HOUSE OF COMMONS

Health and Social Care Committee
Science and Technology Committee

Oral evidence: Coronavirus: lessons learnt, HC 877

Tuesday 24 November 2020

Ordered by the House of Commons to be published on 24 November 2020.

Watch the meeting

Members present:

Health and Social Care Committee: Jeremy Hunt (Chair); Paul Bristow; Rosie Cooper; Dr James Davies; Dr Luke Evans; Neale Hanvey; Barbara Keeley; Taiwo Owatemi; Sarah Owen; Dean Russell; Laura Trott.

Science and Technology Committee: Greg Clark; Aaron Bell; Dawn Butler; Chris Clarkson; Mark Logan; Carol Monaghan; Graham Stringer.

Questions 473 - 619

Witnesses

I: Professor Devi Sridhar, Chair of Global Public Health, University of Edinburgh; and Alex Thomas, Programme Director, Institute for Government.

II: Rt Hon Matt Hancock MP, Secretary of State for Health and Social Care; Jenny Harries, Deputy Chief Medical Officer for England, Department of Health and Social Care; and Clara Swinson, Director General for Global and Public Health, Department of Health and Social Care.

Examination of witnesses

Witnesses: Professor Sridhar and Alex Thomas.

Q473 **Chair:** Welcome to this morning's joint session of the House of Commons Health and Social Care and Science and Technology Select Committees. My name is Jeremy Hunt. I am pleased to be joined by my co-Chair Greg Clark. This morning, we are looking at the lessons that need to be learnt from the pandemic. Later, we will be joined by the Health Secretary, Matt Hancock.

We are particularly focusing this morning on what are called non-pharmaceutical interventions, which are everything other than the vaccines that we have all been talking about, but in particular the role of lockdowns and the effectiveness of public communication, which has been so important throughout the pandemic.

Before we hear from the Health Secretary, we are going to hear from a couple of experts in this area. Professor Devi Sridhar, a very warm welcome to you. You have spoken to us before. Devi holds the chair of global public health at the University of Edinburgh. Alex Thomas is programme director at the Institute for Government, and before that had a long and distinguished career in the civil service, where he had periods working both with me and with my co-Chair Greg Clark. It is very nice to see you again, Alex.

Professor Sridhar, thank you again for joining us. Let me ask a big question. From an epidemiological point of view, how do you think the UK Government did in combating the virus compared with other countries?

Professor Sridhar: It is clear that in the UK we have taken a much higher level of deaths, as well as disability, through the SARS-CoV-2 pandemic than many other countries. I think it comes down to an early decision to treat it as a flu-like event that would pass through the population; an uncontrollable spread that you would try to mitigate through building enough hospitals and medical care so that everybody could get the care they needed, rather than treating it as a SARS-like event, which is what east Asian countries have done, as well as now in the Pacific, Australia and New Zealand, and some countries in Europe like Norway, Finland and Denmark. They are interesting for diverting from the flu model and trying to keep their numbers as low as possible.

Q474 **Chair:** You have championed very publicly what is sometimes called a zero-Covid strategy. You have also been quite critical of some of the delays in getting Test and Trace up and running. Now the Government are talking a lot more about population testing, particularly in Liverpool. Are you reassured that what you have been talking about for many months is now within our grasp?

Professor Sridhar: It is fantastic that we have moved from debates around does testing matter, even for health workers, to community testing and now to mass testing as a way of lifting harsher and more

draconian lockdown restrictions. It is definitely a positive step, but it is about how we actually use the tests and what the ultimate strategy is. This virus will keep spreading as long as we do not have a sustainable suppression strategy.

We know how to bring numbers low. Countries in east Asia have a playbook. It is three things. First, it is test, trace and isolate—managed isolation. The second part is really good communications and guidance to the public on how to avoid getting the virus. The third is border measures. You do not keep reimporting strains of infection. It does not mean sealing yourself off. It means quarantine, testing and precise public health measures at airports and ports.

It is great that we are moving in the direction of testing, but it is not a silver bullet on its own. It has to be part of a package of measures to suppress the virus. We also have to think of what the tests can and cannot do. The incubation period of this virus also makes it tricky. It can be up to 14 days. Someone can test negative and be positive the next day. You have to think about how you do repeated testing and, for those who test positive, how you get them into isolation, as well as their contacts. Ultimately, once you get the numbers really low, how do you protect that through border measures so that you do not reimport a new strain that will just keep spreading among the population?

Q475 **Chair:** Is there anything that you think is missing at the moment in what is planned for the period between now and when we manage to get the vaccine out to everyone who is vulnerable?

Professor Sridhar: We are probably missing a little bit in each of those areas. To go through them, on border measures it feels like the UK was quite late to use travel restrictions and quarantine measures to try to catch cases. In east Asia, even by early January, South Korea was implementing checks on passengers from China. If we split that forward, we saw New Zealand and Australia moving in early March.

It was not until the summer that the UK started using those measures, but probably not in the most effective way. We took the costs of passenger traffic and business travel collapsing—if you look at the numbers through Heathrow, it has really come down—but we did not have the public health benefit of catching people coming back from holidays, to test them at airports and to support them in quarantine, through checking up on them and making sure that people complied with the isolation procedures. That is one of the things on the border issue.

The second one is on test, trace and isolate. We are getting faster testing, so that is positive, through antigen testing. With isolation, the numbers are still too low; for example, some studies say that under 20% of people are actually isolating, which makes the whole exercise a bit pointless because the whole point of testing and tracing is to get people into isolation. Places like New York City have managed to get isolation over 95%. When I asked them how they had done it, it was three things.

One is financial support; you pay people to stay home. It is an act of good will not to infect others, so you need to reward that appropriately and not punish people. The second is emotional and practical support by checking up on people, bringing them essential goods and making sure they are called every day. The third is isolation outside the home, offering hotel rooms and empty spaces in public buildings that people can go to if they do not want to infect others. I think we can tighten up on each of those.

Finally, the communications have to be absolutely clear. We have gone in circles a bit: "Is this really serious? Can we let it spread? Can we shield the vulnerable? Does the testing work? Are these false positives? If cases go up, do hospitalisations go up?" We know the answers to those questions, so we should move past that to clear communications: "Avoid crowded spaces. Wear face coverings. You do not want to get it at any age. You do not want to pass it on. This is a nasty virus." These are the ways that each of us can change our behaviour in small ways to avoid getting it; and we should support industries where the types of riskier settings are and give them the financial support they need.

Q476 **Carol Monaghan:** Thank you to the witnesses this morning. Professor Sridhar, you have already answered some of the questions I was going to ask. Following the lockdown in March, we saw a sharp decline in the number of infections. Knowing what we knew at the time in terms of scientific evidence, did we lock down too late?

Professor Sridhar: Yes; I think the consensus is that we locked down too late. I think the reason was the false dichotomy between the economy and health. The idea was, could we preserve economic activity for as long as possible before putting in place the restrictions? Unfortunately, what we have learnt from across the world is that the countries who went for early, hard lockdowns and got their numbers down quicker have had faster economic recovery.

The economies of countries that took a SARS-like model, which went for elimination—I use "elimination" not in the sense of never having any virus anywhere on the planet, but stopping community transmission and then dealing with any flare-ups—are doing much better. You just need to look at Taiwan and South Korea. Even in Europe, the countries that suppressed the virus have done better. I know it might not seem that way, but it is not the restrictions themselves that are killing the economy in the long term; it is the virus, because it changes people's behaviour and it changes firms' activities and how people want to travel, how they want to move and how they want to consume.

The countries that got that quickly and went into early lockdown to suppress were those that thought they could play a balance. Sweden is an example. Sweden did not save its economy. It looks very similar to its Scandinavian neighbours in terms of the economic hit, but unfortunately its mortality per capita is much higher.

Q477 **Carol Monaghan:** How do you feel about the Prime Minister's comments in his statement yesterday that we were going to try to get some Christmas celebrations taking place?

Professor Sridhar: The problem right now is that people emotionally want to hear reassuring messages. They wanted to hear over the summer that there would be no second wave, and they want to hear now that Christmas will be normal.

I have to speak bluntly. The virus does not care if it is Christmas. We still have pretty high prevalence across the country. It is risky for people to mix indoors, with alcohol, with elderly relatives at this point in time. I guess my message to people would be that we have three really exciting vaccines on the horizon. We have mass testing coming on board. I think Liverpool shows promise. Slovakia as well, as a country, has been doing quite well with mass testing. We have new therapeutics, meaning that if you get Covid today you are much more likely to survive than six months ago, and you can project that six months into the future.

There is a glimmer of hope for people. By March, we will be in a fundamentally different position from now. Perhaps this Christmas will be different. It does not mean that Christmas is cancelled. It is a pandemic Christmas because we are right in the middle of a pandemic. Every part of the world is suffering or under some kind of restrictions one way or the other. Even those who have suppressed it are living in bubbles in some way because of the travel restrictions. That is the message we need to tell people. Just because it is Christmas does not mean the virus is any less risky.

Q478 **Carol Monaghan:** Professor Sridhar, I am aware of the pressure of time this morning, so perhaps you could answer this briefly. Have the Government learnt the correct lessons from the first lockdown?

Professor Sridhar: I think they have learnt a few lessons. Testing is great. I am a bit worried about the move towards removing isolation fully. I think isolation is absolutely essential. Communications have improved in terms of dampening expectations and about the severity of the virus and what it means for hospitalisations. We still need to work on border restrictions. We saw the new strain in Denmark with the mink; we really do not want to import a new strain of this virus right now.

We are moving forward, but probably not as rapidly as one would hope, and we are not really learning the lessons of the countries that are winning, in terms of the least-worst path through this crisis.

Q479 **Mark Logan:** Professor Sridhar, do you believe that the current national restrictions in the UK were inevitable?

Professor Sridhar: No, I do not think they were inevitable. In the summer, we had a period of time when the numbers were crunched. The numbers were really low in Wales, Northern Ireland and Scotland, and pretty low in England. If we go back in time, we could have pushed at

that point to get the numbers low, hold lockdown a few more weeks and then put in place strict border restrictions to say, "You cannot travel."

For example, Norway and Finland told people that domestic tourism was very sticky if they wanted to get in or out of the country, and if they wanted to come back there were quite strict measures to stop imported infections. With the sequencing work that is now coming out, we are learning that one of the predominant strains that caused the second wave, especially in Scotland for example, is a Spanish strain that seems to have come back through holidays abroad and people moving.

The virus moves when people move, so there is no point crunching the curve and taking harsh lockdown measures if, when you lift them, you do not have a way to protect it. That is why we are in this second wave, and have harsher and harsher restrictions. If you do not figure out a way to protect low prevalence, the virus will just keep coming back, and we are way off any kind of herd immunity in terms of population exposure right now.

Q480 **Mark Logan:** Do you think in September or early October we should have had a shorter circuit breaker?

Professor Sridhar: Yes. When the numbers are going up, it is better to move early, shorter and harder than to wait. It is the epidemic curve. The longer it takes to go up, the longer it takes to come down. We have learnt with this virus that what really gets you is the hospitalisation rate. We constantly underestimate it. This is what I think European countries as a whole have done. You get a bit of spread, especially among younger age groups, and it seems like it is not that bad. You think, "Oh, we can sustain a bit of spread," but the hospitalisation rate accelerates quickly among older age groups and then it puts pressure on the NHS and all of a sudden Governments are forced into reactive lockdowns to try to bring the numbers down, which means you have to go harsher and longer later on.

Yes, in September, once the numbers started going up, it would have been better to move early and fast, which is what some of the devolved nations did. Northern Ireland and Wales went into a firebreaker; Scotland started going into harsher restrictions in a graduated way from September.

Q481 **Mark Logan:** Finally, do you think we have done the right things in the last three weeks in England to avoid going into future lockdowns? What would you have suggested to the Government that we should be doing during this period of time?

Professor Sridhar: Testing and tracing is absolutely vital, especially mass testing. This is one of our few ways out of the crisis, aside from having a vaccine, and the vaccine is going to take time to distribute to all the groups that need to have it. There are still questions about whether it

stops transmission of the virus and which age groups you can give it to, given that it has not been trialled in children.

The big lessons are around getting the testing out. Slovakia tested over 3.5 million people—basically its whole adult and teen population—over the course of a weekend, using its military, to avoid lockdown restrictions. They are doing it again. They managed to bring the numbers low. We have to get our test, trace and isolate right, especially the isolate part. I am slightly worried about saying we can lift isolation. We know that isolation is important so that people do not pass it on to others. There are still things we need to sort there, but it is good that we are moving in that direction. There needs to be clear guidance to people about the virus.

The one area we will struggle with for months, as I think all countries will, is night life in pubs, bars, discos and clubs. There are settings in which the virus seems to spread very rapidly. It is not like flu in how it spreads. It spreads more in clusters and at superspreading events. Those settings become very risky, and then the test and trace system struggles. I do not think we can lift all restrictions and have test and trace and border measures. We still have to have some kind of checks over superspreading events, but probably on a more localised basis than we have now.

Chair: We have a second witness in this panel, but I have two colleagues who are very keen to ask you questions, Professor Sridhar, so could I possibly ask you to keep your answers fairly brief?

Q482 **Barbara Keeley:** What impact has the Government's emphasis on national contact tracing had on efforts to control the virus?

