

Health and Social Care Committee

Oral evidence: Coronavirus: recent developments, HC 1121

Thursday 7 January 2021

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Members present: 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.

Questions 1 - 41

Witnesses

I: Rt Hon Matt Hancock MP, Secretary of State, Department of Health and Social Care; and Clara Swinson, Director General, Global and Public Health, Department of Health and Social Care.

Examination of Witnesses

Witnesses: Rt Hon Matt Hancock MP and Clara Swinson.

Q1 **Chair:** Welcome to a special Health and Social Care Select Committee evidence session, following this week's new national lockdown. We are incredibly grateful to the Secretary of State for Health and Social Care, Matt Hancock, for attending at very short notice. With him from the Department is Clara Swinson. Thank you both for coming this afternoon. We have a lot of questions to get through in a short time, so I will get cracking.

Secretary of State, could I start with the timing of the decision to enter the third national lockdown? I think most people understand why it was necessary to take that decision but wonder why it was taken as late as Monday. Was there not evidence the week before? Would it not have reduced the spread of the virus to have made the decision before primary school children went back for just one day?

Matt Hancock: Thank you, Chair, and thank you for facilitating this hour. I am very glad that we have been able to put it in place at such short notice.

Clearly, the decision was absolutely necessary. We had been increasing, as you know, the geographic coverage of the tier 4 restrictions over the weeks preceding the decision to go back into a national lockdown. We saw—we could all see—the growing number of cases, especially starting in London and Kent and Essex, and growing out. We moved rapidly on a number of occasions over December, but by 4 January it became absolutely clear that we needed to do this nationally. In addition, the four CMOs across the whole of the UK took the national alert level to level 5, and the four Governments all took further action at that point to slow the spread of the virus. What really matters now is that people stick to those rules and restrict human contact wherever feasibly possible.

Q2 Chair: If you look at what we knew the week before, we knew that the number of Covid hospital patients had exceeded the number of those in the first wave, SAGE had said that the R rate would be unlikely to fall below 1 if schools went back, and cases went up by 57% in just one week. Did we have to wait until Monday? Could we not have taken that decision on Thursday or Friday of the previous week?

Matt Hancock: We act fast. When we saw the very sharp rises in rates that weekend, we acted on the Monday. In the week preceding it, the case data included the fall-off in the number of people coming forward for testing over Christmas, so the data was less clear. What happened was that, as the data came through in the post-Christmas period, it became extremely clear.

None of these are easy decisions. The health consequences of the decision are absolutely clear, but you have to weigh all the consequences, and it is a heavy balance on both sides of the ledger.

Q3 Chair: May I ask you about border control? We know that was a key part of the response for many countries in east Asia right from the outset, but here, even now in the third lockdown, there are reports of people landing at airports without being checked or reminded of quarantine rules. Why do we not just insist on pre-departure PCR tests, as Singapore and South Korea do?

Matt Hancock: The first thing I would say is that we have a targeted approach to control at the border. For instance, we have full restrictions on anybody coming back from South Africa. The only people who can come into the UK if they have been to South Africa in the last 10 days are British nationals coming home, and they have to quarantine, as in fully stay out of contact with other humans, unless those other people also go into that quarantine—members of their household, for instance.

We brought in similar measures with respect to Denmark earlier, because of the new variant that was found that had come through mink. There are areas of the world where we have strict self-isolation and quarantine requirements, and other countries, which have a lower case rate than we do generally, where the restrictions are less onerous—the so-called travel corridor list.

We take a risk-based approach. After all, if there is a country where the case rates are lower than the UK and people travel here, especially if there is no evidence of new variants, there is not necessarily any higher risk from somebody coming here. The higher risk comes when there is a higher rate abroad or when there is a new variant abroad.

Q4 **Chair:** It is curious that we are still not doing as much as the South Koreans and Singaporeans so long after.

Because there is not much time, I want to ask one final question on care homes. They are asking whether the rules could be changed to allow care home workers to do lateral flow tests at home before arriving for work, to avoid the risk of people hanging out together when they all arrive for a shift at the same time. Could you look into whether that is possible?

Matt Hancock: As with the previous question, it is something I am open to. In this case, it is an MHRA decision. The MHRA has given NHS staff the dispensation to do lateral flow tests themselves because of their clinical experience. They have not yet given that approval for home testing for social care staff, or indeed for the rest of us, but it is something we are working on.

Q5 **Chair:** Would you be happy to look into that with them and write to me with whatever you conclude?

Matt Hancock: We are looking into it, but it is an MHRA decision and, as you know, they are rightly and fiercely independent.

Chair: Indeed.

Q6 **Barbara Keeley:** My questions are around communications. Many people are concerned by the news that we are changing our vaccine dosing regime to leave a 12-week gap between the two doses. I want to ask you about how that change was communicated. Can you set out for us why you chose not to announce it at a press conference with experts like the deputy chief medical officer or the JCVI? They could have set out in full why that change had been made and what evidence they had which meant that it was an appropriate change to make. As I see it, we have been in a situation where we have comments from bodies like the World Health Organisation, and others, publicly disagreeing with our approach. Surely, it would have been better to set out our position in full to give people confidence that the vaccines would still work with that new dosing.

