation, seen during the pandemic, for a range of pathogens and potential hazards. The challenge for UKHSA (and it is not the only organisation with a key role in the sharing and curating of health data) is how, working within its available budget, it can plan for standing data capabilities and surge capacity as part of its pandemic preparedness strategy.

10. UKHSA has published a data strategy which sets out the organisation's strategic approach to the collection, analysis, sharing and storage of health data[15]. UKHSA make the following additional observations.

    (a) First, extant systems for surveillance capable of responding early to a threat and scaling up as necessary must be able to do so along five routes of disease transmission: respiratory (such as COVID-19, Influenza), touch (such as Ebola/Mpox), sexual /blood (such as HIV), oral (such as Cholera, bovine spongiform encephalopathy (BSE)) and vector (such as Zika).

    (b) Second, the "Technical report on the COVID-19 pandemic in the UK" (the Technical Report), of which Professor Harries was a co-author, referred to the importance of data platforms to "*support data sharing and interorganisational collaboration*" but that "*data curation and analysis requires considerable resource*"[16]. UKHSA is implementing a storage and analysis platform (the

[14] UK strategy for mpox control, 2022 to 2023, 11 December 2022.
[15] UKHSA Data Strategy, 11 September 2023.
[16] Technical Report p.158 [INQ000203933]

Enterprise Data Analytics Platform) which will not only allow it to more efficiently curate and analyse data, but which is designed to be scalable and to allow for the safe and effective sharing of data with external partners.

(c) Third, the Technical Report noted the need for data sharing agreements to be in place.[17] Work with other agencies continues on this.

11. Citing the recent Mpox outbreak, witnesses have expressed a concern that the lesson that data should be easier to access and more widely available has not been learned[18]. From the outset UKHSA has advocated for the safe, early and transparent sharing of data as became the norm during the pandemic and for this to be replicated in all organisations (including with and within academia) to improve health protection by promoting the rapid sharing of learning and the development of countermeasures. UKHSA is committed to promoting public access to data[19]. The COVID-19 dashboard[20] was an example of the creation of a safe data set that could be shared widely and UKHSA has developed a new public data dashboard, utilising data from England, and providing information on a wider range of pathogens. However, this is not an area where a "one size fits all approach" applies. The situation, as both Professor Keeling and Mr Freeguard readily acknowledged, is complex:

(a) Ensuring privacy and keeping data safe are paramount concerns and requirements for that to be otherwise risks losing public confidence.

(b) While UKHSA will have a key role in data sharing it does not necessarily own that data. Much of it will come from the NHS. The public health agencies in the devolved nations would similarly recognise the importance of sharing data with the other nations, but how that is done is as Professor Harries observed a sensitive matter[21].

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[17] Ibid at p.149.
[18] Gavin Freeguard- oral evidence on 10 October 2023 [Day6/194/23]; Professor Matt Keeling – oral evidence on 12 October 2023 [Day8/186/22]; Witness Statement of Professor John Edmunds at §16.20 [INQ000273553].
[19] UKHSA Data Strategy, 11 September 2023.
[20] Third Witness Statement of Professor Dame Jenny Harries at §§758-759 [INQ000251906/177]. Scotland, Wales and Northern Ireland had their own dashboards but cooperated with PHE, and then UKHSA, to improve the availability of cross-UK data on the COVID-19 dashboard.
[21] Professor Dame Jenny Harries – evidence on 2 November 2023 [Day28/45/5].

(c) The Mpox outbreak of 2022 is an example of the care that has to be taken when considering how to put very sensitive data in a form where it can be shared with third parties safely. With Mpox, a combination of a small number of cases and the nature of transmission has the potential for a high risk of individual patient identification and stigmatisation.

12. In conclusion, UKHSA recognises that there is further scope to continue improving the sharing of data with the public and third parties and has taken steps to deliver on this objective. Of note, that task does not fall solely to UKHSA. However, UKHSA is sure that other relevant bodies similarly recognise the importance of, and are working towards, making data as accessible as possible.

Delivering Health Equity

13. The pandemic showed how threats to public health can have a disproportionate effect on certain groups within society and highlighted that the approach to preparing for such threats must involve addressing health inequalities proactively so as to build more resilient populations. UKHSA has made health equity (defined as "*the absence of unfair and avoidable or remediable differences in health among population groups defined socially, economically, demographically or geographically*") a core priority across all its work.[22]

14. As the Chair is aware, UKHSA is developing a health equity strategy.[23] Achieving more equitable outcomes requires processes be put in place to identify and address those factors which place certain groups at greater risk of a poor outcome. These include differences between groups in the risk of exposure to a health hazard, their susceptibility to poor outcomes when exposed (be it for example because of underlying illness, living or working conditions) and their capacity to be resilient against these threats.

[22] UKHSA strategic plan 2023-2026 pp. 5, 8, 13, 16, 22, 25, 45 [INQ000235221].
[23] First Witness Statement of Professor Dame Jenny Harries at §641 [INQ000148429/160].