Professor Sridhar: Contact tracing is like detective work. It has to be done at local level by people. You cannot put it into an app. It is very hard to do from call centres. The lesson is that you want to be doing contact tracing at local level, hopefully through NHS public health boards who know the area, who know where people are, who know the communities and know the support people might need once they are contacted and told that they have been exposed to the virus. It is clear that the lesson is go local and do not go national.

Barbara Keeley: An entirely localised approach for contact tracing. Thank you.

Q483 **Paul Bristow:** Professor, you compared the UK's experience with those of east Asian countries and a couple of Scandinavian countries. I am just wondering what weighting you have given to perhaps some of the cultural and historical considerations in east Asian countries—for example, their experience of SARS and the fact that face masks and things like that are much more common there. In terms of Scandinavian countries' geography, they are obviously much less densely populated countries.

Professor Sridhar: Of course, you are right. There are obviously historical factors. South Korea had the experience of MERS, which killed a third of people. That was another coronavirus. When all countries were looking through the fog in early January, of course they started sprinting because they had bitter historical experience of dealing with a very dangerous coronavirus, but I do not think we should overstate it.

All of us are surprised that we are in the state we are in from a year back. The British public have been remarkably compliant and willing to take up face coverings, to go for testing, and to understand the nature of the crisis. We are all more unified across countries than we are separate. Yes, obviously, if you had a SARS or MERS-like event it was easier to respond, but we still had a lot of months to build up testing, and other countries have done it as well. We should not overstate the cultural differences. In the end, we are in a position that is probably more draconian in the lockdown restrictions we have had than east Asia has had. South Korea never had a lockdown. There is much more freedom of movement in Hong Kong and Singapore within the countries than we currently have in the UK. In some ways, we might see them as being strange, but they might look back at us and say, "What are you experiencing? How are you having a second lockdown? Why haven't you sorted this yet?" It is all a balance.

Q484 **Chair:** Let me now come to Alex Thomas, who is programme director at the Institute for Government and has very long experience of the inner workings of the civil service. He now has a job where he is looking at the effectiveness of how government works. Thank you very much for joining us, Alex. When you look at the pandemic, how effective do you think the British state has been?

Alex Thomas: Thank you for having me; it is a pleasure to be here in what is still a novel experience for this former civil servant. As you said, we have been looking at the way the Government have responded. As you would expect, a crisis like this has shown up the strengths and the weaknesses of the state. Inevitably, it is a question of good in parts and bad in other parts.

To pull out a few on both sides, it has demonstrated that there are areas of strength and success. One is the initial economic response from the Treasury, and HMRC and DWP being able to mobilise that sort of operation rapidly. There were people who previously thought that the British state and civil service was quite weak operationally, and it was not one of our strengths. I think it has shown that there is more strength there.

Despite initial difficulties, the ramping up of testing and the ability to do it has been a success and a strength of the state, all the way through to the initial response in the Ministry of Justice and prisons, and the fact that we were not talking about what looked at one stage to be a potentially horrific situation in our prisons. That is testament to the success of some of the actions.

On the other side of the ledger—I will be brief—three structural things have struck me. As Professor Sridhar was saying, the central-local balance does not seem to me to have been right. There is an instinct to go for central responses, particularly around tracing and some of the lockdown decisions, when a more local response might have worked better. I think that is both a reflection of the current political instincts of this Government and a more fundamental question about the instincts of the state.

The second thing, which is really important, is risk and contingency planning capacity. Professor Sridhar rightly highlighted the fact that we were prepared for pandemic influenza as the top of the national risk register and less so for a novel coronavirus. In a sense, it goes a little bit deeper than that. I was reflecting on this from my experience as a civil servant as well.

Risk planning was in a box marked "Civil Contingencies" in the centre of Government and did not reach into other Government Departments strongly or clearly enough. For example, that meant that the Department for Education was underprepared for even a flu pandemic and what might happen in schools, because foresight, anticipation and contingency planning capability was too low.

Finally, and briefly, but we may go into this in more detail, something around the policy communication and decision making area has been demonstrated to be weak. We have phenomenally eminent scientists and policy makers, but the way all of that has come together has at times led to unnecessary delays, not just on the big lockdown decisions but on things around face masks or others. There is something about the way that SAGE and other advice interacts and is drawn together, and the decisions made in the centre—both Ministers making those decisions and the officials advising them and setting out trade-offs—that has shown a weakness. That has been problematic in how the Government have communicated as well.

Q485 **Aaron Bell:** What lessons can we learn from the speed and effectiveness of the decision-making process in Government, particularly over the first lockdown that we were not prepared for? Secondary to that, do you think there was perhaps an optimism bias in the heart of Government, given that previous pandemic scares, like avian flu, bird flu, foot and mouth and so on, had not amounted to much? Was that a problem at the start?

Alex Thomas: On the second point, potentially many of us shared an optimism bias at the beginning; it is easy to forget that the consequences we have seen play out seemed unbelievable at the time. I think it was explicable, but I agree with the thrust behind your question that there was an optimism bias, and maybe some more pessimistic people in Government to surface those sorts of issues would have helped at the time.

On the first point, we have learnt quite a lot about the structures and nature of decision making. There is something structural about the interface between SAGE and the scientists and Ministers. There is lots that could be said about this, but the need to wait for consensus and until the evidence was extremely compelling, which is a strength in some areas, became a weakness in the early phases of the pandemic. The departure from the precautionary principle that politicians make decisions that we saw in Germany and elsewhere was a lesson, I think.

Quite a good example of policy making that came later on, and I raise it because it draws out some of the threads from the SAGE/Minister debate, is the social distancing 1 metre-plus decision. There was a situation where SAGE, from what we see from the minutes, was saying that it should remain at 2 metres. Clearly, there was some discomfort among the professional advisers in Government, but there was also enormous political, social and media pressure to reduce that to allow more businesses to open, and to support the economy.

The Cabinet Office drew all of that together and came up with a series of options, synthesised it, and Ministers were then able to make a clear decision. I would highlight 1 metre-plus as quite a good example of how decision making is supposed to work.

Q486 **Aaron Bell:** Briefly, because we do not have much time, do you agree with the structural changes that the Government have put in place during the pandemic in order to respond better? I am thinking about the Cabinet Committees and the tsar-like appointments of Lord Deighton, Baroness Harding, Kate Bingham and so on. Do you agree with the way the Government have restructured themselves to deal with the pandemic?

Alex Thomas: Yes, I do. I think the strategy and operations separation makes sense. It gives a clearer structure of accountabilities than some of the earlier committees, where Secretaries of State were chairing their own committees. I think it makes sense. In my experience, it is the same model that was used to prepare for some of the no-deal Brexit planning last year. In my experience, for all the challenges, that structure basically worked. I think it is the right thing to do. At times, I think Cobra has been underused. It is good to see it being used a little bit more, particularly to co-ordinate with the devolved Administrations.

On the tsars, I think you absolutely need key individuals to draw things together. We saw the gap in that in the very early stages of the crisis, and we have seen the benefits of that gap being filled. There are some quite serious questions about accountability and appointment, and transparency and propriety around some of those appointments, which should, by now, have been regularised.

Q487 **Dawn Butler:** How important is it that people who are put in those new positions are skilled and experienced in the field that they are asked to run? For instance, how important is it that the person put in charge of Test and Trace knows what they are doing?

Alex Thomas: It is obviously incredibly important that they know what they are doing. The qualifier to that, though, is that does not necessarily mean they need to be a medical expert. Those jobs are as much about leadership, management and logistics as they are about medical interventions or anything else. There are all sorts of different ways of working out whether someone is the appropriate person to appoint for a job. That is why we have clear, fair and open recruitment processes. It should be competence first and politics second.

Q488 **Dawn Butler:** Professor Whitty told this Committee that in an emergency response the Government should only focus on what they can currently deliver as opposed to what they should deliver to give us the maximum chance of saving lives. Do you agree with that assessment?

Alex Thomas: I do not know exactly the context in which Professor Whitty said that. The way you put it seems a little bit strange to me, because one of the things that Governments need to do is to think themselves round corners. It goes a bit to the foresight contingency planning point that I made earlier. It is really important that the Government are able both to respond to the immediate needs of the crisis and to anticipate what is likely to come next. One of the challenges we have seen around communications flipping from positive to negative, and some of the logistics challenges that we have seen, is that the Government—this is a civil service thing as well as a ministerial thing—have not had the capacity to think themselves forward.

That is a way of saying that I do not quite agree with the way you have characterised it. I would want to look at the context a bit more.

Q489 **Sarah Owen:** Alex, we have heard a bit about how this country seems to have been caught off guard because it did not seem to have been affected by SARS as one of the reasons why we have been so poor in protecting our nation. In 2007, we were drawing up plans. Emergency planning was taking place for SARS. What happened to those plans, and why were none of those contingencies taken forward so that we were in a better place this time around?

Alex Thomas: It goes to my point about contingency planning. One of the lessons that your inquiry, and other subsequent ones, will need to look really hard at is the national risk assessment process and the extent to which it is interrogated and challenged. I do not know the specific point on the 2007 plans and where they went. I know that the references in the national risk assessment to novel coronavirus were, it is clear now, too dismissive and too much focused on pandemic influenza.

In government, there is always a tendency to fight the last battle and not to genuinely scan for risks. Swine flu and some of the avian influenza—when I was in DEFRA I worked on foot and mouth, avian influenza and other diseases—meant that there was a natural tendency to draw back. More disrupters and more grumpy people who are able to challenge what they see and assumptions in government is the answer to that.

Q490 **Sarah Owen:** Do you think there would be much more benefit in us looking at forward planning for risk, and investment in how we plan for events like this better in the future, if they seem unlikely or, if for cultural bias reasons, we think that we are immune somehow?

Alex Thomas: Yes, I do. There are all sorts of lessons that we will learn from this about the capability of the state, from NHS capacity and structure all the way through to communications and everything else. One of those is risk management and our contingency planning response.

That is a longer way of saying yes.

Q491 **Sarah Owen:** Professor Sridhar, I have a question related to Paul Bristow's question. Why do you think there is such unwillingness for this Government to learn lessons from countries that have perhaps performed better? Do you think there is cultural bias that SARS, swine flu and avian bird flu affected east Asian countries but not us? Do you think that cultural barrier needs to be looked at for us to progress and to learn lessons, as Alex said?

Professor Sridhar: One of the interesting things in February was the complacency across all rich countries, including the United States, about this virus. The worst thing people could think of was the flu, and the flu kills a lot of people. That is why we got the whole idea and obsession that it was just like a bad flu, whereas in places like west Africa they redeployed their post-Ebola structures towards Covid structures because they knew that an infectious disease can run through society, shut down your schools and hospitals, stop vaccination campaigns and paralyse society for months. There is a sense of complacency because in European countries or in North America we have not seen infectious diseases cause destruction in the way they have been doing on an ongoing basis in poorer countries, who reacted much faster. I think that is definitely there.

Moving forward, the real lesson is that overreaction is better than waiting and watching. It is always better to move fast and early, and then be blamed afterwards for overreacting, than to wait and watch and see a slow-moving car crash emerge.

One of the things people ask is, "Is SARS-CoV-2 disease X?" They say, "Imagine if it had been like Ebola or MERS." In some ways, I think that would have been easier for countries, because if there was something that killed a lot of people, especially healthy young people, we would have all run towards the same goal of maximum suppression and put in place the public health measures needed. Because this is on the border, and the case fatality rate is at 0.5% or 2%, and it largely affects those who are elderly or have health conditions, we have ended up in a circular debate about how serious the problem is, rather than saying, "It is a serious problem, and how do we solve it?" That is one of the lessons. In the future, when a problem emerges, I hope we spend less time wondering, "Should we act?", and more saying, "How do we start running as fast as we can to try to get a handle on this?"

Q492 **Dr Evans:** Professor, we hear a lot about the data that is driving R numbers, K values and things like that. I am interested in the behavioural science behind what is going on. We hear that much less. How much weighting do you believe there is to the behavioural aspects of the advice that comes out, and how does that influence us coming up to Christmas?

Professor Sridhar: That is a great question. The behavioural science is absolutely massive, because you do not need to have state lockdowns if people alter their behaviour on their own through really good guidance. For example, if you ask people to avoid crowded settings or to wear face coverings, you do not need to legislate or mandate it if people understand why it is important to do it.

There are two things we are seeing. First, fatigue is setting in. For a lot of people, it feels endless. They were willing to sacrifice in the spring to save the NHS. What are we doing now? The populations of countries that suppressed/eliminated/took a zero-Covid approach got a pay-off. Yes, New Zealand had a really hard lockdown for three weeks, but they got back to their big rugby games. Norway and Finland had early harsh lockdowns, but then they released most of the restrictions. I feel that the British public have not had that pay-off. They have not had that moment of release or been told, "Your sacrifice has led to a state where you get back your jobs, your life and as much of society as possible."

Q493 **Dr Evans:** Can I pick you up on that point? It is a really important one when it comes to Christmas. On the one hand, the science would say, "Stay locked down." You have already said that the virus does not care about Christmas, but on the other hand we have not seen a pay-off. The behavioural aspect from the Government's point of view is, "Do we put in a law that means people will definitely break it and we have to police it, or do we let people have that short-term win but the pain potentially of having to have measures put back in place?" As a scientist, given what you have said on the behavioural aspect, what would you do?