Matt Hancock: Actually, this was addressed at a press conference on the day it was announced, or rather there was a press conference on the day the change was announced. It was the day, 30 December I think, that the Oxford-AstraZeneca vaccine approval by the MHRA was announced. We have communicated a huge amount since then, both publicly and privately, with communications, for instance, from Jonathan Van-Tam, who has written very clear pieces about why we have acted, and privately to MPs, to make sure that medical briefing is available.

The reason and the justification is really clear and straightforward, which is that it saves more lives. Ultimately, that is the public health

justification. I think it is why there is so much buy-in to this approach. The data show that there is significant protection from both the Oxford and the Pfizer jabs after the first dose. Once you know that is true, given that we have as much supply as we have coming into the country, and being manufactured in the country, of the two doses, you want to use that as effectively as possible to save lives, so it is a public health justification.

Q7 **Barbara Keeley:** I understand. I think we have all been through it enough in terms of trying to find solutions. It was really the communications point, because, clearly, we have all been in a situation of being deluged with queries from the public about it. Let me move on. I understand that issue.

Matt Hancock: Absolutely. I want to pick up the WHO point that you made, though. The WHO were clear in saying that they understood why we took the action that we did. In fact, what they said, and I will read it out, is: "SAGE made a provision for countries in exceptional circumstances"—this is the WHO SAGE; they have a SAGE too—"of vaccine supply constraints in epidemiological settings to delay the administration of a second dose for a few weeks in order to maximise the number of individuals benefiting from a first dose." That is precisely the justification I would give.

Q8 **Barbara Keeley:** Another issue around communication has been about the necessity of certain decisions and the basis on which they have been taken. To give you an example from this week, we know that scientific advice favoured closing schools, but nurseries were left open. It does not seem that there has been an attempt by the Government this week to communicate why they are treating nurseries and early years settings differently, and what evidence underpins that decision. What are you doing to give people reassurance, and publishing not only the evidence underpinning closures but the reasons for leaving other things open?

Matt Hancock: This is an incredibly important point and an important question. We publish the positivity rates by age. We all know that children, thankfully, are highly unlikely to get ill with this dreadful disease. We also know that pre-pubescent children are much less likely to have any degree of disease and the positivity rate is lower, and it is lower still for very young children, for nursery age children. That is the reason we took the judgment that we did.

We often talk about thanking teachers, and of course thanking NHS and social care staff, but nursery staff do a very important job looking after children and helping key workers and those who cannot work from home to get to work during what is a very difficult time. Ultimately, it is a balance of risks.

Q9 **Barbara Keeley:** Can I ask you one final question about communications? I gather that Brexit means that young people like Alfie Dingley, who are taking prescribed cannabis products for epilepsy and other conditions, can no longer have their prescriptions filled within the

EU. Their families only found that out when your Department sent a letter to pharmacy suppliers. The way that your Department has dealt with this has been called "lazy" and "flippant" by the campaigner Professor Mike Barnes. Can you comment on this communications issue and why these medicines are now being denied to people? What could be done to replace those prescribed drugs, because young people with serious medical conditions might now be pushed back into the conditions they had before finding the drug that worked for them?

Matt Hancock: As you know, I have worked hard on this issue—

Barbara Keeley: Yes, I know you have.

Matt Hancock: —and we have improved supply. This is actually a decision by the Dutch Government, and we are obviously working very closely with them to try to change the position. It is not a decision that we can unilaterally change as the UK. We are looking in the short term at an urgent legal fix, and in the medium term working with the Home Office, and of course the Dutch Government, to try to find a way through.

Barbara Keeley: Thank you. Could you look at how you communicate that, though, because the parents and campaigners are feeling out of it? It is important that you reach out to them. I will leave it there because other colleagues want to come in.

Q10 **Laura Trott:** Thank you, Secretary of State, for joining us. I want to take us forward, if everything goes to plan, to talk in a bit more detail about what the situation will look like in the country, and what that will mean for restrictions.

You have outlined very clearly that we are trying to get to a situation whereby we have vaccinated the first four groups, which account for four fifths of the death rate. By that logic, by 1 March, two weeks after you have vaccinated those groups and we would expect immunity to kick in, do you expect deaths in this country to fall by four fifths of their current rate?

Matt Hancock: That all depends on the case rate. Of course, there are two lags that make the modelling slightly more complicated. There is the lag from taking the vaccine to getting the protection from the vaccine, which clinicians estimate at two to three weeks; and the lag from cases to deaths, which we see in the figures, and which, sadly, has remained stubborn. Although new treatments and improvements in clinical practice have reduced the mortality of Covid-19, still the number of cases going up inexorably leads to the number of deaths going up before the vaccine programme can be fully rolled out to those who are most vulnerable.

