HOUSE OF COMMONS

Public Administration and Constitutional Affairs Committee

Oral evidence: Data Transparency and Accountability: Covid 19, HC 803

Thursday 4 February 2021

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Watch the meeting

Members present: Mr William Wragg (Chair); Ronnie Cowan; Jackie Doyle-Price; Rachel Hopkins; Mr David Jones; David Mundell; Tom Randall; Lloyd Russell-Moyle; Karin Smyth.

Questions 295 - 401

Witnesses

I: Rt Hon Penny Mordaunt MP, HM Paymaster General, Cabinet Office; James Bowler CB, Second Permanent Secretary, Cabinet Office, leading the Covid Taskforce; Helen Whately MP, Minister of State for Social Care, Department of Health and Social Care; and Clara Swinson, Director General for Global Health, Department of Health and Social Care.

Examination of Witnesses

Witnesses: Penny Mordaunt, James Bowler, Helen Whately and Clara Swinson.

Q295 **Chair:** Good afternoon and welcome to the Public Administration and Constitutional Affairs Committee. The witnesses and all our Committee members are in their homes and offices across the country. This evidence session is a session in our inquiry into data transparency and accountability related to the Covid-19 pandemic. I am very grateful to all of our witnesses who have given up their time today.

The Committee has heard a lot of evidence from a variety of witnesses, and we would like to test what we have learned with the Government today. I will ask our panel to introduce themselves, starting with representatives from the Cabinet Office.

Penny Mordaunt: Good afternoon, everyone. I am a Minister in the Cabinet Office.

James Bowler: Good afternoon, I am the Second Permanent Secretary in the Cabinet Office.

Helen Whately: Good afternoon, I am the Minister of State for Care.

Clara Swinson: Hello, I am Director General for Global Health in the Department of Health and Social Care.

Q296 **Chair:** Thank you. The Committee has struggled to understand the lines of accountability for the various work strands that form the Government's response to the Covid pandemic. I will first ask James Bowler and Clara Swinson to tell us to which Minister you report in each of your areas of responsibility?

James Bowler: I am Second Permanent Secretary to the Cabinet Office. Therefore, I am line managed by the Cabinet Secretary and I report into the Chancellor of the Duchy of Lancaster. The Cabinet Office forms a secretariat, so I head what is called the Covid-19 taskforce and the role of that secretariat is to bring together all analysis, information and policy for collective decision-making in Government. As such, the Cabinet Committees take decisions on that, and ultimately the Prime Minister.

Q297 **Chair:** Does that taskforce report to the Minister for the Cabinet Office or directly to the Prime Minister?

James Bowler: I guess it reports to the Prime Minister, because it essentially does the Committee structure of which ultimately the Prime Minister sits on top of Cabinet and Cabinet Committees.

Q298 **Chair:** Thank you very much. Ms Swinson.

Clara Swinson: Yes, in the Department of Health and Social Care working obviously with our Secretary of State for Health and then our set of Ministers of State and Parliamentary Secretaries according to their portfolios. I report to my Permanent Secretary, Sir Chris Wormald.

Q299 **Chair:** Ms Mordaunt, in May the National Statistician told us that the virus was receding but not fast enough and we needed to be careful not to cede a second peak. Did the decision to relax national restrictions before summer take full account of the data indicating that it might be too soon?

Penny Mordaunt: Thank you for that question. I think that is probably better directed to the taskforce in Health. I was not involved in those decisions at that time. I have been brought in recently as a Deputy Chair of Covid-O, but only in the last few weeks to deputise when CDL is not able to attend. I have no first-hand knowledge of that particular situation at the time. What I can tell you is what I know of the mechanics of how information is produced, and the Cabinet Office, as James set out, is responsible for the co-ordination—if you like the mechanics—across Government, liaising with the Joint Biosecurity Centre, Public Health England, ONS, SAGE, Government Departments and also local government, importantly. It will put the information into various products, including the Covid dashboard, which people will be familiar with. I am trying to be helpful but I—

Q300 **Chair:** No, I appreciate that. That is fine. We are going to come on to

explore those mechanics in due course, but perhaps Minister Whately could illuminate us with an answer.

Helen Whately: I will do my best for you, Chair. What I can say is that, clearly throughout the pandemic, Government decisions have been informed by the data and informed by expert scientific advice. What we also know is that data doesn't only give you the answer yes or no but it gives you the basis on which Ministers can then make decisions.

With regards to coming out of the first lockdown, I was not involved in those decisions. My role was oversight over the Joint Biosecurity Centre, something that was subsequent to that, and I can talk about the processes that the Joint Biosecurity Centre is involved in, the analysis and the data that the Joint Biosecurity Centre looks at and how it then informs the decisions on tiering, but I cannot go back as far as the first lockdown.

Q301 **Chair:** In which case, can either of the Ministers tell us who at the time was responsible for that decision?