Professor Sridhar: I think it comes back to communications and messaging. I get asked this all the time. What I would say to people is, "Do you want to infect the people you love, or be responsible in your home, or bring it into their home over Christmas?" We are in a pandemic. You can still see your family. You can still celebrate with your communities, but in safer ways. Get outside. We know that outside is so much safer than inside. Go for a walk; have a meal outside. If you are going to be inside, ventilate. Open your windows and make sure there is plenty of air circulation. If you are going to see elderly or vulnerable individuals, you can isolate for two weeks if you are able to, so that you do not expose them. If you really want to be extra cautious, there are rapid tests you can take, in addition to the incubation period.

We are in a pandemic. People need to recognise that it is not going to be a normal Christmas. Christmas is not cancelled, but it is going to feel substantially different because of what we are going through. We do not want to pay for Christmas with January hospitalisations and February

deaths. We have been in this a long time, and we know the vaccine is coming. Delaying makes perfect sense right now, given that we have the science delivering on the timescales it is.

Q494 **Dr Evans:** How do you quantify, if you even can, the difference between the scientific data and the behavioural aspect of the way in which people respond? We are not perfect humans in the way we respond, so it is hard to model. What weighting should Government give to the hard science of what the virus does—because we can prove that—versus the behavioural aspect that we have to model and see?

Professor Sridhar: That is a great question, because it is easier to follow the numbers and follow models that will tell you how many infections or hospitalisations you are likely to see based on social interaction among different individuals than you are with behavioural science.

In the end, these are political decisions. All that science can do is say, "These are the three options; these are the pros and cons of each; this is what it is going to mean; this is what each could probably look like in the next three months," and then leaders have to decide which ones they want to take, based on, in a democracy, public opinion and what is best for the majority of people in the country. In the end, these are not scientific decisions; they are clearly political.

Q495 **Dean Russell:** Professor, thank you so much for being a witness today. I have a couple of questions. I was conscious that one of the comments you made earlier was about the fact that in the early stages there was a decision to let the virus go through the population. My understanding is that that would mean herd immunity; I am pretty confident that Sir Patrick Vallance repeatedly said herd immunity, or so it was said. Actually, he has said many times since then that that was not the strategy. My take was that the stay at home approach was very much an isolation strategy. I would be keen to understand a bit more what you mean by that, please.

Professor Sridhar: If you go back and read the SAGE minutes from February—they have all now been publicly released—they see this, when it emerged in January, as an uncontrollable infection. They thought that every country would succumb to it. The modelling showed that China would have over 100,000 infections a day and that 80% to 90% of the Chinese population would be exposed to it.

Then something remarkable happened. Countries started to control it. South Korea controlled its first wave. China brought down the numbers through quite a stark approach; I do not think we should take away everything from what they have done. Other east Asian countries, such as Hong Kong and Singapore—some of the ones that were earliest hit—started to manage it. All of a sudden, it became clear that it was not going to be an uncontrollable infection. It does not spread like flu. It

spreads through clusters. You can contact trace it, manage it and eliminate it.

To come back to the herd immunity approach, the idea was that no country could stop it. That is what the SAGE minutes actually say. They say there is no point contact tracing because at some point it is going to be so endemic in the country. I know that herd immunity has come up over and over, and what the threshold is. It basically means that enough people have it that it stops transmitting, because there is enough immunity built up. But the threshold seems quite high.

There are two examples. One is New York City. Certain boroughs of New York City were hit incredibly hard. There was zero prevalence, which means antibody prevalence, of over 50%. They are still seeing acceleration in those communities. There are studies coming out of the Brazilian Amazon, where they have attack rates of 75% and it is still increasing, meaning that the threshold is likely to be around 80% to 90%. That is important for our vaccination strategies if we are to try to build up herd immunity through vaccination, as we have done with measles.

Q496 **Dean Russell:** That then led to the stay at home approach anyway. Were there early mullings and discussions about that, and then the political decision made was different, or are you saying that scientifically the Government were being advised to go down a herd immunity route and they chose not to? I am trying to understand. I am sorry to ask the same question again.

Professor Sridhar: I am sorry if I did not answer it before. I think the SAGE advice changed, if you read the minutes. In February, it was to stay open and mitigate: the 2011 flu plan. In early March, when they started to model and saw the hospitalisation rate in Italy and what it would mean for the NHS, they pushed for lockdown at that point. There was always concern about the economy. If you go into these measures, what is your exit strategy? Once you lock down, how do you release restrictions?

Other countries just went into lockdowns without having a plan for how they would do it. They sorted it as they went through it, whereas, if you read the SAGE minutes, I think there was concern that if you locked down, how could you ever ease restrictions? There was the feeling that there would not be a vaccine or enough testing available in the short term. They undervalued time.

Q497 **Dean Russell:** As a former physicist, I remember that there always used to be a joke that, if you have 10 experts in the room, you will have 11 opinions. I am interested to know from as eminent a scientist as yourself, is there a difference of view in the scientific community around all of this? Obviously, there are different views on what the outcome was. Is it a political, ideological difference in the approach? I hear many different views on the Select Committee, in the media and elsewhere, and of

course reading the minutes from different meetings. I am interested to know why there is such variance in the scientific community's approach, given what we know a year on.

Professor Sridhar: At the start, there was such uncertainty that it was like looking through fog. If I think back to January, we did not even know if there was human-to-human transmission. That was where we were. We did not understand how it transmitted. We did not know who was affected by it; there was such limited data from China. The uncertainty creates scientists guessing, based on their expertise, what they think might emerge.

We have much more consensus now, 10 months in. The consensus is around suppression. It is around test and trace. It is around buying time for a vaccine. We are even seeing Sweden moving towards that kind of approach. We have much more certainty around vaccine candidates, around therapies, around immunity, around who it affects, around hospitalisation and also around long Covid and chronic morbidity in young people. As time goes on, we will see less and less in-fighting among scientists and more and more cohesion, which is what we are seeing between SAGE, Independent SAGE and independent scientists. The majority of scientists around the world are pretty much aligned right now, whereas a year back there was too much uncertainty to be able to reach consensus.

Q498 **Dean Russell:** I am conscious that at times Professor Whitty and Sir Patrick Vallance have come in for some quite hard talk over the year and some disagreements from the wider community. Do you think that is fair, or do you think that they have done the best job they possibly can, given what they know and their incredible track records in these areas?

Professor Sridhar: I have a lot of respect for both of them. They are both senior professionals, obviously dedicated to human health, public health and protecting life. I do not think anyone could question their motivations or their expertise.

Where we might need to look in the future is the composition of SAGE. I think there was too much put on modelling and on certain types of expertise. You did not have anyone who had public health experience. You did not have anyone with international experience of having studied east Asian responses. There were big blind spots, and it was quite a small group as well. I know they have increased it over time, but a small group of scientists was making decisions at that point, from the minutes.

In the end, it comes down to why you need scrutiny of SAGE and the science by peer review. There was no transparency in the minutes at that point, or what the basis was for following the science. I do not want to say anything negative about either of them. No one can envy the position that they are in and the decisions they are trying to make on a daily basis.

Q499 **Greg Clark:** On that point, Professor Sridhar, we have some very eminent people serving on SAGE and working very hard, and we know from evidence that this Committee has taken that the Government—especially during the first phase of the pandemic—followed all of the material recommendations of SAGE, but you reflected on the fact that we did not do some of the things that other countries around the world were doing, so have we attempted to have too much of a British exceptionalist approach? On reflection and for the future, in the context of a global pandemic, might we be more inclined to follow WHO advice than seek to have a bespoke UK system of advice?

Professor Sridhar: I think that is right. Having followed the press briefings and technical information since January, I think WHO advice has been pretty spot-on. The question is, was there a cleverer way out than other countries? Was there a way to avoid the public health slog of building up testing, border measures and trying to chase the virus down? Was it all pointless? That is where perhaps the idea comes of being too clever and saying, "Those countries are just crashing their economies chasing something that in the end you just cannot pin down."

It is very similar to Sweden. They followed their public health agency very closely, too. They wrote a piece in *The Lancet* which said that every country was going to succumb to the virus, and the question is just your health service's capacity, so build hospitals and the threshold for how many people you can treat, because in the end that is what will make the difference between countries.

They could have looked at China, which is where New Zealand pivoted; they were on the flu plan but they pivoted, based on a mission to China in February. Bruce Aylward came back after spending a week there and said, "Actually, there is a playbook for how to control this. It involves contact tracing, testing, isolation, really good guidance and border restrictions. There are things you can do." South Korea started showing the advantages of mass testing, and of its test and trace, to keep its economy open. There was a way to look at that, and start running quickly down that path.

Germany learnt from that. That is why it went down the mass testing route really quickly and has managed to keep its numbers low. It is also bringing people into treatment quite quickly. It says to people, even in the first week, "If you are unwell, come into hospital. Don't stay home." The earlier people get treatment, the better their outcomes are. That has become clear from across the world, and it is why South Korea has one of the lowest case fatality rates; it treats people very early.

Q500 **Chair:** Thank you very much indeed. Alex Thomas, there is a big debate at the moment in Parliament about the awarding of PPE contracts and the fast-tracking of appointments to key positions such as the person responsible for Test and Trace and so on. On the one hand, all these things were done quickly and improperly, and people with contacts got big contracts. On the other hand, the Government say there is a

pandemic and they had to move very fast. You are now the honest broker at the Institute for Government. The Secretary of State has arrived and is listening. What is your objective view of the rights and wrongs of those decisions?

Alex Thomas: Thank you for that. It is totally legitimate in the early stages of a crisis or a pandemic to balance off the risk of improper use of money or fraud, as the Treasury did in the income support schemes, to get fast action. It goes back to some of the earlier points about anticipation. There comes a moment when the crisis becomes the normal for the next defined period—the year, or whatever—when it is important for public confidence and for the integrity of the state to regularise that. That applies both to the procurement contracts, as in the National Audit Office report that we saw the other day, and to appointments.

My honest view is that the Government have been a little bit on the slow side on that, but it is a balance. It is totally legitimate in the early phases of a crisis to throw everything at it. That is a judgment, in the end, that Ministers make as the representatives of citizens. It is important now to make sure that the public have confidence in those processes and that we root out any suggestion that there is impropriety or anything around those contracts.

Chair: Thank you very much indeed, and thank you for joining us this morning. Professor Sridhar, thank you for joining us from Edinburgh. It is very important evidence. We really appreciate your giving up the time.

Examination of witnesses

Witnesses: Rt Hon Matt Hancock MP, Jenny Harries and Clara Swinson.

Q501 **Chair:** We have the Health Secretary here. Thank you very much indeed for joining us. We know how busy you are. Thanks, too, to your team at DHSC, who are working incredibly hard and have been during the pandemic. They are not often credited in the way that frontline NHS workers are.

Joining us virtually is Clara Swinson, who is the director general of global and public health at DHSC, and Dr Jenny Harries, the deputy chief medical officer. Thank you for joining us.

Secretary of State, we have had good news in the last few weeks. Yesterday, the Prime Minister said that he hoped that the vast majority of vulnerable people would have the vaccine by Easter. Of course, the virus will not be eradicated by Easter, but if all those vulnerable people get vaccinated by Easter, what will social distancing look like after Easter?

Matt Hancock: The answer is that it depends on the impact of the roll-out of the vaccine on the transmission of the disease and on the number of people who have a serious morbidity or indeed die from coronavirus. The same tools and data that we use to judge what should happen to

NPIs now—the social distancing interventions—are, essentially, the same measures because they are the things that we are trying to protect against. We are trying to protect against cases of coronavirus, hospitalisations by coronavirus and, very much, deaths from coronavirus.

The vaccine trials can successfully test in the large numbers of people in the trials—the tens of thousands of people in each of the three that have so far reported positive efficacy—whether they protect an individual. There is some evidence in the AstraZeneca trial of protection from transmission; that you not only protect yourself from coronavirus, but reduce the likelihood of you transmitting. We have been able to measure that because, in the AstraZeneca trial, unlike the other two trials, there was regular testing of some of the participants all the way through. However, you cannot know the true impact of that, and you cannot calibrate it mathematically, until you have seen the impact of having vaccinated a large number of people.

Q502 **Chair:** People watching at home just want to get a sense of this. Is it possible that we could be back to normal after Easter?

Matt Hancock: After Easter, we think that we will be getting back to normal. There are some things that are no regrets. Washing your hands more and some parts of social distancing are no regrets things that I think will become commonplace, but the damaging social distancing interventions that have big downsides, whether economic or social in terms of our wellbeing, I should hope we can lift after Easter if the two vaccines are approved by the regulator, which is an independent decision for the MHRA.

Q503 **Chair:** Thank you. This joint inquiry that our two Select Committees are doing is about learning the lessons going forward from what we experienced in the pandemic. You have said many times that you were following the science. Do you think you got the right scientific advice at the outset of the pandemic?

Matt Hancock: This is slightly dangerous, Chair, but I am going to question the premise of your first question on this subject. I always tried to say that I was guided by the science. I noticed that in your evidence session the scientist from Edinburgh said that people followed the science. I always try to take the approach of being guided by the science.

Q504 **Chair:** But you did say "follow the science" a number of times.

Matt Hancock: I may have said it colloquially, but the approach that I took, and far more rigorously tried to describe, was being guided by the science.

Q505 **Chair:** Was the scientific advice that you got—

Matt Hancock: Let's get on to the substance, because the difference between following the science and being guided by the science is that, if you are following the science, it implies an automaticity, as opposed to

ministerial judgment, taking into account all of the effects based on the science. That is a truer reflection of what we do.

The scientific advice was the best that was available. It is tough because we started by knowing nothing at all about this virus. We knew nothing about its biological properties or its impact on humans, and nothing about how it transmitted and the social side of it. That information built over time.