With those two caveats on the modelling, I am as confident as I can be, based on all the clinical advice that I have seen, and all my own reading of the data, that the number of deaths in this country will fall, for any given number of cases, once the vaccine is rolled out to the vulnerable groups. We are aiming for this by 15 February, and to have offered a slot by 15 February for a vaccination to everybody in cohorts 1 to 4. Cohorts

1 to 4 cover just over 85% of all those who have died from Covid in the pandemic so far.

Q11 **Laura Trott:** What do you expect to happen to hospitalisation levels?

Matt Hancock: I would also expect hospitalisation levels to fall but, ironically, not as quickly as deaths in the first instance. The reason is that people who are slightly younger spend longer in hospital, often because they survive, when somebody who is very old and frail might not survive for as long. I would expect hospitalisations to fall, but I would expect to see the number of deaths falling faster at first because of the way we are taking a very targeted approach in the vaccine roll-out to vaccinate those who are most vulnerable first; that is the over-80s, care home residents and, of course, the NHS staff and care home staff who look after them.

Q12 **Laura Trott:** Understood. When you approach relaxing the restrictions, obviously everyone admitted to hospital for coronavirus is a huge worry, but what is the level of hospitalisations at which you think we will be able to start to relax restrictions?

Matt Hancock: I do not quite look at it that way, and the reason is twofold. First, we have set out the conditions that we will look at for the relaxation of the NPIs—the restrictions—which are that there isn't another major new variant of the disease that causes difficulties, that the vaccination programme is working and that the number of hospitalisations and deaths is coming down. I do not have a fixed number for any one of those four in my head, if you see what I mean. We do not have fixed thresholds on it, but you can see the direction of travel.

Q13 **Laura Trott:** Understood. What do you expect the situation to be with mass testing as we move into the end of February and March, and how will that play into our being able to relax the restrictions?

Matt Hancock: Mass testing will continue to be very important. Mass testing, and crucially the isolation that comes with it, is a very important factor in keeping R down. The lower the total number of cases, the more effective mass testing can be at keeping the R rate down. But even as we release restrictions, and even as we have vaccinated the most vulnerable, mass testing will be incredibly important, especially for people of working age, until we get the vaccination programme all the way through the entire adult population, which is of course our goal but will come a bit later. Mass testing will continue to be important.

There is another way to answer the same question, which is that there are two things that mass testing does. One is surveillance: understanding where the virus is and how fast it is growing. The ONS study is the most important part of our surveillance, but our genomic surveillance, where we do half the genomic testing in the world, is incredibly important as well. That is one part.

The second part is testing, essentially, for behaviour change, which is testing so that people know they have the disease and therefore must isolate, and ensuring that their contacts isolate through the

contact-tracing system. Both of those will continue to be important for the months to come.

Q14 **Taiwo Owatemi:** Secretary of State, I am a pharmacist, so can I ask you to explain why community pharmacists were not considered initially in the roll-out of the vaccination scheme? There are five points that should have been considered in how our profession is able to carry out these vaccinations. The first point is experience in the storage of the vaccination. Community pharmacists, as you know, have experience in monitoring fridge temperatures and ensuring that drugs are stored at the right temperature. They should have access to patient information, which we do, and we have the ability to determine whether a patient is eligible or would have any allergies. Thirdly, they have to have had the appropriate training and they have to have continuous training, which pharmacists have every year. Fourthly, they have to have experience in vaccination, and this year alone pharmacists have done 2 million flu vaccinations.

Lastly, and this is one of the difficulties you have been having, they have to have close proximity so that patients can access their services. Given that 90% of the population are about 20 minutes' walk away from a local pharmacist, as pharmacists, we were surprised that we were not in the Government's mind in the initial vaccination programme, and at the fact that we have to apply for something that we have more than enough experience to be able to do.

Matt Hancock: Thank you very much. I am a massive supporter of community pharmacies. I think they do an amazing job. You set that out in terms of the job they do for the flu vaccine. In fact, that has been growing since I have been Health Secretary and, indeed, under the previous Health Secretary; the number of flu jabs done through pharmacies has grown.

Because of the -70° storage requirement, the Pfizer vaccine was not appropriate for community pharmacy, but we are now expanding the number of pharmacies that are going to be delivering the Oxford-AstraZeneca vaccine. Because we have to make sure that the vaccine we have goes as far as it possibly can, and because it comes in packs—the Oxford-AstraZeneca vaccine comes in packs of 800 to 1,000—making sure that we have throughput at the sites is very important.

The good news is that we are confident that we have enough delivery sites coming on stream. Whether it is the hundreds of GP sites that are already set up, the 200 more that are coming on stream this week, the over 200 hospital sites that will go up to 270 in England, and more in the devolved nations, or the mass vaccination centres, seven of which will open next week, with the 200 pharmacy sites as well, we are confident that we have those sites. We will keep working with community pharmacy to see whether we can expand that, to see how the roll-out goes, and which of the different types of sites are more effective.