Helen Whately: I am sure the Secretary of State for Health would be able to give you more than I am able to give you at this point.

Penny Mordaunt: Perhaps if I can give you some clarity on the organigram. Ultimately, these decisions are taken and owned by the whole of Government. That is the decision-making body. Normally they are taken at Covid Operations meetings, which are large meetings incorporating the whole of Government. On occasion they will be taken by a smaller group of people, as you would normally do on things like national security issues. The Prime Minister can convene a smaller group. That is the decision-making body. What else you are asking for is: who is responsible for ensuring the right pieces of information are informing Ministers? The responsibilities for that, the co-ordination of that and the quality of that is with the Cabinet Office. We are the mechanics, but it is with individual Government Departments and their particular responsibilities that are responsible for the commissioning, the quality of the data, both quantitative and qualitative, and also the publication of that data, including the agencies and organisations—like SAGE—that they work with. That is the mechanics of it.

Q302 **Chair:** That is interesting. Regarding the quantitative and the qualitative data, how was the data available on potential infections considered alongside other data in reaching that decision? I am not asking who made the decision but, in terms of the mechanics, how was that weighted?

James Bowler: Just on the facts: the lockdown began on 23 March. A roadmap was published on how to unlock on 11 May. That was produced by the Cabinet Office, and collective decision-making was done via Cabinet and Cabinet Committee to inform it.

Regarding the data used, it was a mix of health, economic and social data: level rates and location of infection; core healthcare metrics, with care homes being key to that; mobility data; school attendance; economic data;

and international comparisons. It is worth saying that that roadmap, as it was called, had a staggered set of unlocking coming out of the first lockdown. Schools returned first, on 1 June, followed by non-essential retail on 15 June and hospitality from 4 July thereafter.

It is probably worth saying to set the scene, since that first lockdown and since the National Statistician—with whom we work incredibly closely—gave you evidence. The data and analysis to underpin our decision-making have improved dramatically, I think, in four ways. We have, as of April, a dashboard that is improving daily. It now includes over 100 metrics—

Q303 **Chair:** Forgive my rudeness, Mr Bowler, but we are aware of that. With all due respect, as a Committee, what we are interested in is finding out how decisions are made. You outlined very succinctly for us the measures that were taken into account. My question was asking as to the weighting that was given to them. Does such a weighting exist?

James Bowler: The analysis is presented fairly formally to Ministers, both in briefings and then at the start of each Committee meeting. A strategic proposal is put to the set of Ministers, and they weigh up the various different things, particularly health versus economics. There is no absolute equation or formal weighting that I could give you.

Q304 **Chair:** It is an arbitrary decision. As well informed as it may be, it is a fairly arbitrary decision. Is that right?

James Bowler: It is a judgment.

Chair: If we get into semantics we will be here all day.

Penny Mordaunt: It might be helpful for James to speak a little bit about the analysis and data directorate, because that is a section of the taskforce that he chairs that is fusing all of this information. It will have in it social researchers, data scientists and also, critically, operational delivery expertise. That is where all these bits of information that are coming from Departments are fused. That might be helpful.

Q305 **Chair:** Indeed. As we go through our questions no doubt that will be able to be brought in as part of the answers, but we must put the questions to you rather than have an exposition given by the different Departments of quite substantial information that we are already aware of. We are just interested in the decision-making process. We will proceed with questions.

In that vein, the National Statistician told the Committee that the Government had much better data to understand the virus by the end of September than they did in the spring. Minister Mordaunt, can you tell us what was done to ramp up that data collection and the areas of focus?

Penny Mordaunt: I know that the recommendations that were made to the taskforce and the Cabinet Office, where there were failings in terms of the data that were collected, all of those recommendations were acted on, and I understand that in recent correspondence that has been verified.

James is best placed to take you through each point, but I know that his team have, in effect, received the all clear from the ONS.

James Bowler: The major points were about a local level of statistical knowledge and accessibility. At a local level, the ONS survey has been expanded so that you can get down to a local level of data. The weekly tests have gone up from 3,000 a week to 15,000. The test and trace capacity has now been increased up to a daily capacity of over 750,000 tests, so that data can be delivered at a local level and the dashboard has been massively enhanced to pull together all the metrics in one place where there are now over 100, of which over 60 are at a local level. It has some 1 million users a day, between 800,000 and 1 million users. That is the main response to the National Statistician's points. I am happy to expand on any of that.

Q306 **Chair:** It is very helpful. I personally, and I am sure many members of this Committee, would commend the work that has taken place. The movement that has happened since the onset of the pandemic in terms of the data available is truly impressive. I will put that on the record, but my focus for questions is on how that data is used and by whom. That is the essential purpose of the inquiry.