Q506 **Chair:** You say it was the best that was available, but it was not the same as the scientific advice that was being given in South Korea. SAGE did not model test and trace as a response. They modelled testing at the early stages, but the plan was very clear to stop testing once you had community transmission. In South Korea, they were modelling test and trace as a strategy right through the pandemic, right from the start. We did not get there until the end of April. I just want to come back to this. Did you get the best scientific advice right at the outset?

Matt Hancock: There are a couple of things on that. The first thing is that on testing it is wrong to say that the advice was to stop testing, and we did not stop testing. We ramped testing up all the time. The problem was that the linear increase in the availability of testing was slower than the rise in—

Q507 **Chair:** I do not want to be disrespectful, but there are so many questions to get through. The advice was very clear to stop community testing.

Matt Hancock: That is different.

Q508 **Chair:** But that was not the advice that was being followed in Korea, Taiwan, Singapore or all those other countries. They were—

Matt Hancock: But this is aiming at the wrong target. Stopping community testing was a consequence of having to focus the tests on people in hospital because there it has a direct impact on treatment. The big difference was that South Korea and others, following their experience of SARS, moved to NPIs much earlier. If you think about the—

Q509 **Chair:** Sorry to interrupt, but it was not just NPIs, was it? Your clear advice was to stop community testing, which you announced—

Matt Hancock: I was told to stop community testing and that we should also stop contact tracing.

Q510 **Chair:** But the World Health Organisation advice was to carry on testing in the community right the way through. That is what I am really trying to get to. Did you get the right scientific advice at that point?

Matt Hancock: I think I got the best scientific advice that my scientific advisers could give me. Can we learn from it? That is what this whole process is all about.

Let me put it a different way. There is absolutely no doubt that we can, we should and we must learn from all the international examples and

from our own experience here about how we can best deal with a pandemic of any sort.

Let me give you one example. Project Cygnus is now published. The problem with Project Cygnus was not the exercise itself, which you no doubt remember well. The exercise was conducted well and all the lessons from it were noted and acted upon. We would not have had the Coronavirus Act in draft had we not had Project Cygnus. It was a very important project.

The problem was that it started from the assumption that we were going to have a pandemic flu that was already rampant and widespread. It was an exercise in what you would do in the period at which lots of people were already dying. What it did not ask were the prior questions, "What type of pandemic is most likely? What are the different characteristics of different pandemics"—flu or coronavirus being two obvious examples—"and can we act to stop getting into the position at which Project Cygnus started off?" Those are the prior questions that I think it is very important for everyone around the world to be asking as part of the lessons from this.

Q511 **Chair:** That is why you have announced the setting up of a new British version of the Robert Koch Institute, which will, hopefully, do that horizon scanning.

Matt Hancock: Yes.

Q512 **Chair:** Can we go back? We clearly learned lessons from around the world, which is why, when you came back from your own bout with the illness, you set up the big testing programme, the big test and trace programme. Other countries used test and trace—again I am going back to east Asia—as a way of avoiding lockdowns. We ended up having to have a second lockdown. Is that because the test and trace programme did not meet your expectations, or were there other factors?

Matt Hancock: The test and trace programme ahead of the second lockdown was functioning to reduce transmission enormously. By the time of the second lockdown, it had already broken the chains of transmission hundreds of thousands of times. The problem was, as happened in so many other European countries, that the overall number of cases started going up. I do not lay that at the door of Test and Trace at all because it had expanded unbelievably fast in the circumstances. As we will see, we are constantly improving testing and tracing, but the biggest gap, the biggest fall-off, between the actual cases in the community and the total number of people who were contact traced was actually of people who were asymptomatic getting a test. That was the biggest gap.

Q513 **Chair:** Why then did SAGE say in September that it thought Test and Trace was only having a marginal impact on controlling the transmission of the virus?

Matt Hancock: Because there were so many other things that were leading to upward pressure on the number of cases. That is why we had to bring in stronger NPIs, stronger social distancing measures.

Q514 **Chair:** But it seems strange, when you had made a huge investment of £12 billion and massive increases in the amount of testing going on, that in September it would say that all that effort was only having a marginal impact.

Matt Hancock: You have to look at what Test and Trace was doing in totality, as opposed to the very specific part that you mentioned. In totality, we would not have had the ability to test the people that we did unless we had built the capacity. We would not now be in a position of being able to roll out very widespread community testing unless we had taken the action that we did.

The central point is that Test and Trace on its own cannot keep the virus under control. That is true in all countries. For instance, in some of the far eastern countries, where they see a number of cases they put in huge testing capability. I think mass testing has the ability to do that in a way that testing of symptomatic people and then contact tracing finds it much harder to do. Nowhere uses test and trace without NPIs attached to it to control the virus. To lay this at the door of Test and Trace, I think, is wrong.

Q515 **Chair:** Professor Sridhar talked about the importance of compliance when people are asked to isolate. We have had fairly low compliance rates from around 20% up to 54%, which was the latest number I saw. She talked about New York City, where they have managed to get up to 95% compliance with requests to isolate. What have you learnt going forward about how we can boost compliance?

Matt Hancock: I think the incentives to self-isolate are very important. The £500 payment is very important. I am sceptical of some of the very high numbers, when there are reports of very high proportions of people following those rules. I would want to look into the surveys and the incentives of people when answering those questions. Likewise, I am highly sceptical of the very low numbers. For instance, with the 20% figure you refer to, the question is asked in a particular way about whether they fully and at all times, in that isolation, abided by it and stayed at home entirely. What matters is the radical reduction in the number of contacts. That is not to say it is not an incredibly important area where we have learnt throughout the crisis and brought in stronger measures.

Q516 **Chair:** Who is responsible for getting the compliance rate up on isolation? Is that Test and Trace's job?

Matt Hancock: Test and Trace, yes, but it is actually a cross-Government effort. It requires law enforcement and it requires Treasury for the payment and the financial support that people get. It is a cross-Government effort and it is brought together at Covid-O.

Q517 **Carol Monaghan:** Secretary of State, you have already mentioned scientific advice that you were receiving. I do not think any of us wants to be critical of those who were receiving the advice, but Professor Sridhar talked about the composition of SAGE and the high proportion of modellers as part of that. Have you made any attempt to widen the diversity of scientific advice that you are taking?

Matt Hancock: Absolutely. I listened to some of those comments. I thought it was a bit strange to say that SAGE does not have any public health expertise when it is chaired by one of the world's finest epidemiologists in Chris Whitty. I may ask Jenny Harries to come in on this as well. I thought the part that I heard at the end of the session was not an accurate description of SAGE.

Nevertheless, on your direct question, we absolutely listen to a broad range of advice. The formal way in which the SAGE advice is brought to Ministers is, quite properly, through the CSA and the CMO. We listen very carefully to them. I also listen to all sorts of voices and scientific arguments. I read some of the material direct, but you also need a process through which—

Q518 **Carol Monaghan:** Could I stop you there? One of the areas where we were told very early in the pandemic that there was a deficit was manufacturing engineers who would be contributing to things like screens, machines for hospitals and even test kits. Are these kinds of individuals now part of the advice that is being given, and offering advice to Government?

Matt Hancock: I do not think that having engineers and operational skills and capabilities on SAGE would be right at all. That is not the job of SAGE. It is a scientific advisory committee. Of course, we use enormously all the skills that you have mentioned in the assessment of what is the right policy and the roll-out of it. It comes down to—

Q519 **Carol Monaghan:** I am sorry to interrupt you again, but we have just heard the Chair talking about Test and Trace. We have heard about the lack of capability. One of the reasons for the lack of capability was limited numbers of test kits. It is about the very people who would actually be able to advise on how we can best increase capacity in that area. I find it strange that you are saying they would not form part of the advice early on.

Matt Hancock: Of course, they form part of the advice. It is just nothing to do with SAGE.

Q520 **Carol Monaghan:** I will move on. In early March, the UK was rejecting the idea of lockdown. We could see lockdowns happening in other countries, worldwide and across Europe. We know, for example, that Germany had a very robust response early on. We kept hearing about reducing the peak and flattening the curve. The director of the Wellcome Trust, Sir Jeremy Farrar, has said that we were too slow to lock down and, "as a result, the epidemic took off and we weren't able to control it."

Should we have put our lockdown measures in place earlier in the pandemic?

Matt Hancock: This was a point at which we directly followed the science; we were guided by it, and took that scientific advice—

Q521 **Carol Monaghan:** But the scientific advice was coming from modellers. My previous question was asking about diversity. I am asking you now, in hindsight should we have locked down earlier, knowing what was happening across the world and in other parts of Europe?

Matt Hancock: There are so many ways to answer that question. The first thing is that I am not sure putting engineers on to SAGE would have made any difference to the advice at that juncture. I think that is something of a red herring. We get advice on engineering requirements for any policy quite separately.

There will of course, rightly, be a debate about the question you ask as to what the advice should have been at the time. What I would say in defence of the advice that we were given, which we followed, is that we put our lockdown measures in earlier within the pandemic curve than other comparable countries in Europe. What is more, the four nations of the United Kingdom moved at the same time. They were, essentially, basing the decisions on the advice of the four CMOs and the scientific advice that came to them.

Q522 **Carol Monaghan:** I am slightly confused because five minutes ago you told the Chair that you didn't follow scientific advice; you were guided by it. Now you are saying that you did follow scientific advice. Which is it?

Matt Hancock: I was very precise in what I said. In this instance and in the period that you are talking about, we absolutely took, listened to and followed the scientific advice that was given, and based our decisions on that. My point about saying that the better phrase is to be guided by the science is that there are times when that was not the case.

There are many examples when I can remember the scientific advice being different. For instance, right at the start of the pandemic when we were bringing people back from Wuhan, before we knew that the virus had escaped from China, the advice was not to quarantine those people on return. I overruled it and decided that those people needed to quarantine. That is an example of why Ministers are there, to take into account the scientific advice and then make a decision. In the case you were mentioning, the March lockdown decisions, we took the scientific advice and we followed it precisely.

Q523 **Carol Monaghan:** What lessons have we learnt from the first lockdown?

Matt Hancock: We have learnt a huge amount of lessons. It might be worth bringing Jenny—

Chair: Can we make this brief, Secretary of State?

Matt Hancock: Probably the best example is schools. We have kept schools open in this second peak. We have done that based on a rigorous analysis of the impact of schools being open on the transmission of the disease; on the impact of the disease on children; and then a judgment on top of that of the wider societal benefit of schools being open, not least for education. The scientific advice was that schools are lower risk than we thought. We did not really know the first time around. It was very hard to know. Added to that were the social benefits of education. That was one of the things we learnt.

Q524 **Aaron Bell:** Secretary of State, thank you for your time today. Following on from what Carol was saying about being guided by and following the science, clearly with the current national restrictions the Government took a different view. SAGE gave advice on 21 September, and we did not introduce national restrictions until 31 October. What was the reason for doing that?

Matt Hancock: The reason is that we wanted to pursue the regional tiered approach because of the lower and wider implications of that. Again, the scientific advice takes into account the epidemiology, of course, but Ministers, rightly, will also take into account other considerations. At the time, both the prevalence and the rate of growth of the virus in many parts of the country was very low. We judged that, while we, of course, understood the science advice on the epidemiology, it would have been disproportionate to put in place a national lockdown at that time.

Over the forthcoming six weeks or so, things changed. The trigger that persuaded me that we needed to go into national lockdown, having been essentially the architect of the tiered system and a big supporter of it, was that we saw case rates suddenly and quite sharply going up in almost every part of England. Even in the low prevalence areas, you could see that they were going to get to high prevalence if we did not act. That is a very good example of the difference between being guided by and following the science.

Q525 **Aaron Bell:** Was rejecting the call for a national circuit breaker on the basis that you did not think it would necessarily work, or that it was not necessary?

Matt Hancock: At that time, I think a so-called circuit breaker would have been disproportionate. The challenge with a circuit breaker—the idea of a two-week break—is what happens afterwards. That is the debate we are currently engaged in right now in England in terms of what happens following the Prime Minister's announcement yesterday. What happens after a lockdown? A lockdown is a lockdown is a lockdown. You can call it a circuit breaker if you like. A circuit breaker is just a two-week lockdown. Here, the second time around, we went for a four-week lockdown, but critically then returning to a tiered system that is better calibrated having learnt the impact of the tiered system in September and October, when the third tier was not strong enough to get the R

below 1 and therefore cases falling. Therefore, we need a slightly tougher third tier so that we can have confidence that we can bring cases down under the tiered system.

Q526 **Aaron Bell:** My colleague Mark Logan will ask a bit more about easing restrictions. Do I understand that you do not believe that a two-week circuit break would ultimately have ended up being two weeks? You think it would probably have been longer.

Matt Hancock: Something would have had to come after it, because the sad truth is that, until we get a vaccine that can effectively stop this thing, NPIs are the tool we have that is most effective. The question is how to get to a point at which we can sustainably keep the virus under control.

Let's go back to the strategy. The strategy is to suppress the virus and to protect the economy, education and the NHS until a vaccine can make us safe. We are going to use mass testing as much as we can to suppress the virus, but unfortunately NPIs are also necessary. Whether you have a two-week lockdown or a four-week lockdown, it is simply a stronger set of NPIs to get the numbers coming down and under control. We will then replace it with a tiered system.

Q527 **Mark Logan:** Secretary of State, what will Christmas look like this year?