There is a particular role that community pharmacy will be able to play and where they will have a particular advantage. The roll-out has to be a universal roll-out as much as possible, and we need to make sure that we get to all communities. Community pharmacies, precisely as you said, are highly engaged in their local community, often more local than any other healthcare setting, and therefore will be able to support getting right into the communities we need to reach. GPs can do that well, too, and indeed are already doing it, but there is a big role for community pharmacy, especially in making sure that we reach all parts with this vaccination roll-out.

Q15 Taiwo Owatemi: From what I understand, once the vaccine has been delivered to a vaccination centre, it can be stored for up to five days in a temperature of 2° to 8°, which most community pharmacies are able to do. That is to do with the Pfizer vaccination, and it means that initially we should have been part of that plan because that is the right storage temperature once it is to be given.

Matt Hancock: For Pfizer, it can be stored for only five days at 2° to 8°, but that includes the time to get it from the hub to the site. When a box of 975 Pfizer doses goes to a GP surgery, they have three and a half days, by the time it gets there, to use it. You need that throughput of people to use it and to ensure that there is no wastage. The Oxford one is easier and hence is more appropriate for community pharmacy, and they will be involved in the next stage of the roll-out. We are piloting it this week to make sure that the processes are right, and that will start next week.

Q16 Taiwo Owatemi: My next two questions are based around conspiracy theories and some rumours that have been going around regarding both the vaccination and the Nightingale. The first question regarding vaccination is: can you agree with me that, for the Government to reach their 2 million target, there has to be public trust and confidence in the roll-out? One question that many members of the public have been asking is why there is not a dashboard available that provides up-to-date vaccination information within people's local area, for them to determine and for them to understand how the vaccine has been rolled out. Given that we did that with the testing, when are the Government planning to roll out a dashboard for vaccination?

Chair: Could we make that a brief answer, Secretary of State, because we have to move on?

Matt Hancock: The honest and true answer is that, as we grow this programme, we are going to put more and more information into the public domain. When you start a big programme like this, the first thing to do is get the straightforward verified information—how many vaccines you have done. We started it on a weekly basis. We are moving to a daily basis. We will put out more and more of that sort of information as the programme grows.

Chair: Thank you.

Q17 **Dr Evans:** My questions are around risk. The Covid alert level 5 definition is, “material risk of healthcare services being overwhelmed.” What is your assessment of the absolute risk to the NHS at the moment as a percentage? Are we 10% or 50% likely to hit this in the next two weeks?

Matt Hancock: It is impossible to put a number on it. I do not mean that as a cop-out. I mean that in reality. What happens, and you know this better than anybody being an NHS doctor, is that as the pressure on the NHS grows, so it is more stretched in delivering the services that people need. We have seen in this second peak that areas have had to cancel routine electives, first, the so-called P4 electives—those where a delay may be uncomfortable but is not a problem—and then P3, where they really ought to be done in the next three months but it is okay if they are delayed a little. That is the pressure people have—

Q18 **Dr Evans:** Secretary of State, you probably saw the leaked document about what is going on in London. Do you have every faith that we are able to cope in London in the NHS?

Matt Hancock: Yes, I am sure the NHS is going to do everything it possibly can to ensure that everybody gets the care they need. First, in London we built significantly more critical care capacity over the summer. We spent the summer extending critical care capacity. We also have the Nightingale on stand-by. There were some rumours that it had been decommissioned. They were wrong. The Nightingale is on stand-by. Of course, the Nightingale is the physical capacity, but we also need the people, hence bringing people back into the NHS. Ultimately, when hospitals are busy and full, clinicians become more stretched. That is why we should all be so grateful for the service that they are giving.

Q19 **Dr Evans:** Laura Trott made some points earlier about the ambitious plan to get 13 million vaccinated, which is fantastic. You have talked about the 85% change in the risk there. Do you have a concern about what that means for the population who are not vaccinated, who do not see the virus as such a risk, and how they will behave?

Matt Hancock: We always have to monitor these sorts of behaviours. What I would say though is that, especially in this national lockdown situation, people are, by and large, very respectful of the rules. There are some people who break the rules—of course there are—but, generally, compliance has been good. That is very important because it is the only way we can control this until we have the vaccine rolled out.

When the vaccine is rolled out more broadly and vulnerable groups are protected, I hope that people continue to be respectful, and take personal responsibility for trying to reduce the spread of the virus, because that way we can lift more restrictions.

Q20 **Dr Evans:** Professor Whitty talks a lot about the fact that society is going to need to have a discussion about risk, a bit like we do in traffic—what is the right speed limit and how we approach dualling carriageways and things like that. What conversations are happening in Government around facilitating this? When do you see it coming into play? Many

people in hospitality and other businesses will be thinking that, when the vaccine comes, we need to get back to normal. When is that right point going to come? I appreciate you cannot answer that directly, but the discussions are really important in how we feed in.