Just a final question from me before I move to my colleague, Karin Smyth, again from the National Statistician, who in September told us that we therefore had the data so that the Government could make earlier decisions. With that in mind, do you think decisions have been made early enough? Why, for example, was the decision to keep English schools closed after Christmas made only after many children had returned for their first day? A Minister may wish to take that question.

Penny Mordaunt: It is, first of all, very well understood that giving the public, giving businesses, giving public servants as much notice as possible is a good thing. From having seen decisions being taken in Whitehall, I know that that is very much thought through. Where there has been no notice given it is because of a rapidly changing picture. There is always great pressure on Ministers to take the path of least resistance.

All MPs will know how disappointing it is not to be able to have the Christmas that people planned for and other such decisions. Businesses taking on stock in the run-up to Christmas. We are very conscious of those issues. The Government are also trying to keep the economy as open as possible, but people are responding to the data given. Although I was not directly involved in those decisions I understand that there was a substantial concern, particularly around the emerging picture and the new variants.

James Bowler: I was going to make the same point as the Paymaster General at the end there. This is a good example of using data quickly and transparently. Obviously, the new variant that started in Kent was being picked up with the NERVTAG paper at the end of December. That paper was published very quickly, two days or so after it was received by the

Government, which is testimony to making sure that there is transparency on analysis and data out there.

With one of the core findings that the new variant is 50% to 70% more transmissible, it absolutely played into the different approach to schools, which was the right decision and necessary. All of that was happening at a time when we would have wished to have found out at a different time to give more notice, but that was not the case.

Q307 **Chair:** I will put it as fairly as I can—because I realise that the Ministers have to contend with Members of the House of Commons who are not often the easiest people—was that decision made so late because of the amount of political resistance that there was to closing schools as a point of principle?

Penny Mordaunt: I think the answer is no. Clearly, Ministers listen to MPs, colleagues. I will plug my daily calls again: I am available every day at 10 am to listen to parliamentary colleagues to take their feedback on board. The reason why the Government wanted to keep schools open was because it is a good thing for children. I think one of the priorities that the Government have is to get children back into school at the earliest occasion. That was the prime motivation, I think, for the Government wanting to keep schools open.

Chair: Thank you, I would agree that that is entirely the right motivation.

Q308 **Karin Smyth:** I want to talk about lockdown and tiering. If I may just pick up with Minister Mordaunt this issue of advance notification to local people who are dealing with this pandemic and the importance of that, which I totally agree with. Back in July we talked about how the local situation was being thought about by the Government, and we referred back to that in November. On Tuesday, when he made his statement, the Secretary of State announced that there were new mutations seen in Bristol—11 cases in Bristol and 32 in Liverpool—and that extra testing and door-to-door tests would be a new approach adopted.

Do you think that local Members of Parliament should have been informed about this before the Secretary of State spoke? You are both local MPs, do you think local MPs should be aware of that sort of statement before it is made from the Despatch Box?

Penny Mordaunt: The answer to that, personally speaking, is yes. You will remember from when I have given evidence—

Q309 **Karin Smyth:** Thank you for that. I appreciate that honesty. Do you certainly think that the local authority should know that that statement is being made from the Despatch Box?

Penny Mordaunt: I was going on to say that you will remember—from the evidence that I have given to this Committee before—that I think we should be giving more information at a local level. That is absolutely shared by my other colleagues in Government. I think that the LRS and local authorities are at the frontline of this response, and that information,

whether it is with regard to public health or with regard to how certain things operationally are going on the ground, is very important indeed. I know that the work that James is doing, and also that is going on in Health, is trying to move that to a better position. A key example of that is very local, ward-level information about the vaccine rollout, for example.

Karin Smyth: We will come back to that. Thank you for that. We will come back to the vaccine rollout, but if I could just pick up on this particular example.

Penny Mordaunt: Local data is incredibly important, and I know from my own experience as a local MP—who was put into a higher tier earlier than elsewhere—that getting information about the presence of the variant was very difficult indeed. I think that is a fair criticism.

Q310 **Karin Smyth:** Thank you. Ms Whately, I have no criticism of Public Health England south-west and the local public health team in Bristol, but for them not to be informed before the Secretary of State makes an announcement, and, although they were aware of the variants, not to give them time to be able to look at that closely, to have that statement from the Despatch Box, do you think that is acceptable?

Helen Whately: I wasn't involved in that specific process. I have something really relevant to say. I know that, wherever possible, we have briefed MPs and involved local authorities and MPs in the decision-making. I have been involved and have chaired many calls with Members of Parliament—

Karin Smyth: All of which are appreciated. If I can—

Helen Whately: No, this is relevant. If I call MPs saying, "There is likely to be an announcement to do with your area, and there is going to be a tiering change," before I have even finished chairing one of those calls that information is on Twitter and then being announced on the national media, rather than being announced to Parliament. Because we were briefing MPs it was then on national media, but we all know that we try to announce things to Parliament.