Matt Hancock: I don't yet know, Mark. It won't look exactly the same as normal, that is for sure. It is very important that we continue to respect the spread of the virus. I am not leading on the discussions with the devolved authorities on what the exact measures will be.

Q528 **Mark Logan:** From my constituents' point of view, at the end of July this year, a lot of them felt that their Eid celebrations were cancelled. A few weeks ago, quite a lot of my Hindu community felt that Diwali was cancelled for them. Are we considering the perception of unfairness when we are looking at Christmas this year?

Matt Hancock: Yes. I am very sensitive to that point. We did think about it. We have engaged and discussed it. The conclusion we have come to, which I agree with very strongly, is that Christmas is a national holiday. It is the biggest national holiday we have. Of course, it has particular importance for Christians, but it is an important national holiday for everybody in this country. While of course we considered the impact on those of other faiths and none, Christmas is a special time for everyone in this country.

Q529 **Mark Logan:** I know that we are very hopeful that by springtime things will be back to relative normality, but, between now and then, would you expect another national lockdown to happen?

Matt Hancock: No; I very much hope not to, by having a tiered system that is calibrated to be able to bring the virus under control where that is necessary.

Q530 **Taiwo Owatemi:** Secretary of State, I want to ask some questions with regard to diagnostic capacity earlier in the year. On 4 February, SAGE highlighted for the Government the shortages around diagnostic capacity. Why did it take until April for the Government to announce their new testing strategy?

Matt Hancock: This is a really important question. In the very early period, Public Health England did a brilliant job developing a test at huge rapidity. It began scaling up testing capacity. It was clear that we needed to go faster, so around mid-March we broadened the responsibility for delivering testing capacity from just Public Health England—that became pillar 1—and I took in hand, into the Department, the responsibility for delivering testing capacity. On top of pillar 1, which is the PHE/NHS testing capacity, we introduced pillar 2, which became the Lighthouse labs programme. Pillar 3 was for antibody testing, and pillar 4 was for surveillance testing. It was then that I was able to drive the radical increase in capacity for testing that we can see today.

Q531 **Taiwo Owatemi:** Given that the Government took their time in increasing diagnostic capacity, what exactly have the Government learnt from that delay?

Matt Hancock: What I would say is that our challenge at the start was that we started with a very small diagnostics capacity. We started with labs in the NHS and PHE, but the NHS labs were obviously focused on the diagnostics for patients and the PHE capacity was, essentially, a scientific capacity. What we did not have was large-scale community testing capacity.

The main lesson I would take away is that, having built this global-scale diagnostics capability, we now test more people than any other country in Europe. Having built this, we must hold on to it, and afterwards we must use it not just for coronavirus but for everything. In fact, I want to have a change in the British way of doing things: if in doubt, get a test. That does not just refer to coronavirus but to any illness you might have.

Why in Britain do we think it is acceptable to soldier on and go into work if you have flu symptoms or a runny nose, thus making your colleagues ill? I think that is something that is going to have to change. In future, if you have flu-like symptoms, you should get a test for it and find out what is wrong with you. If you need to stay at home to protect others, you should stay at home. We are peculiarly unusual and outliers in soldiering on and still going to work. It is the culture that, as long as you can get out of bed, you should still get into work. That should change.

This year, there have been far fewer respiratory and other communicable diseases turning up in the NHS. I think that is partly because of social distancing. The social distancing measures have an impact on the transmission of other diseases as well. I want this massive diagnostics capacity to be core to how we treat people in the NHS, so that we help

people to stay healthy in the first place, rather than just looking after them when they are ill.

Q532 **Taiwo Owatemi:** Given that we had university labs that were open and that local authorities wanted to help, did you not think that was something we should have learnt from, and that we should have brought them in much earlier than was done?

Matt Hancock: We did that to a large degree. There were some concerns that we should have gone further. I will explain the answer as to why we did not do that.

What we did was to bring in the capacity that universities had, in particular their lab machines. The universities were brilliant in helping us to build the first Lighthouse lab in Milton Keynes. The challenge around testing, though, is not just the machines and the lab itself. It is the whole logistics chain, from getting a test near to somebody, or indeed by post, through to getting the result sent to them and digitally into their patient record. The logistics around testing are huge, and are in fact far more complicated than the actual testing device itself, once you have the machine.

The challenge with the university labs and other labs was one of scale. It was to scale up at the pace we needed to scale up. Essentially, we needed testing laboratory factories. We are now increasingly using the university capacity, but that is because we have such capacity in the mass Lighthouse labs that we are able also to stitch in the smaller scientific capacity. It was about scale.

It is a bit like PPE, when people complained to me that they could produce 10,000 gowns and we did not give them a contract. It is just a matter of scale. We were trying, and we absolutely succeeded, to drive a massive expansion in scale. For that, we needed huge labs.

Q533 **Dawn Butler:** Picking up on the last bit you mentioned, I think there was an issue with the communication systems used in the laboratory centres that you built and the universities and established Public Health mechanisms that slowed down progress, communication and functionality.

I wanted to talk about—

Matt Hancock: I absolutely acknowledge that. Another lesson and another benefit that countries like South Korea had was that they had the IT systems in place to be able to do a lot of this. Building those IT systems at pace has been a huge and very difficult effort.

Q534 **Dawn Butler:** What proportion of contact tracing is carried out by local teams?

Matt Hancock: I will try to find the figures for you. We publish figures on contact tracing every Thursday. The broad picture is an increasing proportion, because we are getting the contacts to local teams as early as

we can. I am pleased that we built massive central capacity for contact tracing as well, because otherwise we simply could not have coped with the scale of contact tracing needed. If you talk to my international counterparts about contact tracing, and we do, the ones who do not have a central system are absolutely tearing their hair out. You need the massive central system and the boots on the ground who really know the local area. The key is the stitch-up between the two.

Q535 **Dawn Butler:** We have found now, as a lot of people said at the beginning, that local tracing systems are much more effective than the national ones. For instance, my constituency in Brent has a good programme that they are rolling out. How much additional resource has been provided to local authorities to help with the rolling out of the programme?

Matt Hancock: An additional £8 per resident per council has been passed over to support this effort.

Q536 **Dawn Butler:** How does that compare with what was given to private companies for contact tracing?

Matt Hancock: A lot of that is, in turn, spent on private companies to do local contact tracing. If you want to get a public/private split, you have to look at a different set of figures because you are looking at who is employed directly by a public authority, as opposed to who is brought in by contract. I can get that split, but it is immaterial. What matters is the service that you are delivering.

Q537 **Dawn Butler:** I agree. It seems like the local service has been better than the national service.

Matt Hancock: No; it is the combination of the two that works. One of the reasons that the local service can work a lot better is of course that there are boots on the ground, but it cannot do that without the national system taking the big numbers. What happens is that the national system is the first to get engaged. They cover off around 60% of the contacts.

Q538 **Dawn Butler:** They do the easy ones—

Matt Hancock: Not necessarily. It depends on the circumstances of individuals. For instance, the local system does care homes. Care homes are much easier to contact trace than almost any other setting. The local system does schools. If one person in a bubble in a school tests positive, everybody else in that bubble is a contact, and obviously that means that, if you just look at the raw percentages, the numbers look like you have done an amazing job. Contact tracing a school or a nursing home is easier than contact tracing individuals, and those are largely done by the local area. That is why this unfortunate attempt where some people try—I am sure you won't—to imply public sector good, private sector bad, or local good, national bad, is completely counterproductive when we are trying to save lives.

Q539 **Dawn Butler:** I think it is more that you get much more value for money with the public sector. It is much more effective, reaching 80%, whereas the private sector costs a lot of money and averages out at about 48%. I think that is the comparison.

Matt Hancock: I have described why those figures are not the right way to make the comparison. It is just unfortunate, and I put on the record, after that exchange my thanks to all those working in private sector contact tracing. I really dislike it when people try to do them down.

Q540 **Rosie Cooper:** Secretary of State, we hear about potential concessions being made if you test negative several times a week, and possibly a major reduction to isolation procedures if you test negative daily. Is there the funding and the capability to deliver that in reality across the UK? Can we actually deliver it rather than it being just a wish list?

How can we establish the security and identity of the person being tested? How is that assured? We might get a situation where somebody gets their test done and it is the wrong individual.

Matt Hancock: Two great questions. I am going to ask Jenny Harries to come in on this because the scientific advice behind it is important as well.

On capability, the answer is that we can only do this because of the enormous testing capability that we have built, as we heard earlier in the discussion, from almost nothing at the start of the year. That is thanks to the unbelievable private sector companies that have done amazing science and produced these testing capabilities. We have the test capacity.

Your second question asks about the challenges, logistical arrangements, identity assurance and making sure that we get the tests to the right people. This is currently being trialled, from this week, in Liverpool. We will then roll it out to NHS and social care staff. Should those pilots go well, in January we will roll it out nationally.

We have the test kits; that is in hand. The hard bit is the logistics. The point about identity assurance is very important. We will want to know that people are doing the test. The evidence is that, when people test positive, they are much more likely to isolate. The isolation figures that the Chair referred to earlier do not distinguish people who have actually tested positive themselves. The evidence we have is that people who themselves have tested positive are much more likely to follow self-isolation, not least because they may well be ill. All the points you raise are part of the challenge of rolling out the programme. I will bring in Jenny on the science.

Jenny Harries: None of those is formally in use as a national measure at the moment, partly because they are undergoing very stringent evaluation. The usability and feasibility of tests in the field is part of understanding the scientific value of those tests.

Having said that, they actually look very good—for example, where they are tested in specific settings, whether it be schools or workplaces. Obviously, there is a degree of oversight in a potentially higher-risk setting, or a community focus that allows data to be collected. All the data from positive tests will be linked back to the national PHE data system. That is a critical point.

All of the tests have to comply with the UK standard, to ensure that the tests are only those that will deliver the right results. There are numerous lateral flow devices that have run through initial testing—over 130—but only a handful come out at the other end. Particular research has gone on with the London School of Hygiene and Tropical Medicine around—

Q541 **Rosie Cooper:** Forgive me for interrupting. The question was about whether we have the capacity to actually deliver that testing regime, where we are telling people to get tested several times a week or maybe every day. Following on from that, if you have tested negative twice in a week and you suddenly get symptoms, the lure of the football match you want to go to on Saturday might cause you to get somebody else to take the final test, or somehow get round the system. How do we distinguish between reality—what we can deliver on the ground—and what is essentially a wish list, and how much does it rely on the Army and external forces?

Jenny Harries: The important thing is that exactly those issues need to be worked out, which is exactly why the pilots are being run. So far they have been very successful and are potentially of particularly good use in care home settings for testing healthcare workers there.

Matt Hancock: I was going to say exactly the same. This is why we are piloting them, to answer all the questions that Rosie asks.

Chair: We are going to move on to the question of public messaging.

Q542 **Neale Hanvey:** I would like to pick up on a question on testing, Secretary of State. It relates to several media appearances where you have stated that the lateral flow tests have a high degree of specificity and accuracy. Can you explain or set out the reasons why you have that confidence?

Matt Hancock: Yes. In fact, Jenny Harries has just set it out. We put lateral flow tests and potential new technologies through a rigorous programme at Porton Down. Over 100 new tests have gone through that programme, but at the latest count fewer than six have been approved. We have published the results, so that is why we can have that confidence.

Q543 **Neale Hanvey:** What is your view on the reported variables in that success rate in the *BMJ*, where they highlight that the accuracy and specificity of the test—in other words, its success—is based on the environment in which the test is conducted and by whom? They say that the high degree of accuracy results are conducted in a lab with specialist

staff, whereas, when it is conducted by healthcare staff or other staff outwith that controlled environment, the success rate drops to 50%. I am a bit concerned. In giving the public confidence that this is a robust test, do you think you are overegging it a bit by saying that it is 99.6%, when actually the real-world efficacy is around 58%?

Matt Hancock: The point that you raise is an important one: what matters is the sensitivity and specificity of tests when used in the field. I do not recognise the figures that you raise, not least because, after having tested the new generation tests at Porton, we then put them through rigorous field testing. For instance, we tested 5,000 of the first lateral flow devices alongside 5,000 PCR tests of the same people at the same time, in the field. That gave us confidence in the assessment of the tests. You are quite right that what matters is what happens in the field, not in the lab. I am glad that the team went through the same assurance process as well.

Q544 **Neale Hanvey:** Would you comment on another article in the *BMJ* from last week, where they characterised the current strategy as "an unevaluated, under-designed and costly mess"?

Matt Hancock: My assessment of that description is that it is wrong.

Q545 **Neale Hanvey:** You don't have any concern about the in-field accuracy dropping to 50%.

Matt Hancock: That is not the basis of the results of all the testing that we have done.

Q546 **Neale Hanvey:** I appreciate that you are basing it on the 99.6%.

Matt Hancock: No, that wasn't—

Q547 **Neale Hanvey:** What I am asking is, do you think it gives an accurate representation of the programme to the general public when we can see that the accuracy of the actual results, which are published in the *BMJ*—these are not my figures—is somewhere around 50% or 58%?

Matt Hancock: No. As I was saying, the reason we have gone through this validation is in order only to use tests in which we have confidence, and to use them for the right purpose.

The difference between assessment of a test whose purpose is to find out if somebody is currently infectious, rather than whether they have or have had the disease, is important. A test that is calibrated to find out if somebody is infectious can have an important purpose, especially if it is easier to use in the field, but you would not use it for other purposes where you might want to know if somebody is not yet infectious but may potentially have the disease. There are different tests that have different use cases. I do not know if Jenny wants to come in on this point as well.