Matt Hancock: I think we need a national discussion about it, frankly. Of course, the Government have a view, as do clinical advisers to Government and politicians, because, ultimately, these are political judgments in the best sense, as in weighing very big concerns and balancing big judgments, based on the best clinical advice. Parliament has an important role, and indeed this Select Committee will have a very important role, in balancing considerations of how we deal with this over the medium term.

We have seen that with the new variants. It is likely that when a new variant comes—thankfully, there is no evidence of one that will escape the vaccine, but should that happen—we will need to iterate the vaccine in the same way we do for flu. It is totally normal for flu. We have done this for decades. That is where this will end up, but the path of getting from here to there, taking into account all the other impacts—the economic impacts and the other health impacts of the actions we will have to take—is, ultimately, a national debate.

Q21 **Sarah Owen:** Following the death of Mary Agyapong, a pregnant nurse from Luton, her husband Ernest Boateng started a petition that now has over 100,000 signatures, calling for greater protection for pregnant women throughout the pandemic. We saw a doubling of stillbirths in the last lockdown. Are there plans to review the guidance, and for shielding before 28 weeks?

Matt Hancock: This is very much a clinical question. My heart goes out to those who are affected. It is one of the many awful things about this disease, but it is absolutely one where I would take the clinical advice. Dr Jenny Harries leads on this question. In the approach we have taken to shielding, we have learned from some of the negative impacts of shielding first time around, and we have iterated that based on the clinical advice. If there is specific advice to make a change in this area, it has not reached my desk yet. I do not know whether Clara Swinson wants to come in on the details.

Clara Swinson: In terms of the definition of the clinically extremely vulnerable, almost a year into this pandemic we know a lot more about that. As the Secretary of State said, the deputy chief medical officer leads this work, and will be looking at both overall cohorts of people and individuals for a conversation about those most at risk, including pregnant women, if that is appropriate.

Q22 **Chair:** Could she write to us with her latest view on that and whether it has changed?

Clara Swinson: I am sure she could.

Q23 **Sarah Owen:** Secretary of State, there is a big difference between

offered and delivered. How many vaccines are you hoping to deliver by mid-February to the top four priority list?

Matt Hancock: I would love it if uptake was 100%. Ultimately, that would be wonderful. We are not going to let up. We want to make sure that everybody gets this vaccine, unless they have a very specific clinical reason not to; there are some exemptions but they are very rare. I cannot put a figure on it because I want it to be as high as possible.

The point about the exact language of the target is that people will be offered to have had the vaccine. It is not that you might get an offer on the 14th for a vaccine in a couple of weeks' time; it is that you will have been offered to have had the vaccine by 15 February, if that makes sense. I want everybody to take up those offers.

Q24 **Sarah Owen:** So 13 million would have had the opportunity to have had the vaccine by mid-February?

Matt Hancock: Yes. The word "offered" is not there to imply that we could say we had hit the target by writing you a letter—

Sarah Owen: Or posting testing kits.

Matt Hancock: —and making sure that the offer is available. It is that you will have been offered to have had the vaccine by that date. The reason we use the word "offered" is, of course, that if somebody refuses to have the vaccine—I think that is a mistake if they do not have a clinical reason—we are not seeking to mandate vaccination, so I cannot, as Secretary of State, reasonably set a target of having vaccinated all those people, because, unfortunately, some of them will not take up the vaccine even though it is the right thing to do.

Q25 **Sarah Owen:** If a new variant comes that does not react well to the vaccine, what is the plan for the next year or two years, while we are also rolling out the vaccine?

Matt Hancock: We are working precisely on that question. The answer is that, as with the flu vaccine each year, for a given vaccine platform—for a given type of vaccine that has been clinically trialled and approved—if you make small adjustments to it, it may not need the full year-long trials process that a new vaccine needs. That, of course, is a decision for the independent MHRA. The way I have described it in public is that, if you are lucky enough to have a Range Rover and you get a new wing mirror stuck on it, it is still a Range Rover, and it should be classified as such. In the same way, if you make a small change to a vaccine, it is essentially a regulatory clinical decision as to whether that needs to go through the full panoply of the full three phases of clinical trials.

Q26 **Dean Russell:** I would like to ask about some of the long-term impacts. One of the long-term impacts that I am aware of, from speaking to everyone, from schools through to people in the community, and from emails, is the impact on mental health. Could you please outline what measures are being undertaken right now to help support the mental health of the nation?

Matt Hancock: Yes, this is incredibly important. I am acutely aware of the mental health impacts of bringing in a lockdown, to Dr Evans's question earlier and indeed the Chair's at the start. We are putting in place more support for mental health services this year than last, and there will be more to come. I was very glad that, at the spending review, the Chancellor announced more support for mental health services.

