UK COVID-19 INQUIRY

OPENING STATEMENT ON BEHALF OF
THE UNITED KINGDOM HEALTH SECURITY AGENCY
FOR MODULE 6

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1. The UK Health Security Agency ('UKHSA') is an executive agency of the Department of Health and Social Care ('DHSC') and undertakes certain statutory functions on behalf of the Secretary of State for Health and Social Care ('the Secretary of State') Established on 1 April 2021, UKHSA became fully operational on 1 October 2021. Its 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 several predecessor organisations including Public Health England ('PHE'), NHS Test and Trace ('NHSTT') and the Joint Biosecurity Centre ('JBC').

2. Like PHE before it, UKHSA does not have direct responsibility for the delivery of adult social care ('ASC') or a formal remit for the sector. The operational support that the Agency provides to the ASC sector derives predominantly from its expertise in health protection science and data analytics and surveillance. In delivering that support, UKHSA works in collaboration with other bodies including NHS England, local authorities and providers of ASC.

3. UKHSA has submitted a corporate witness statement for Module 6 and the Inquiry will be hearing evidence from Professor Susan Hopkins, Chief Medical Advisor at UKHSA, in the second week of its scheduled hearings. UKHSA does not seek here to address every issue which will be explored in this module but mindful of the importance that is rightly placed on looking forward, this opening statement is focused on how the Agency contributes today to supporting the ASC sector and outlines some key themes relevant to pandemic preparedness.

The structure of the ASC Sector

4. Any consideration of how an operational agency such as UKHSA supports the ASC sector needs to recognise that the way in which the sector has evolved, its scale and organisation and how it operates today presents challenges.

(a) First, the breadth of settings in which ASC services and support are provided means that a range of individuals with differing needs and care arrangements comes within the scope of the sector. It has been estimated that there are over 18,000 ASC providers. Those accessing social care include not only those defined as elderly but for example people with learning disabilities or young adults supported to live in a small home. They can be resident in a care home or a nursing home, be receiving support through community ASC services, be in supported living accommodation or in their own home.

(b) Second, unlike the NHS, the sector does not have a centralised or single management framework. Private companies of varying size, regulated by the Care Quality Commission ('CQC'), are substantial providers of ASC whether commissioned by a public body or on a private basis. Public bodies also provide such regulated care. There is also non-regulated paid care. A significant amount of the care provided across the sector comes from unpaid carers including family members. Those who provide care span a range of disciplines from social care staff employed to work in care homes to carers supporting someone in their own home.

(c) Third, the sector is characterised by a significant turnover of staff and high vacancy rates. The work is often poorly paid, demanding and sometimes underappreciated. ASC staff may work in more than one setting. There is reliance on temporary and/or agency staff to supplement the workforce in many settings.

(d) Fourth, many recipients of ASC are inherently vulnerable due to their age and/or comorbidities. For example, by their very nature, residents in care homes for older adults are highly vulnerable to the effects of any respiratory infection.

(e) Finally, the sector remains under significant pressure. Demographic changes mean that the demand for the services it offers is rising and given the population demographic change will rise further over the next decade. The cost of care is increasing at a time of challenging public funding, including the resources available to local government.

Roles and Responsibilities

5. Reflecting the decentralised structure of the ASC sector, responsibility for policy, the functions undertaken within the sector and how they are delivered requires engagement with government departments, other public bodies and private entities at both a local and national level. At both national and local level, different government departments, public bodies and private entities have responsibilities for strategic policy, the scope of functions carried out and operational delivery within the sector.

6. DHSC is the lead organisation for ASC, with responsibility for strategic oversight, including policy, in England. The Ministry of Housing, Communities & Local Government ('MHCLG') oversees the commissioners of state-funded ASC (i.e., local authorities).

7. Nationally, NHS England has been an important partner not least because many of those residing in care homes will have moved to such settings following discharge from hospital care, and some people receiving ASC are NHS funded. As the Inquiry will be aware, the functions of NHS England are being merged into DHSC.

8. Local authorities have statutory responsibility for the assessment of their population care needs and the commissioning and delivery of ASC. The model of delivery is dispersed across local councils with the Directors of Public Health and Directors of Adult Social Care providing system leadership within local authorities.

9. In England the CQC, as the independent regulator, monitors, inspects and regulates ASC providers. Since 1 April 2023, the CQC has had a statutory duty to assess and review how a local authority delivered its functions relating to ASC in England. The Secretary of State has a power to intervene where a local authority is assessed as failing to meet its statutory obligations.

10. There are also a diverse set of organisations who speak on behalf of those within the ASC sector including the Local Government Association ('LGA'), the Association of Directors of Adult Social Services (ADASS), the Outstanding Society, Care England and the National Care Forum.

UKHSA's role in supporting the ASC Sector

11. On becoming operational, UKHSA took on many of the functions previously carried out by PHE. In terms of supporting the ASC sector during the pandemic, those functions in outline were:

    (a) To conduct research into SARS-CoV-2.