15. By way of update, in collaboration with local and national partners as well as the voluntary and community sector, UKHSA has set out a three-year plan to deliver its "Health Equity for Health Security Strategy"[24]. Learning from the COVID-19 pandemic, the strategy seeks to strengthen UKHSA's capability as an organisation to prevent or mitigate the disproportionate impact experienced by certain individuals and communities and to improve the agency's response to health security incidents, including as part of pandemic planning. There are four key aspects to the strategy:[25]

(a) Ensuring that, wherever it can be robustly achieved the data UKHSA collects and analyses is disaggregated[26] by factors such as deprivation or ethnicity. That approach better allows for identifying how diseases and other health threats are impacting on different groups in society and informs understanding of the effectiveness of different interventions or research requirements where knowledge is absent. UKHSA has proactively aligned its approach to the Core20PLUS framework[27] adopted by NHS England to identify the populations that it will routinely (but not exclusively) consider in its work.

(b) Adopting a "people and place" approach. Considering both where groups are living and their individual circumstances and characteristics allows us to make our health protection services more effective.

(c) Strengthening partnerships with other organisations. This is vital given many of the determinants of health and health inequalities are outside UKHSA's direct remit. The structures in place to develop necessary collaboration with public health agencies in the devolved nations have been discussed above. UKHSA continues to work closely with local and central government departments, Directors of Public

[24] Achieving more equitable outcomes: UKHSA Health Equity for Health Security Strategy, 8 November 2023.
[25] Ibid.
[26] As to why disaggregating data is important see further the Fourth Witness Statement of Professor Dame Jenny Harries at §11.3 [INQ000273807/150].
[27] This initiative is intended to reduce healthcare inequalities at both national and system level. The approach defines a target population being the most deprived 20% of the national population "PLUS" specific population groups identified as local level – such as those experiencing long-term health conditions, inclusion health groups (e.g. those experiencing homelessness). UKHSA also includes those with clinical vulnerabilities.

Health, NHSE, industry, academia and community and specialist representative patient groups.

(d) Embedding health equity within all UKHSA's work processes and programmes, for example through establishing a health equity hub to support staff with information and resources. In addition, an Equalities, Ethics and Communities Committee of the UKHSA Advisory Board has been established. It assists by giving advice on reducing health inequalities and engaging with communities[28].

UKHSA's Centre for Pandemic Preparedness

16. Sir Patrick Vallance proposed an academic centre for pandemic preparedness, funded by government, which would bring together experts from a wide range of disciplines[29]. He envisaged that such a centre would work with UKHSA to provide ongoing monitoring of national and international developments and propose the research and reforms necessary to meet the risks posed by emerging viruses and diseases[30]. Relevant to any recommendations that flow from this evidence is that UKHSA has already established a Centre for Pandemic Preparedness ("CPP"), something which was prioritised[31].

17. Sir Patrick's observation[32] that care must be taken to prepare not for the last pandemic but for the next is a proposition which UKHSA fully endorses and indeed had already adopted. The core purpose of the UKHSA CPP is to take a strategic approach to ensure the UK can help prevent future pandemics, respond more quickly when they arise and is more effective and efficient in reducing the negative impact of health threats. The CPP has a coordinating role within UKHSA, bringing together relevant functions and capabilities across the organisation, identifying gaps in health protection preparedness and working externally with industry, academia and the international community.

18. As part of this remit the UKHSA CPP provides the secretariat to the UK contribution to the 100 Day Mission, a global collaboration[33], is instituting new working relationships

[28] UKHSA Advisory Board: Equalities, Ethics and Communities Committee terms of reference.
[29] Sir Patrick Vallance - evidence on 20 November 2023 [Day22/102/15] and [Day22/106/18].
[30] First Witness Statement of Sir Patrick Vallance at §105 [INQ000147810/33].
[31] Professor Dame Jenny Harries – oral evidence on 29 November 2023 [Day28/37/9].
[32] First Witness Statement of Sir Patrick Vallance at §104 [INQ000147810/33].
[33] First Witness Statement of Professor Dame Jenny Harries at §§638-639 [INQ000148429/159].

with industry and collaborating on practical plans to link newly developed Institutes of Pandemic Preparedness in academic centres across the UK to central government through UKHSA.

19. UKHSA strongly agrees with Sir Patrick's central point as to the importance of continuing the development of links between government and academia and ensuring these are well known to, and utilised by, all involved in pandemic response. As Professor Harries noted, UKHSA already has links with a number of universities across the UK through individual technical connections, teaching, supporting research students and importantly, the National Institute for Health and Care Research Health Protection Research Units (HPRUs). The latter are research partnerships between UKHSA and a university. Those working in HPRUs have twin roles working part time in academia and part-time in a clinical or UKHSA role so promoting the sharing of data and knowledge between different sectors.[34]

Conclusion

20. UKHSA looks forward to receiving the Chair's findings and recommendations in respect of both Modules 1 and 2. The COVID-19 pandemic had a devasting impact on so many both in the UK and around the world. As a new organisation, born in the pandemic with a brief to mitigate the risks and outcomes of future threats, UKHSA holds a keen and evidenced interest in ensuring it builds on the findings of the Inquiry's investigation to respond to health threats, save lives and protect the economy. UKHSA will continue to assist the Inquiry and play its part in ensuring that the work of the Inquiry does have a positive impact on public health.

UK Health Security Agency
15 January 2024

[34] Professor Dame Jenny Harries – oral evidence on 29 November 2023 [Day28/35/11] and [Day28/36/21].