Q548 **Neale Hanvey:** Let me give another example. Of 96,000 people without symptoms who were tested in Liverpool, only 842 of them went on to

have a positive test. Given that those people generally have a high viral load or are actively shedding to some degree, what check has been done on the sample of the 96,000 people who did not test positive to establish whether they were carrying the virus and were infected?

Matt Hancock: That is exactly—

Chair: I will bring in Jenny Harries on this point, and then I am going to move on. Jenny Harries, do you want to address that point?

Jenny Harries: It may be helpful if we send in a note afterwards to explain this, because it is quite technical for public viewing. I think what the Member was saying was about their use in different disease prevalence in different communities. Certainly, that is a point of the feasibility of testing.

These tests vary between 57% and around 75%, depending on whether they are experienced users or not. Where they are being used in healthcare settings, that is absolutely fine. Where they are used systematically, for example for a visitor who continues to visit a care home regularly, that is likely to be very good as well. The specificity is around 99.5% as opposed to a gold standard of 99.95%.

All of those things are absolutely taken into account, and the comparator is that they will work very well over the infectious period. Often, a PCR test picks up small amounts of viral disease, but it does not mean that the individual is necessarily infectious. All those things have been considered, and we are happy to send a separate note afterwards to confirm.

Chair: That would be very helpful. Thank you very much.

Q549 **Sarah Owen:** Secretary of State, was Eat Out to Help Out a mistake, especially at a time when Covid-19 cases had already begun to rise?

Matt Hancock: You always have to balance the needs of all the different considerations, the economy and the hospitality sector in particular, with the direct impact of NPIs. That is what we do all the time. Obviously, supporting the hospitality industry has been a very important part of trying to get through this, in particular over the summer, when the number of cases was incredibly low and many people could enjoy hospitality outdoors.

Q550 **Sarah Owen:** You talked about the economic impact, but in places like mine in Luton North we got the lowest money from Eat Out to Help Out—only £25,000. You claimed nearly double that in takeaways for your own team. I am just going to ask a couple more questions about Eat Out to Help Out, and whether you believe that that was the right thing to do for the health of the nation.

In making big policy decisions like Eat Out to Help Out and the restrictions in the tier structures that will soon follow, will you consider publishing risk, impact and possibly transmission assessments for places

like restaurants, pubs, gyms, schools and outdoor activities?

Matt Hancock: Jenny can speak to the science around the transmission of individual places, but I want to pick you up on one thing. I have not claimed for anything.

Q551 **Sarah Owen:** I asked you specifically whether you will publish risk assessments for places like restaurants, pubs, gyms, schools and outdoor activities.

Matt Hancock: I was going to ask Jenny to come in on the already enormous amount of published information.

Q552 **Sarah Owen:** I am sorry, but publishing those assessments is within your power and not Jenny's.

Matt Hancock: I am terribly sorry. First, I was answering a specific accusation in the first question, which I reject. You mentioned the amount of meals that we provided in the Department, and for the NHS, by the way, during the peak. I will defend to the death the fact that when people are working seven days a week, 18 hours a day, it is perfectly reasonable that we should feed them. I think my team are amazing and they have pulled an amazing shift this year. They deserve to be fed while they are doing that work. I joked on the radio that this is probably the best value for money food that you could ever buy because it allowed the people who were working so hard to tackle this pandemic to keep working.

As for the accusation—I don't know whether it was intended or not—that I personally had claimed for anything, it is completely wrong. I have absolutely no personal interest in any of this, other than saving lives for the nation. Having said all of that—

Q553 **Sarah Owen:** In terms of saving lives for the nation, will you publish risk, impact and/or transmission assessments for things like restaurants, pubs, gyms, schools and outdoor activities, particularly when you have big policy decisions like Eat Out to Help Out?

Matt Hancock: I was going to come on to that other part of your question and ask Jenny Harries to describe the evidence that we have already published in this space. The reason I am doing it that way is that we already publish a huge amount of evidence, as much as there can be. The evidence is not perfect, because this is an imperfect science.

Q554 **Sarah Owen:** Why didn't you publish the risk or impact assessment on Eat Out to Help Out before taking that decision?

Matt Hancock: We make decisions based on what we think is the best balance in a difficult circumstance where the evidence base is imperfect. Maybe Jenny can set out the evidence base that we have, which we extensively publish.

Jenny Harries: Thank you, Secretary of State. One of the points to answer in response to that question is the timing of our knowledge. Over the time period since the start of the pandemic, it has become increasingly clear, for example, that aerosol transmission, and therefore ventilation, is a really important part of managing risk with this infection.

At the start of the pandemic, we could make general statements that would recognise in public health terms about being in close proximity to individuals in an environment with poor ventilation, particularly in the winter, and you are there for social reasons—the classic example would be a bar or a pub. What we know now, going forward, is that we have more evidence accruing over the summer period that leads us to recognise particularly that the increased likelihood of aerosol transmission is very much associated with things like singing and speech, which tends to be louder in social settings, aerobic activity, and places where you are not wearing face coverings. It is particularly where you are eating and where you are at the gym and at parties and family gatherings.

There is a mechanical element to the risk associated with this. The triangulation is to say, "What happened in those areas, and in those tiers, where different interventions have been put in?" What we find, looking back, is that in areas where there have been hospitality interventions we can see there has been some impact. There is direct epidemiological evidence, which again is difficult because you are looking at clusters of disease. People often do not remember precisely where they have been or how many people they have been with. They often translate that through to, "I was at home," which is the place where you spend most of your time. Where that has been looked at in detail, right across the world in Japan, Hong Kong and in Seoul, where there are large clusters, we see the association between hospitality and leisure venues and cases.

The gold standard is looking at genomics, where you are actually tracking a particular virus backwards. Where they have done that—for example, in the States at CDC Atlanta—you broadly find a risk ratio of about 2.8 to 3.8 in relation to hospitality settings.

Chair: Does that answer your question, Sarah?

Q555 **Sarah Owen:** It does. The only other question, Dr Harries, is, what role do you think the Eat Out to Help Out scheme played in the imposition of the current national lockdown?

Jenny Harries: I cannot answer that. As the Secretary of State said, obviously it was a summer month period and that is very different from now. From a public health perspective now, for a hospitality setting, going into winter, where people are indoors and ventilation is much lower, is a much riskier time period.

Going back to some of the earlier comments, it is very difficult, because, as we all recognise, there are behavioural elements, modelling elements

and mental health elements as well. It is quite difficult to produce one quantitative assessment of that.

Q556 **Paul Bristow:** Secretary of State, the Treasury's chief economic adviser has said that no specific estimate of the economic impacts of non-pharmaceutical interventions has been made. Is that correct?

Matt Hancock: It would be a matter for the Treasury. I have no reason to think that she is wrong.

Q557 **Paul Bristow:** There is obviously a balance to be struck over restrictions. That applies again regarding the treatment other than health conditions. Are you confident that the NPIs will be shown to be beneficial overall?

Matt Hancock: 100% I am, yes. If I answer the question in a different way, of course we understand the economic impact of the NPIs. Of course we do. In fact, in the Cabinet papers that are prepared for the decision-making meetings, a description of the likely economic impact is made. The first question you asked was specifically about quantifying that. It is really hard to do that, but we of course understand the impact and feel it, and take it into account.

In a way, that is why we tried to run the tiering system for as long as possible, until it became obvious that we needed to go to a national lockdown. If rates are very low in one part of the country and not rising, I would not want to impose NPIs on that area that are not necessary. One of the insights behind why I came up with the tiering system in the first place was to try to protect some parts of the country from having NPIs that are necessary in other parts of the country, but not there.

The new tiers are calibrated to be firmer, especially in tier 3, than the previous set, in order to make sure that we have the tool to be able to get cases down. My answer to your question is, yes, we know, and we understand. We feel the economic impacts—of course we do—but the quantification is extremely hard.

Q558 **Paul Bristow:** Do you think deaths averted or quality of life years saved are the only relevant factors? Do you not think, perhaps, unprecedented harm to freedoms and liberties in our normal life should be part of those considerations?

Matt Hancock: Yes, I absolutely do. I think you have to consider all these things. This comes back to the debate we were having at the start of the session about following the science versus being guided by the science. The medical science is only part of the equation to come out with the best judgment that you can. Sometimes people overestimate the amount of information there was, especially in the early days. Of course, decisions impinging on freedom weigh heavily on me, and certainly on the Prime Minister. The economic impacts are obvious. I came into politics to try to improve economic chances for people. That was the background that led me here. Now I find myself doing this.

The reason I can say 100% that I think the NPIs have been necessary is that we know that if the cases go up, and R is above 1, ultimately that is exponential and that means they will go up more and more sharply. The inevitable consequence of that is that we will bring in strong NPIs to bring it down, and that has a bigger economic consequence. Therefore, the lesson of hit it hard and hit it early is an important one.

Q559 **Paul Bristow:** I have personally seen quite a lot of anecdotal evidence, and even experienced some anecdotal evidence, that Covid has been recorded as a factor on a precautionary basis, often without proper evidence, on death certificates. Are you confident that death certificates throughout this pandemic have always been an accurate basis in assessing prevalence of Covid?

Matt Hancock: It is a serious challenge. The question you raise is an entirely reasonable one. You will have seen over the summer the difficulties we got into over the publication of the deaths measure. The original PHE measure included anybody who had tested positive for coronavirus, which was perfectly valid at the start, but by the summer people were dying of other things, having previously had and recovered from coronavirus. The measures on death certificates are what they are. The chief medical officer, if he was sitting here, would always say that the only true measure is the measure of excess deaths, because that is the one measure that is internationally comparable and that you cannot avoid.

Paul Bristow: Thank you.

Q560 **Dean Russell:** Across my constituency, I have been chatting to quite a few headteachers. They are concerned about the fact that they were not on the priority list—the first 11—for vaccinations. From an economic perspective, schools have helped parents go to work and made sure that grandparents are not looking after young children. I want to get a sense of why they were not on that priority list, and what other support is in place for our incredible teacher workforce.

Matt Hancock: I will give a short answer and then ask Clara Swinson to come in. The prioritisation of vaccines is incredibly important. We take advice from the Joint Committee on Vaccination and Immunisation. Our judgment is that you need to go in order of clinical priority for two reasons: the first is to reduce directly as soon as possible the number of people dying from Covid; the second is that it is the best way to recover economically as well. Stopping people going to hospital and dying from Covid is the quickest way to lift NPIs, which is the thing that will get the economy going.

On the evidence I have seen, teachers are not at more risk of catching Covid than the wider population, but I understand the pressures on teachers in particular of having to isolate if they are a contact. If we manage to get repeat testing working instead of isolation for contacts,

that will be a huge benefit to schools. I hope we can get there in the new year.

Clara Swinson: The provisional prioritisation by the JCVI is based on age and is also for health and care workers. Like any other adult, a teacher under 65 who is at high risk would be covered in the one to 10, but, as the Secretary of State said, on the basis of the rest of the population. JCVI will assess each individual vaccine as it comes on, and all being well, if the vaccines come through, the Government have procured enough both for those in the first provisional prioritisation, and then we will need to move on to prioritisation for those under 65, the rest of the adult population.

Q561 **Dean Russell:** To take that slightly further, I mentioned that schools had enabled parents to go to work. One of the things that caused a huge number of days lost in the workplace this year was the impact on mental health. One fact that I saw earlier this year, which I wrote about, was that over 32 million days of unpaid leave were taken in the UK, equating to £4.2 billion in losses. That was due primarily to sickness leave related to mental health. That risk will go forward in the next few years. I want to understand how mental health is being prioritised by the Government and the Department to support all those who are affected by the pandemic this year.

Matt Hancock: It is incredibly important. The Minister for mental health has set out more detail, in the last few hours, about extra support we are putting in to support people. There are undoubtedly mental health impacts of lockdown and, very sadly, some quite serious mental health impacts of coronavirus itself, because in some it can be a neurological condition. It is a very serious challenge, and we are putting in extra funding to support colleagues in the mental health field.

Q562 **Dean Russell:** One thing that has emerged over the past few months is the severe impact of long Covid. What level of research is being undertaken at the moment on what the very long-term impacts of long Covid might be? I appreciate that it has not been around long enough to know all the details, but what measures are being put in place on both the research and the treatment side?

Matt Hancock: Long Covid is really serious for some people. It is a problem we have to support the NHS to address. We are doing that both through funding from the National Institute of Health Research and the NHS itself, which has now opened a long Covid service. I think eight centres are already open, and 40 will be open by the end of the year covering all parts of England. The NHS in Scotland, Wales and Northern Ireland is also working on that.

It is very difficult. As you say, the science is very early. There is also a very wide array of symptoms, so it is quite hard to get to the bottom of it, but it is very serious for those who are impacted. My heart goes out to them. It is an incredibly frustrating position to be in, especially if you are

nine or 10 months on from having had Covid and are not getting better and, typically, are exhausted most of the time, often with associated pain or neurological conditions. It can be really debilitating.

Chair: We have had a lot of correspondence on that. Thank you for the support of your officials in trying to get to the bottom of some of those issues.

Q563 **Greg Clark:** In its minutes on 21 September considering the lockdown measures, SAGE said, "Policy makers will need to consider analysis of economic impacts and the associated harms alongside this epidemiological assessment, and that work is currently underway under the auspices of the Chief Economist." Are you one of those policy makers? Are you part of the decisions as to how lockdown measures are imposed?