In addition, we have to make sure over the medium term that we update our laws on mental health. I can tell you that next week we will be bringing forward the mental health White Paper following Sir Simon Wessely's report, which he published just over a year ago. We are taking on board the vast majority of his proposals and, indeed, adding some further ones. I then hope to be able to legislate a new mental health Act in this Parliament, to replace the 1980s Act, which is now very much out of date. I hope this is a highly consensual process and very much an open book approach. I am sure the Select Committee will have an important role in making sure we get the details right. I am very grateful to the whole team and all the stakeholders we have been working with that we have been able to get to the point where we will be launching that next week.

Q27 **Dean Russell:** That is excellent news and very welcome. Could I ask a bit about the long term? Professor Whitty talked about the vaccine as not one that you take once and that is it forever. We have talked about measures for next year. This time next year, where do you think the country will be? Will we be having a national vaccine roll-out programme? Will we still be testing? Have the economic measures been looked into as well?

Matt Hancock: There is absolutely no doubt that vaccines and testing will still be a feature next year. We will need both the surveillance testing, to be able to understand where the virus is, and we will need testing for people who have symptoms, in the same way that you get tested for all sorts of other things. In fact, I want to have more testing. I have talked to the Select Committee before about the dictum "If in doubt, get a test." It should apply across the board. It should apply to flu and other illnesses as well as to Covid-19 and other coronaviruses.

On the vaccine, I anticipate that we will probably need to revaccinate because we do not know the longevity of the protection from these vaccines. We do not know how frequent it will need to be. It might need to be every six months or every year. With the flu jab we vaccinate every year, and we update it according to any mutations that have taken place. We do that over the autumn because, although you can catch flu in the summer, it is highly unlikely. It is because of lower ventilation and much more time spent indoors that flu transmits more easily during the autumn. I anticipate Covid and flu vaccinations long into the future.

Q28 **Dean Russell:** Looking ahead, to get a bit of relief on mental health and light at the end of the tunnel, do you foresee this being the last of the lockdowns now that the vaccinations are being rolled out?

Matt Hancock: I do, yes.

Q29 **Rosie Cooper:** Secretary of State, how many doses of vaccine have been wasted or unused? Have you considered allowing anybody from the first four tiers to be called in to use those doses, rather than rigidly finishing each tier before starting another, to make sure that nothing is wasted? What is the current position for getting tests for the asymptomatic who are shielding or disabled and cannot get to a centre? Are they still available by post?

Matt Hancock: The answer to the last question is yes. The home channel is working well. We have spare capacity in the testing system, both for PCR tests and lateral flow devices.

On the first two questions on the use of the vaccine and on wastage, obviously we want to minimise wastage. That goes without saying. In the last few days, we have changed the guidance so that if it is possible to draw six doses from a vial rather than the standard five, if you can get six full doses into the syringe, you can do that. In fact, in many practices that is what they are doing. I was at the Bloomsbury practice this morning and they were drawing—

Q30 **Rosie Cooper:** Secretary of State, I am not talking about the number. I am talking about the numbers that do not get into arms. How can we make sure that those six doses are actually used and not wasted? How are you getting the throughput?

Matt Hancock: I was coming on to that, because they are linked. If you can get six doses out of each vial, instead of five, you are increasing the total number of doses by 20%, which is obviously good news.

On the second part of the answer, in terms of making sure that there are enough people to put that vaccine into, the advice we give centres is that they should use any spare doses that would otherwise go off primarily on NHS and social care staff. In hospitals, that is often easy because there are lots of NHS staff around. The primary care networks have links to social care to invite social care workers in at the end of the day, or at the end of a box if they are getting to the point where the time on the box is running out since it was defrosted. In the first instance, while we are currently vaccinating groups 1 and 2, one of the reasons that we are taking groups 1 and 2 together is to be able to ensure that we minimise wastage by inviting NHS staff to—

Q31 **Rosie Cooper:** Secretary of State, I get that. The question was whether we are allowing them to move across the tiers. I am anxious because of time and there are a couple of things I want to get through. The BMA has called for all health and social care staff to be vaccinated by the end of January. You talk as if that is going to happen.

Have you made assessments about the workforce challenges over the next three months? The same exhausted group of people are doing the caring, the nursing and the vaccinating. I hear today the unions have offered help. Are you going to use the Army? How are you going to get

through that quickly? I would appreciate a short answer because there is one final question I would like to ask you.

Matt Hancock: Of course I understand the workforce pressures; hence we are trying to bring more people in. I have taken out a whole series of what I thought were over-burdensome training requirements. You no longer need to do fire safety training and anti-terrorism training to get back into the NHS to do vaccinations.

There is a broader workforce point as well. It is not just about what we are asking the NHS to do in terms of vaccines. It is also about what is happening in our hospitals, which is that there are very significant pressures.