    (b) To collate data on notified infection outbreaks in care homes.

    (c) To support the production of guidance owned by other departments by contributing expert public health advice.

    (d) To produce guidance on Infection Prevention and Control ("IPC") measures to prevent and manage outbreaks of COVID-19 in care homes.

    (e) To provide direct support for care settings and sector stakeholders via PHE's Health Protection Teams ("HPTs").

12. Importantly of course, many, if not all, of these functions are applicable to responding to any pathogen presenting a risk to those who use or work in the ASC sector. They apply to work that PHE undertook before and during the pandemic and that UKHSA now undertakes in response to a range of pathogens.

13. Both during the pandemic and subsequently, UKHSA has endeavoured to learn from the experience of the pandemic so that it can better support the ASC sector. Since April 2022, UKHSA has had a dedicated ASC Team to embed the provision of science, research evidence, and advice on public health threats to the ASC sector as a permanent function within the Agency in a way that previously did not exist. The ASC Team works with UKHSA's nine regional HPTs to identify trends arising from health protection incidents (including outbreaks of infectious disease) within the ASC sector. These can then be shared with partners at both a local and national level and used to inform the development of guidance and advice.

14. The ASC Team also takes a lead role on behalf of UKHSA in the production of national guidance for the ASC sector where this is commissioned by DHSC. The pandemic highlighted the need to develop guidance that was more focused on the specific circumstances of the sector. National guidance cannot cater for every type of ASC setting but learning from the pandemic has resulted in guidance based on general principles that seeks to take account of the needs of different settings, uses appropriate language and is sufficiently flexible to be adaptable in different settings. In general, UKHSA contributes expert advice to the guidance published by DHSC for the sector. There are instances where guidance is co-badged with DHSC or another organisation or where, because it is primarily scientific in content, it will be led and published by UKHSA.

15. The UKHSA HPTs are a key element of support for those involved in providing and monitoring ASC. Personnel in the HPTs are trained to investigate and manage health protection incidents including outbreaks of disease and have a key role in surveillance and epidemiology. They provide specialist health protection advice and support to community IPC teams in the NHS and local authorities as well as directly to ASC providers. The UKHSA HPTs have long established relationships with Local Authority Directors of Public Health and participate in a range of local partnership structures such as Health Protection Committees or Boards, Local Resilience Forums and Health and Wellbeing Boards. For local partners, the UKHSA HPTs are a route into the wider services and support available within UKHSA; for UKHSA they are a conduit for gathering intelligence and data at a local level.

16. UKHSA has always sought to use data as effectively as possible. As at the start of the pandemic, it remains the case that there is a lack of comprehensive population and health data at a national level about those who live and work in the ASC sector. Real time outbreak data is necessary to identify the emergence of an infectious disease in an ASC setting and to understand both its transmission dynamics and impact. If that data can be separated by denominators such as the population size of the setting or the type of provision offered, then it allows for better understanding of how risk differs across settings. The more granular the data, the more tailored and proportionate advice can be about which control measures should be adopted, and which interventions might be most effective.

17. UKHSA tries to integrate the data sources to which it has access so that they can be used to give as close to real time data as possible. An example of this is the ASC Dashboard; an England-wide resource which aims to capture the occurrence of and trends in infectious disease outbreaks in care homes based on reporting from UKHSA HPTs. Data held on the Dashboard is stratified by key care home characteristics including size and registration type(s). Work is ongoing to strengthen the information available on the Dashboard by linking it to other data sources such as that from laboratories, hospital episode statistics and CQC incident reports.

18. A key lesson from the pandemic has been that, at least at the beginning, there was an over-reliance on a localised response with a consequent lack of central government strategic oversight. That changed as the pandemic progressed. Stronger relationships between central and local entities make for better information sharing, particular in such a diffuse sector as ASC. With that in mind, UKHSA's ASC Team chairs monthly Management of Care Home Hazards and Outbreaks ('MOCHHO') meetings which bring different external stakeholders, including DHSC, CQC, NHS England and local government, together to discuss the production of health protection advice, to share data and to discuss emerging trends and needs, and to facilitate inter-agency working.

19. UKHSA participates in DHSC's Operational Resilience Forum and, through its annual ASC symposium as well as its annual conference, offers an opportunity for representatives from DHSC, CQC and provider organisations to hear from academics

and experts in public health. The ASC Team also presents the result of its own research studies and evidence reviews.

20. UKHSA's broader capabilities are relevant to the support that it can provide to the ASC sector. The April 2020 Easter 6 Study, discussed in detail in UKHSA's corporate witness statement, made a significant contribution to the evidence base on transmission and asymptomatic infection in care homes. It showed the importance of being able to call upon scientific expertise at speed. Similarly, UKHSA's experience in supporting the delivery of vaccination programmes is relevant to protecting those accessing ASC in a future pandemic.