Matt Hancock: Yes, of course. That is a precise formulation of being guided by the science.

Q564 **Greg Clark:** There is SAGE advice and other advice; you referred to engineering advice. Given that you are part of the policy-making team that makes those decisions, have you seen the economic advice?

Matt Hancock: I have seen the economic advice that is prepared ahead of those meetings. The previous discussion we had on this was based on its being incredibly hard to have a numerical estimate of the impact of any measure, not least—

Q565 **Greg Clark:** But there is advice. There is written advice and papers that you can get.

Matt Hancock: There is written advice in the Cabinet papers.

Q566 **Greg Clark:** Why can't we see it? We see SAGE papers; they are published. Our Committees called for them, and that resulted in the publication of all the papers SAGE considers and the minutes of its meetings. Given that it has been very clear that there is a stream of pure scientific advice and very important other assessments, why should they not be published?

Matt Hancock: Cabinet papers are not typically published to protect decision making.

Q567 **Greg Clark:** Why should they be more protected than SAGE papers?

Matt Hancock: I would make a distinction. The SAGE papers are the result of a discussion of the scientific community on SAGE, which then comes to the chief medical officer and the CSA. The CMO and the CSA then put their advice in Cabinet papers to us, as the decision makers in Cabinet, typically Cabinet Committees. Those papers are not published, quite rightly, because Ministers need to have the space to make decisions.

However, having said that, on the economic front, while it is harder to put the figures on the economic impact, you also need to consider the counterfactual. The counterfactual in economic impact is even harder to work out than the direct impact of the measures.

Q568 **Greg Clark:** All the more reason to see the assessments that have been made. The counterfactuals are important in scientific advice as well.

Matt Hancock: Yes, but, on the economic side, the problem is that if the virus gets out of control you need to bring in other NPIs.

Q569 **Greg Clark:** Why is it a secret, Secretary of State? We have important debates in this House. SAGE themselves have said that it is important to consider the economic impacts and others. Scientists publish their advice. Why shouldn't you publish the other crucial advice that pertains to these very important decisions affecting the whole country and all our constituents?

Matt Hancock: I think it is reasonable for Cabinet Committees to be able to be served papers by the civil service, guided by the science, on which they make decisions, that are not fettered by the thought that they may soon be published. It is a long-standing convention of how you run government that there has to be a protected space for decision making.

Q570 **Greg Clark:** The Prime Minister made a statement yesterday about a new set of tiered restrictions. Have you considered the economic and other impacts of the different tiers that are proposed?

Matt Hancock: Of course we have considered that, yes.

Q571 **Greg Clark:** But have you?

Matt Hancock: Yes, of course.

Q572 **Greg Clark:** So you have been part of that.

Matt Hancock: I consider that as part of coming to a view about what we need to do. The way I think about it is this: it is critical in a tiered system for it to work that we have R below 1—

Greg Clark: No one is doubting the—

Matt Hancock: I was going to come to the economic point.

Q573 **Greg Clark:** Can Parliament not be taken into your confidence in the way that it is with the scientific advice that is given to you?

Matt Hancock: The advice forms the basis of those Cabinet papers. I see the Cabinet papers for the economic assessment, and I think it is reasonable that they should be written without the expectation of imminent publication.

Q574 **Greg Clark:** Do you challenge and question that advice?

Matt Hancock: Yes. What I was trying to say in a slightly too long-winded way in my previous answer—apologies—was that what we are trying to pull off is the set of measures that will get R below 1 that has the minimum damaging economic impact; otherwise, if you don't manage to get R below 1, you have an even more damaging economic impact.

Q575 **Greg Clark:** No one at all doubts the intention, but we want to be reassured that policy is being taken on a rigorous basis. In terms of challenging and questioning the advice, on 31 October, Halloween, Sir Patrick Vallance presented a slide that included a scenario in which there would be a peak of 4,000 daily deaths. Had you seen that slide before it was presented?

Matt Hancock: I had seen it and I understood it to be what it was, which was one of four different projections.

Q576 **Greg Clark:** But it was out of date, wasn't it?

Matt Hancock: It was clear and it said so on the chart, and I took that into account, along with everything else.

Q577 **Greg Clark:** Did you question whether it should be presented to the public on that date?

Matt Hancock: I thought it was a reasonable judgment for the CSA, not for me.

Q578 **Greg Clark:** Even though there was other more recent advice, part of your challenge was not to suggest that the more recent data should be used.

Matt Hancock: I thought that presenting a series of options was important because it made it absolutely crystal clear to anybody listening to that presentation that these things are not certain. We are not dealing in a world where we know exactly what the consequences of each decision will be. You have to deal in a world of uncertainty. That is one of the biggest challenges of the whole pandemic.

Q579 **Greg Clark:** It has been useful to see that advice and there has been some scrutiny of it, but we do not have the chance to do that with the economic advice and the other assessments. Will you consider making that available to Parliament?

Matt Hancock: I will talk to the Chancellor about it.

Q580 **Barbara Keeley:** I have a few questions on visits to care homes and on Covid and people with learning disabilities. On visits, why has it taken more than a month to begin the pilot of regular testing for care home visiting, when vulnerable people with dementia have been denied visitors for so long already, and when will we see the roll-out of visits to other areas of the country?

Matt Hancock: We have those pilots running now. There has not been a delay; it has been about getting it out as quickly as can safely happen.

The debate about visiting in care homes has to take into account both sides of the equation. Sometimes, I think the public debate is only about the restrictions against visiting. There is also the vital importance of protecting people who live in care homes from Covid, which we all understand. In the second peak, the proportion of people living in care homes who died was lower than first time around. These are some of the lessons that we learnt. We have to act carefully and cautiously. I hope that the roll-out will be available to all care homes by Christmas. That is the goal we are working to.

Q581 **Barbara Keeley:** Public Health England recently published data suggesting that people with learning disabilities are six times more likely to have died from Covid-19 than the general population, yet the response so far from Ministers is that there will be a review of that report. What action can we expect on the level of disparity in deaths from Covid among people with learning disabilities?

Matt Hancock: Ensuring that we protect people with learning disabilities is absolutely critical, and we look into it in the same way as we look into all of those who are more affected by Covid. In a second, I will ask Jenny to come in.

The critical part of that analysis, before we get to the policy, which I will come on to, is to make sure that you also take into account comorbidities. After age and sex, obesity is one of the other major factors, and there are other comorbidities that we have to take into account. However, even taking all those comorbidities into account, there is higher prevalence of mortality from Covid among people with learning disabilities. We consider that when we look at the clinically extremely vulnerable group and the support we give them. It is through—

Q582 **Barbara Keeley:** People with learning disabilities are not clinically extremely vulnerable. One of the points you might want to take into account is that care staff working with people with learning disabilities did not get access to regular testing until at least September. The report from Public Health England has been out for some time. I feel there has not been any attention paid to the needs of people with learning disabilities; certainly, testing was not rolled out.

Matt Hancock: We discussed the capacity of testing earlier in the session. People talk in the abstract about the capacity for testing. One of the reasons it matters is to be able to do, as we did in September, exactly what you say, and also roll out testing to enable visiting in care homes. Testing capacity really matters.

Q583 **Barbara Keeley:** It is not just care homes. A lot of people with learning disabilities live on a supported basis in the community and there has not been community testing.

Matt Hancock: Of course.

Barbara Keeley: Those people weren't prioritised, were they?

Matt Hancock: What matters is the clinical risk. I want to pick up a couple of things. You asked me a question about care homes, which is why I answered about care homes. When it comes to the clinically extremely vulnerable, there isn't a blanket view that all those with learning disabilities are extremely clinically vulnerable, but there are groups where vulnerability can be assessed. It is worth bringing in Jenny Harries because this is her area of specialism. She has done an incredible amount of work trying to get the best possible support.

Q584 **Barbara Keeley:** To clarify, my first question was about care homes. This question is about people with learning disabilities, and they do not all live in care homes. Some of them do. Quite a lot of them live in mental health units.

Jenny Harries: I am very familiar with the PHE report; I reviewed it myself. There was also the LeDeR report, published recently by NHSE, which was more a qualitative assessment of deaths among those with learning disabilities, but nevertheless was an important source. In fact, the Minister for Care asked the SAGE care sub-group that I have chaired since July to look at both reports, which I think we did last Friday, or very recently, because of the potential importance of the information.

There is one very basic point that we all need to learn going forward, which is that the data is extremely unreliable. That is not to get away from the findings of the report, but a key point going forward for learning disabled populations is to ensure that primary care data on learning disability is strong, particularly on ethnicity. The reason I mention that is that it makes it very difficult to understand the true risk inherent in some of the data presented. The PHE report is very much extrapolated data, because that is the only way it can handle it. A really important point about learning disability going forward is around the data.

Some learning disabled people, not all, fall within the clinically extremely vulnerable group because they have other conditions with learning disability, so they will be picked up with the clinically extremely vulnerable. One of the key issues about both of those reports is that the data does not distinguish well enough between those with Down's syndrome and those with other learning disabilities. Down's syndrome is one where we have already acted and ensured that, where we have seen increased risk, those individuals—they are adults—are currently being moved over into the clinically extremely vulnerable group. I hope it is reassuring that they are being actively looked at and acted upon. We definitely need better data going forward, and we will keep monitoring that.

Q585 **Barbara Keeley:** To go back to visiting, it is not just about older people. Many families of people with learning disabilities in care homes or mental health units are not able to visit. There are a lot of blanket bans on visiting for the families of younger people. At a meeting with families last week, I was told by a mother that her son's social worker had to ask the care staff in a home to bring her son to the window so that she could

check he was still alive.

Who can check on the care being delivered in those places when there is a blanket ban on visits? There was real concern among the families I talked to that they were not allowed to visit and check on the care being delivered. Secretary of State, you and I know that there are very high levels of inadequate care for that group of people.

Matt Hancock: Formal responsibility for the system falls to the CQC, who have the—

Q586 **Barbara Keeley:** Who haven't been inspecting during the pandemic. They haven't been inspecting.

Matt Hancock: They have access and they are able to inspect. The reason I said "formal responsibility" is that a huge amount of the checking and looking after people in those settings is done by families and loved ones. I hope we will be able to get them visiting soon.

Q587 **Barbara Keeley:** Would you make that a priority, because it is an important commitment?

Matt Hancock: Yes.

Q588 **Chair:** I want to follow up the issue of potential discrimination against people with learning disabilities. The vaccine guidance issued by the JCVI says that all older people, including healthy 65-year-olds, have to get the vaccine before anyone with learning disabilities under the age of 65 gets it. Could you look into that? I know that vaccine guidance is continually under review, but can you look into that and let us know whether, on the basis of some of the questions you have heard, that is something you will reconsider? For people with learning disabilities, who have a much higher chance of fatality from Covid, that feels discriminatory.

Matt Hancock: Yes. In fact, I have already asked Professor Van-Tam, our clinical link to the JCVI, to consider exactly that question. JCVI is, rightly, an independent clinical group, but it is totally reasonable for my clinical advisers to ask them questions and I have set that in train.

Q589 **Laura Trott:** When you were last in front of the Committee, Secretary of State, I asked you about parental access to neonatal units. Bliss, which is a charity that supports premature and sick babies, still reports limited access for parents. What is being done to address that?

Matt Hancock: It is incredibly important. We changed the national guidance to the NHS to allow for and encourage visiting. I think that guidance should be followed.

Q590 **Laura Trott:** In cases where units are not allowing parents unfettered access, what is the process for fixing that?

Matt Hancock: The process for fixing that is that it is a responsibility for NHS England and NHS Improvement as, essentially, the regulator of hospitals. We need a continued drive to open this up and use testing to

give people additional assurance that having a partner with you can be done in a safe way.

Q591 **Laura Trott:** Is a testing regime being considered for parental access to neonatal units and paediatric wards?

Matt Hancock: Yes, it is being considered. We are not there yet, but I hope that we can get the clinical protocols signed off.

Q592 **Laura Trott:** What would be required to do that? Is there any reason why it is being held up versus, for example, visits to care homes?

Matt Hancock: In the same way that visits to care homes are being piloted, we will need to make sure that the clinical protocols are signed off so that it is safe, and then the logistics of roll-out in this case should be relatively straightforward because they are hospital settings.

Q593 **Laura Trott:** Do you have a timeframe for that?

Matt Hancock: I cannot give you a timeframe today, but I will write to the Committee when we have managed to establish one.

Q594 **Aaron Bell:** Following up the very first question the Chair asked at the start of the session about the impact of a vaccine on the future of NPIs, you said in general terms that you hope to release them. The reason most healthy people have been prepared to follow the NPIs and make the sacrifice is that they understand their responsibilities to the most vulnerable in society.

How far down the priority list do we have to go before we can start to take off those NPIs for everybody else, because when you get down to point 7—moderate-risk adults under 65 years of age—and once we have vaccinated them, doesn't the case for the NPIs dissolve? At that point, people could take their own risks about seeing others, socialising and all those sorts of things.

Matt Hancock: That is absolutely the goal. A couple of things make it challenging in practice. The first is that, when you say vaccinate, that has to mean both doses and a short period after the second dose, so it is not immediate. The Pfizer vaccine requires two jabs 21 days apart; the AstraZeneca is two jabs 28 days apart. There is a bit of time that we need to go through.