Q32 **Rosie Cooper:** Finally, the Government have increased dental charges on patients and activity targets on practices out of sync from January this year. Dental practices cannot get up to anything like the levels they were because of social distancing and decontamination between patients. That could be reduced by high-quality but expensive ventilation, unaffordable for most dentists. It is clear that dentists are facing an existential threat. Wales has committed £450,000 for ventilation. I have asked about this in Parliament. Other than talking about it, what are we doing to help dentists get back up to scratch? There were 20 million lost appointments last year.

Matt Hancock: We have funded dentists all the way through the crisis. That funding now, unlike in the first lockdown, is partly in return for activity, whereas in the first lockdown dentists were closed but were funded nevertheless. That is the approach we are taking. Of course the ventilation is important and the PPE is free, but I really hope that we can keep dentistry going through this third lockdown, as we did in the second lockdown, rather than closing them as we did in the first.

Q33 **Neale Hanvey:** Clearly, we are not in a place that any of us wants to be. I do not want to go over political points about U-turns and the like, but I want to talk a little bit about the Government's approach and how we forward plan from here, and, hopefully, you will take stock of how we got to where we are.

I understand completely your desire to ask everyone in the Chamber to get behind the Government and to move forward as collectively as possible. I assure you that certainly many of my colleagues and others on the Committee will be doing as much of that as they possibly can. When those appeals to get behind the Government strategy are made, it is very difficult to do that when people like myself, who have significant clinical and management experience in the NHS, or people who are esteemed clinicians in their own right, ask questions that are completely logical and sensible but they are rebuffed in a way that may be considered discourteous at times. That does not really engender a collaborative or collegiate response. How do you feel you may be able to improve that sense of collective endeavour and perhaps give us the kinds of answers that we hope to get?

If I could give you an example, I have had briefings from interested groups today asking me very specific questions that they want answered, but because I struggle sometimes with confidence in the quality of answer I am going to get, I need to talk to you about the way that we operate in this pandemic. I guess my question for you is this: is there any way that you can improve the communication, particularly in the Chamber, so that we feel there is a shared sense of endeavour?

Matt Hancock: Yes. I am absolutely up for that, Neale. I think you have put it well, and diplomatically, if I may say so. Sometimes, debates in the House of Commons Chamber are robust, but, frankly, over Covid it has been very largely about all of us pulling together to try to get the right outcome. After all—you represent a seat in Scotland—the strategies of the Scottish Government and the UK Government are closely co-ordinated and, essentially, the same. There are, of course, adjustments because there are different circumstances, as with Wales and Northern Ireland, but, nevertheless, we work very closely with the devolved nations. In fact, after this I am going to have a call with Jeane Freeman, who is the Cabinet Secretary for Health in Scotland.

The other thing we try to do is talk privately. For instance, on Tuesday morning I held a private cross-party briefing for MPs following the new measures in England. Essentially, the answer is yes, let's work together as much as we can.

Q34 **Neale Hanvey:** In that regard, at the beginning of February, and at the last meeting that we had where you attended, I was assured that I would receive further information on lateral flow tests that would assuage my concerns. I have still not received anything from the Department on that. I still have outstanding and quite significant written questions about the protocols that were followed for the Liverpool study—if I can call it that, because, until I see some research protocol, I struggle to call it a study. The fundamental issue is, will you please attempt to answer questions as best you can in the Chamber rather than get into a combative response that is really not helpful? That is my plea.

Matt Hancock: Yes, there is no doubt I am absolutely up for that. In fact, yesterday, I ended up correcting my Labour opposite number's speech as we went along and made suggestions, which some of the newspapers thought was amusing. Neale, I am up for that constructive dialogue if you are. I will get back to you on the point you made. You should have got your reply by now.

Neale Hanvey: I cannot guarantee you will always like the question, however. It is well intentioned.

Matt Hancock: That is the nature of democracy.

Q35 **Dr Davies:** Thank you, Secretary of State. First, a question about rapid testing. Can you tell us what percentage of frontline NHS staff now have access to twice-weekly lateral flow tests?

Matt Hancock: In England, I am told it is 100%.

Dr Davies: Fantastic.

Matt Hancock: If somebody has not been given them, let me know, but we have supplied 100% to the frontline in hospitals.

Q36 **Dr Davies:** They are yet to roll out in north Wales at all. That is very interesting.

In terms of vaccination, can you tell me when you anticipate knowing whether those who have been vaccinated are still able to transmit Covid?

Matt Hancock: That is an incredibly important question that I do not know the answer to, and I want to know. Obviously, we have a pharmacovigilance programme to follow people who have been vaccinated. It is the hardest question—to find out whether they still transmit—for obvious reasons, but we are studying that. I will write to you as soon as I know when we will know. In fact, I might ask the CMO to write to you, doctor to doctor, with his best estimate of when we will be able to assess that. We will not be able to put a date on it yet, I am sure, but it is about how we get to that assessment.

Q37 **Dr Davies:** That will be much appreciated. The next question concerns the capacity of vaccine production to meet our targets. Do you have concerns over the availability of the vaccines?