21. Finally, the work that UKHSA undertakes in other areas as part of its strategy to build scalable systems is intended to benefit the ASC sector as much as other parts of society. That includes a UK-focused approach to identifying priority pathogen families and the establishment of the Diagnostics Accelerator to boost the country's ability to diagnose and test for new and emerging infectious disease threats.

Lessons for the future

22. As to the lessons that can be learned to improve the resilience of the ASC sector for future pandemics, UKHSA highlights the following four themes.

Encouraging innovation in science

23. The response to any future pandemic will require a strong domestic science and research base. That brings benefit to every part of society including the ASC sector. The pandemic demonstrated that the country's science and research base, both public and private, was an area of strength. Examples include PHE's development of a PCR assay for SARS-CoV-2 within days of Chinese scientists publishing genome sequences for the virus and its work evaluating commercial PCR tests. The speed at which vaccines were developed has been rightly applauded. There were also areas of weakness such as the lack of scalable diagnostic testing capacity at the start of the pandemic.

24. Sustaining our scientific base and so the UK's standing as a centre of research, requires a certain level of funding to maintain expertise. It needs the maintenance of links with international colleagues and collaboration between the public and private sectors. As important as such practical steps are, they must be accompanied by an appreciation that scientific research does not always bring immediate results and will often confer unintended or wider benefits. Nor will every initiative succeed. Future funding for pandemic preparedness needs therefore to give space for innovation and to accept the risk that is inherent in research.

Public Health and Social Measures in the ASC sector

25. Public Health and Social Measures ('PHSMs') are what used to be described as Non-Pharmaceutical Interventions, a term with which this Inquiry is familiar. They refer to those measures such as physical distancing or mask wearing which are implemented to reduce the risk of impact of transmission of an infectious disease.

26. A future pandemic could involve a very different pathogen to SARS-CoV-2. Taking steps now to improve the evidence base on the impact of different and diverse PHSMs on the ASC sector will allow for better understanding of the benefits and harms of any intervention not only to those who access ASC but also those who work within the sector. The care home sector, which was affected significantly during this pandemic, is an area where the difficult balances that need to be given weight are particularly acute. Factors such as the impact of isolation from family, meeting existing health needs of a vulnerable population, preventing a decline in physical function because of reduced physical activity and/or increased bedrest, and managing the use of non-permanent staff would need to be considered. Ventilation is one of the most effective interventions to reduce transmission of respiratory infections and minimise the need for restrictive measures. How that can be used to best effect, even on a temporary basis, given the differing physical layout of care settings and the impact of high or low temperatures on the elderly, warrants further investigation.

27. Similarly, collecting data on those who live and work in the care home sector, a group particularly vulnerable to the health impacts of a future pandemic, will inform the use of interventions and the development of policy. Building on the support it provided to the

Vivaldi suite of studies conducted during the pandemic, UKHSA has helped fund the Vivaldi Social Care Observatory study about which the Inquiry will hear evidence during this module. This study aims to monitor infections in a sample of care homes linking individual level resident data by NHS number with a range of health data.

Strengthening data infrastructure

28. Following on from the preceding paragraph, having access to a wide range of data sources is obviously beneficial to UKHSA's work in data surveillance. UKHSA continues to develop systems to integrate data sources to provide scalable real-time data to understand and combat emerging threats. The ability to continue to develop and deliver these systems and tools is inevitably dependent on government decisions on funding and the legal basis for data sharing across the health and care systems.

29. The ASC sector's fragmented structure makes developing a coherent cross-sector strategy for data collection, transfer and storage a significant task. The UK health data infrastructure is however developing rapidly, and there is now a range of population health data sources that use NHS data. That offers an opportunity to adopt an incremental approach focused in the first instance on regulated entities. A strategic national approach to the integration of care home data would bring immense benefits not only to preparing for a future pandemic but to routine health and social care delivery.

30. While UKHSA can play its part in the development of systems to better utilise data to the benefit of the ASC sector, this raises wider questions not just of investment but of governance. UKHSA has raised the latter in previous modules. Addressing governance is not straightforward but is fundamental to the decisions that shape how data is used to so the country can be better prepared for the future. It brings into play issues around consent, the need for statutory regulation, and the need to consider in advance and to plan for those emergency situations where it will be agreed that data is to be shared without prior agreement.

Fostering national to local collaboration

31. Perhaps the most important lesson is that neither an entirely localised nor a top-down approach is best suited to support the ASC sector in the event of a future pandemic. As explained above, the sector engages a range of different bodies operating locally and national and with different roles, some, like UKHSA, being operational within the ASC sector. There is a need to continue to deepen the mechanisms by which different agencies and organisations come together to share knowledge and information. It is only by establishing such mechanisms that agencies can collectively discuss how to support all care providers including who are in unregulated care or who provide unpaid care.

32. UKHSA will continue to assist the Inquiry with its work and play its part in learning lessons for the benefit of public health in the ASC sector.

UKHSA

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