We will need the vaccination programme to deliver to all those people, but, should we manage to get the number of deaths and hospitalisations down sharply because of the vaccination programme—if the vaccination programme works, and we should have confidence that it will because it has in the clinical trials; it is the safety data, and that data, that needs to be checked by the MHRA—we will get to the point where we are protecting the most vulnerable. Then the argument for more personal responsibility in how we respond to this rather than NPIs, particularly NPIs that damage the economy, society or wellbeing, is where we will get to.

Q595 **Aaron Bell:** Does that mean that we will have to tolerate higher overall case rates if we are confident that the case rate among the most vulnerable is effectively zero or close to it because of the vaccination programme?

Matt Hancock: This thinking underpins us saying that we think we will start to get back to normal after Easter. A case rate in lower morbidity and mortality groups is obviously less damaging to everybody. For instance, the risk and the problem with the big student outbreaks in September is that it gets into the wider community. That was exactly what happened in places like Nottingham and others. Once you have given the opportunity to protect older and more vulnerable people, the public health rationale, particularly for strict and damaging measures, is reduced. It is exactly the balance we talked about earlier in the session.

An important consideration is that there is long Covid too, which affects people irrespective of age. If the vaccines reduce transmission of the virus, we may get to a point where enough people are vaccinated that the virus stops transmitting, because on its own, or with non-damaging NPIs, if you like—washing hands, and so on—it brings R below 1. Then the virus will not be able to take hold and you will not even get the long Covid consequences because you will not get the case rates. Even on the grounds of just protecting those most at risk, there is a case for the argument you put in terms of removing some of the most damaging NPIs, but there is an even better option—we do not know whether it will come to pass, but it might—that on its own, with basic hygiene and the no regrets NPIs, the vaccine gets R below 1. If that comes to pass—I am not predicting it, but I am explaining that it is one potential outcome—that is brilliant for everyone.

Q596 **Aaron Bell:** I want to get a final answer on the first question I asked. Is there a particular category of people you want to get to on the priority list before you consider we have protected the most vulnerable? Is it down to point 7—moderate-risk adults under 65?

Matt Hancock: The JCVI advice is that we should go down to point 10.

Q597 **Dr Evans:** As this is lessons learnt, I am interested in looking at the positive legacy and the future, given everything we have been through in the pandemic. On the legacy side, when you came before us you talked about the role of telemedicine and referrals to A&E, particularly, as something that might stay in the future. Could you update us on whether that is likely to be the case?

Matt Hancock: That is a really important part of the work we are doing. Learning the lessons from what did not go well is important, but learning the lessons from what did is sometimes easy to forget in the circumstances, but absolutely critical.

On telemedicine, we should keep the benefits we have gained. The proportion of telemedicine dropped back by a couple of percentage points, which tells me that we have settled at about the right level; for

instance, about 45% of primary care appointments are now by telemedicine. Before, everybody knew it should be higher. Now the question is, what is the right level? That feels about right to me.

We have also made big advances in the NHS on reducing bureaucracy. I am publishing a paper today on busting bureaucracy in the NHS, taking forward measures that we have learnt through the crisis are important for helping people to get on and do their job in a safe way, but without some of the layers of bureaucracy that had built up, and taking forward some of the proposals that had been developed but not yet put in place by the NHS. Those are two things, but there is a whole range of things we have learnt that have gone well.

Q598 **Dr Evans:** Is there a dedicated team looking at that? Going forward, millions of people have signed up to an app that, hopefully, we will not need to use in the summer. We have a testing capacity that you hinted at with the super-labs coming on, and an army of volunteers who signed up to support the NHS. I believe there is a ten-minute rule Bill today about using that and keeping some NHS reserves. Are plans in place? Do you have a dedicated team looking at all the positive things we can take forward that will make the NHS better?

Matt Hancock: Yes. I will bring in Clara in a second. My strategy team in the Department looks at all of these things and of course I work with the NHS on it. I can tell you now that the app has over 20 million unique downloads, which is absolutely superb. We have built the diagnostic capacity, and it is critical that we keep that and have a long-term diagnostics industry.

Q599 **Dr Evans:** Are you planning a use for that app now that we have 20 million people signed up?

Matt Hancock: I hope we can get more people. I was going to come to this. As well as telemedicine, which in a way is the most obvious use of digital technology in medicine, I want to ensure that we use the crisis to accelerate the engagement of all citizens, or at least the vast majority, with their healthcare through modern technology. You would not do that directly through the Covid app because it is anonymous, but people are far more engaged with their health. We can use some of the technology we have had to build, and that we talked about earlier, to help to ensure that patients are more engaged with their healthcare and can easily access the data around their health care, and that we have better and appropriate data sharing within the health system that can save lives.

Q600 **Dr Evans:** I asked you in the House about the potential of doing the equivalent of virus drills in care homes. That was after this Committee heard evidence about what happens in Hong Kong. Is that something the NHS will consider taking forward to implement? Like fire drills, we would have a virus drill, particularly in care homes and vulnerable settings.

Matt Hancock: In care homes, it would not be for the NHS. Nevertheless, it is a terrific idea, and I will give it to my team that takes forward ideas like that to see if we should put it in place afterwards.

Q601 **Graham Stringer:** Secretary of State, why have you decided, when you are imposing different tiers on regions, not to negotiate with locally elected representatives?

Matt Hancock: The reason we are doing it differently is that in most cases when we negotiated with most areas in the previous tiered arrangement we had a high-quality discussion that led to better outcomes. A case in point is Liverpool, where the case rate has fallen by over two thirds in the past three weeks. In fact, Joe Anderson texted me during this hearing. He has done a magnificent job, and the teamwork between the national team and the local team was of very high quality. Unfortunately, that was not the case in all local areas.

Q602 **Graham Stringer:** Are you talking about Greater Manchester?

Matt Hancock: That would be one example, but not the only one. Sadly, in the case of Greater Manchester, cases carried on going up while we were trying to put in place the measures that were necessary. Instead, we have proposed a set of tiers that are fixed, a set of measures within the tiers that are fixed, and also financial support agreed by formula rather than negotiation.

We will of course engage with local authorities. Some of that engagement is going on today, ahead of the Gold meeting and the decisions that will be announced on Thursday. We will engage with colleagues as well. I had a Zoom meeting last night to which all cross-party MPs were invited. We will have that engagement, but what we will not have is a two-week long negotiation while the cases still go up, which is bad for public health.

Q603 **Graham Stringer:** Will you be publishing the precise criteria that determine which region goes into which tier?

Matt Hancock: I addressed this in the House yesterday when I was standing in for the PM. We have set out the five indicators that we will look at, but we cannot credibly put a set of statistics on those because, when you are looking at five different measures, you have to take into account the basket and the cap, because there can be circumstances where there is an individual case. I mentioned yesterday a case at a barracks, where the problem was confined literally to barracks and it would have been unreasonable to follow an automatic process based on fixed thresholds. That is why we have come to the decision we have.

Q604 **Graham Stringer:** Will you publish a cost-benefit analysis for each region?

Matt Hancock: We publish all the data that underpins the decision we make. My goal is to ensure that we publish the data on which the decision is made, and we publish the decision and an explanation for that

decision so that people can understand why we have had to take the decisions.

Q605 **Graham Stringer:** That does not include a cost-benefit analysis.

Matt Hancock: By its nature, it will include the considerations we have taken into account.

Q606 **Graham Stringer:** So it is not a full cost-benefit analysis. The point I am coming to—I understand the difficulties, where you have a very tight infected group of people, of transposing that into hard criteria—is that you will end up making political decisions and you are not going to negotiate with elected politicians. So how would I as an outside observer be able to tell that you are not just practising arbitrary government?

Matt Hancock: Because we are going to publish the data on which the decisions are made and explain those decisions. Those decisions are not political, but they are ministerial in that they take into account all necessary considerations.

Q607 **Greg Clark:** Will those decisions be scientifically informed, particularly to reflect real patterns of community and movement, not arbitrary administrative boundaries? For example, in the case of Kent the movement in west Kent is up and down to London and across to East Sussex, which is very different from the north Kent coastal area. Will that be reflected rigorously in the decisions that you make?

Matt Hancock: Yes.

Q608 **Dawn Butler:** During this lessons learnt evidence session it is important that we know what went right, so that we can do more of it, and that we know what went wrong, so that we can stop it and never do it again. *Byline Times* published the official Government records of meetings. One of your Ministers at the Department of Health met Topham Guerin to discuss Test and Trace marketing. I am a bit confused as to why you refused to answer this question at the evidence session on 21 July. Either you do not know what is going on in your Department, or you did not send further clarification, as the Chair suggested you could do, or you deliberately misled the Committee. Which one is it?

Matt Hancock: I have not deliberately misled the Committee. I do not really understand the previous—

Q609 **Dawn Butler:** On 21 July, I asked you about the involvement of Topham Guerin with Test and Trace in the Department of Health, and you said it had nothing to do with the Department. I am looking at the ministerial records. One of your Ministers met with Topham Guerin to discuss Test and Trace marketing, so it has got something to do with your Department.

Matt Hancock: We meet an awful lot of people. We meet people who can help us to tackle this virus. As far as I understand it, Topham Guerin is an organisation that can help understand public sentiment and public

views. The public's views are a material factor in how successful a public health intervention can be. It is not just about taking the decisions we have been talking about and implementing them; it is about how the public respond.

Q610 **Dawn Butler:** I totally understand, so do you know of the involvement of Topham Guerin and what they have done for your Department?

Matt Hancock: No.

Q611 **Dawn Butler:** They were given £1.5 million to do marketing for your Department. They must have done a good job because that contract has now been extended, and they have been given another £1.5 million. They were given £3 million in total. It is really important that we understand the role that Topham Guerin have played in the Department and that you inform the Committee what they have done and how they have done it, so that we know whether we have received value for money. Your Minister, Lord Bethell, said that lots of contracts had been given by informal arrangements. I wonder whether Topham Guerin were given this contract because they worked on the Conservative 2019 election campaign.

Matt Hancock: As I say, Topham Guerin is an excellent organisation. We use all sorts of excellent organisations in the Department of Health, and understanding the public's response to the actions that were taken is absolutely critical. I do not think there is any issue at all.

Q612 **Dawn Butler:** Thank you. It is interesting that you say it is an excellent organisation.

Matt Hancock: There is also a point about formality. All contracts in the Department are properly signed off, and that is done by the brilliant civil service team, taking into account the conditions at the time.

Q613 **Dawn Butler:** Secretary of State, I think the recent report of the National Audit Office says something very different. In fact—

Matt Hancock: On the contrary—if I can respond to that point—the National Audit Office report demonstrated that within the Department there are sign-off steps that make sure, even though we had to move incredibly fast to save lives, that all contracts were signed off properly and appropriately within the civil service, within the rules. The fact that the National Audit Office is able to audit all of these contracts demonstrates the transparency of the system within which we operate.

Q614 **Dawn Butler:** The National Audit Office said that not all the paperwork it needed was present to enable it to follow the trail of contracts that had been issued. There are two points I want to make. You said that Topham Guerin is a great organisation. It has been found that, during the general election in 2019, 88% of their most shared adverts online between 1 and 4 December contained misleading information. I am not sure that quite qualifies them as a good organisation.

To go back to the National Audit Office, it said that a company was put in the high priority lane by a mistake. How is that possible?

Matt Hancock: The National Audit Office report, contrary to what you have just said, explained that it was able to look at all the contracts signed. I think it is a strength of the British system that the National Audit Office can do that. There was a massive amount of work to get PPE to keep people safe. I am absolutely delighted that the National Audit Office found no evidence—

Q615 **Dawn Butler:** How can a company be put in a high priority lane by mistake?

Matt Hancock: Because all requests went through all of the appropriate stages of procurement—

Q616 **Dawn Butler:** This company went on to get a £350 million contract.

Matt Hancock: Many businesses went on to deliver services for the NHS.

Q617 **Dawn Butler:** But it was done by mistake and it did not deliver.

Matt Hancock: I am terribly sorry to disappoint you in this, but all requests went through the proper procurement process. Of course, that procurement process was the emergency process rather than the normal one because we were in an emergency. In terms of the particular route you talk about, we absolutely prioritised credible offers to make sure that they could be—

Dawn Butler: Secretary of State, how do—

Matt Hancock: If I could finish the answer to the question, we prioritised credible offers where we found them and we took in credible offers from all comers. In fact, we did a public call to arms. We had support and proposals, which were looked at, from members of the Labour party and members of the Liberal Democrats. The BMA were brilliant; we worked with them. We worked with the RCN. We worked with anybody to make sure that we could get as much, in this case, PPE as possible in those contracting arrangements, and that is all borne out by the National Audit Office report.

Q618 **Dawn Butler:** Nobody is denying that it was a difficult job. Nobody is denying that it was a mammoth feat to get to where we are, but if we are to learn the lessons we have to be honest about what has happened.

Matt Hancock: That is right, and we are, and the National Audit Office, I am delighted to say, is able to come and audit all these things.

Q619 **Rosie Cooper:** It is reported that four Treasury civil servants are leading the health and social care taskforce. What involvement and input do you have with that taskforce, and will the Government publish its terms of reference and the minutes of its meetings to allay fears that there are secret plans to reorganise the NHS?

Matt Hancock: The policy on the NHS is set by the Department, in close consultation with the Prime Minister, No. 10 and, where relevant, other Government Departments.

Chair: There is lots to be unpacked in future sessions. Secretary of State, you have been very generous with your time this morning. There is a lot on. We are very grateful to you and to Clara Swinson and Dr Jenny Harries for joining us this morning. Thank you very much indeed.