Matt Hancock: Obviously, we would all want more vaccine to be available, but I want to be really clear about what the challenge is and where the rate-limiting step is. We have, as we were discussing earlier in the session, hundreds of places across the UK that are vaccinating. That is not the capacity constraint. The capacity constraint is the supply of the approved vaccine. That does not mean there has been a delay, and it is not a criticism at all of the manufacturers. They are working as fast as they can. It is that making this stuff is hard. As I said in the Chamber yesterday, if you are into baking, it is a bit like growing your yeast. It is a biological process. That is the delivery schedule, and we are delivering the kit that we have. That is where the constraint is.

Q38 **Dr Davies:** Understood. Finally, there is huge interest of course in the JCVI priority groups for receipt of the vaccine. I know there are nine groups in phase 1. We are working through them and, hopefully, we will reach level 4 by mid-February, but you will be aware of calls from teachers, from those who work in nurseries, from funeral directors, the police and so forth—essentially, people who have contact with people on a regular basis—to be given some kind of priority. I know currently they feature under phase 2. What is the political process for agreeing the priorities? Do you think there is any prospect that some of those individuals might move up alongside groups in phase 1?

Matt Hancock: The JCVI prioritisation is really clear, and we are committed to vaccinating according to that clinical priority. The order after that clinical priority, essentially for the under-50s who do not have conditions that make them particularly vulnerable to Covid, is not yet decided. I am sure it will be debated, and then we will come to a decision. Teachers and nursery workers have a good case to make, as do

the police and other public servants, and key workers across the board. That is a debate we will need to have and then come to a decision on.

Chair: Thank you. We have been making excellent progress. Last but not least, Paul Bristow.

Q39 **Paul Bristow:** Secretary of State, the BBC has reported that King's College hospital trust has cancelled all priority 2 operations—the operations that doctors say need to be carried out within 28 days either to save life or to stop disease progression. Given NHS capacity issues, is this likely to be repeated in other parts of the country?

Matt Hancock: Obviously, we try to minimise that, but it has happened elsewhere in this second peak, and of course in the first peak as well. It is an indication of the degree of pressure that London hospitals are under. It is a big challenge, and it reiterates the central importance of people following the lockdown and restricting as much as possible the contact they have with other people.

Q40 **Paul Bristow:** There is a time and logistical challenge for our NHS. Will this have an impact on other NHS core services, such as GP availability or GP referrals for urgent treatment such as cancer? What do you think the unintended consequences of the NHS focusing all its time, or a significant proportion of its time, rightly, on the vaccination programme could be on other core services?

Matt Hancock: We have obviously considered this very carefully. One of the reasons we are doing it through groups of GP practices, through the primary care networks, is that most GP practices are contributing to, but not having to take full responsibility for, a Covid vaccination centre. Essentially, groups of GP practices are coming together, with each lending a number of people to create the Covid vaccination team. That allows us to keep many GP services running as normal, but obviously that has to focus on the most important healthcare needs.

Indeed, we took clinical advice on the relative importance of vaccination compared with other things that GPs need to do. The NHS, led by Dr Nikki Kanani, who is the NHS's top GP, is advising GPs on how to do this. Ultimately, a lot of it will be down to the individual judgment of GPs in practices right across the land. It is exactly the sort of judgment that GPs are trained to make, which is how to assess the order of priority of different patients when there is a very large chunk of Covid vaccinations to get through for a whole load of their patients.

In addition, from next week, we will be opening the seven major vaccination centres to be able to get really high throughput and take some of that burden off GPs, as well as using the community pharmacists we were talking about, to make sure that we can get through the vaccination programme as quickly as supply allows.

Q41 **Paul Bristow:** I have one final question. Obviously the NHS is being impacted by staff shortages due to Covid. I am interested to know what effect you feel this is having on the delivery of other core services such

as cancer. You have touched on this already, but just to make it very clear, with that in mind, and staff shortages becoming a feature, certainly in Peterborough, is it time now to prioritise all NHS staff for vaccination in the coming weeks?

Matt Hancock: We absolutely will ensure that all NHS staff are offered a vaccine in the coming weeks, and certainly by 15 February, because they are all in category 2, and therefore that is the target. I very much hope that the uptake among NHS staff will be right at the top level. This year, we have seen a record uptake of the flu vaccine among NHS staff. Over 80% of over 65-year-olds have taken the flu vaccine, which is 10 percentage points higher than last year, which itself was a record high. We are seeing a very high level of take-up. NHS staff will all be offered a vaccine over the coming weeks. I hope we can get through all of category 2, which includes all health and social care staff, sooner than 15 February, but that is the target we are committed to hit.

Chair: Secretary of State, we are very conscious that this is a nightmarishly challenging week for the NHS, so thank you for giving up your time this afternoon. Could you please pass on our thanks to all NHS and care staff, who are going the extra mile and working incredibly hard this week—probably the most challenging week the NHS has ever had? We are incredibly grateful for their service. Thank you for your time this afternoon. I declare this afternoon's meeting over.