I would say that there is a dilemma here between always wanting to involve Members of Parliament when things affect their constituents. Also, there is the consequence that then sometimes turns out to be effectively putting the information in the public domain at that moment.

Q311 **Karin Smyth:** Some of our colleagues are perhaps not as dutiful as some of us might be. The key point here is it is 48 hours later. It is two days later. What the Secretary of State said at the Despatch Box is still not clear to the people of Bristol, or indeed to the leaders who have to implement and manage this. Managing the communications around something as important as this is a prime example of something we should have got sorted last summer.

My question is—and if you cannot answer it now, it may be for civil

servants—why is the communication not given to local leaders that a statement of that magnitude is being made at the Despatch Box? Has something gone seriously wrong here, or is this a problem that is systemic and has still not been resolved almost a year into the pandemic? Mr Bowler, has something gone wrong here?

James Bowler: I don't know what happened exactly on that statement. I am sure it would be preferable for local MPs to know. In defence of the Government's policy, this is about trying to act extremely quickly to make sure that we can stamp out and contain a new variant of the virus. In those circumstances, we are often taking decisions exceptionally quickly on travel and all the rest of it.

Q312 **Karin Smyth:** I understand that, but is it acceptable? Has something gone wrong, where two days later the communication is still not clear on what action is being taken from a statement at the Despatch Box? Has something gone wrong in this case—perhaps people can come back to us later—or is this still systemic with the way the Government are operating in relation to local authorities?

James Bowler: On the major interventions with local authorities, the Government have committed to giving two weeks' notice before schools will open. There is a big trade-off there, because every single day—

Karin Smyth: Mr Bowler, you are not answering my question.

James Bowler: I am sorry, I will answer your question. There is a big trade-off between timeliness of information on schools. We have taken the trade-off to have two weeks' notice before schools open. That is a trade-off because each day the data changes and each day we get a better picture, so we will have to be taking a decision two weeks before we enact it, but that is the right thing to do. On the—

Q313 **Karin Smyth:** Let's be clear—I have got it in front of me—the Secretary of State made an announcement, and he made an announcement of action, which two days later we are still not clear on, let alone a few hours later. I do not think I am going to get an answer from anybody. If this is a mistake, I am happy to accept that, but if it is a systemic problem it needs to be resolved.

Penny Mordaunt: Let me try to answer this very directly. It is the Government's intention that in all aspects—whether it is going into particular lockdown restrictions, whether it is additional testing, whatever the issue is—local public health, local authorities and, of course, the local resilience forums are cited, consulted and fully aware of what is going on. If things are moving at such a pace that that cannot be done, and we can certainly find out about this specific situation—

Chair: I think we will move on from that.

Penny Mordaunt: I will just finally say that, because of the speed that things are happening, we have put in other measures, whether it is LRFs and the communication they have with the centre, or indeed through

parliamentary colleagues. I will say again, every day I am available to speak with fellow MPs, and quite often I get inquiries from colleagues saying, "I need to find out what is happening about this?" or, "My LRF is not getting this information. They need it." We are totally committed to ensuring that all best efforts are being made on every front of this pandemic.

Chair: Thank you. We will do more local as we move through the session, but I would be grateful if we could move on.

Q314 **Karin Smyth:** We are clear it is very fast, but we need to get the announcements with the information. We understand that the information is there in the system. It is about the announcement.

If I could come on to the wider tiering situation, the five indicators underpinning tiering decisions in November were different from the tests put in place in June. Why were they changed, Ms Mordaunt?

Penny Mordaunt: I think that would be one for James Bowler.

James Bowler: It is about learning and knowing, and each time we know more. In November we set a clear objective of what we are trying to do. We published it in a strategy and we said, "These are the five measures that we will look at." The reason we chose those five is that we thought that they were the most pertinent. They included the new data that we had on case rates for over-60s. We chose that because obviously we know that over-60s are more likely to be seriously ill and potentially die from this pandemic. This was classic learning and adapting, but I think that the winter plan published in November was very good at setting out a transparent approach of how we were going to operate.

Colleagues in DHSC can tell you how the Joint Biosecurity Centre then operationalised all of this, but those five measures were set out before we started. They were publicly available thereafter, and then we had a very formal process of assessing them and doing it. I thought that was the right way to go about it.

Q315 **Karin Smyth:** Are those the indicators that will be set for the framework for the future so that we can chart a path back to normality?

James Bowler: Yes. The next step on that is that we will bring in the evidence we have to date by 15 February. We will publish a strategy on 22 February for unlocking, potentially starting on 8 March. Ministers will need to decide whether those are the continued indicators. There is a new and very welcome additional thing to consider, which is the deployment of the vaccine. The big data question on the vaccine is its effectiveness, and we are very much looking at data and analysis on that. We are at early days. My expectation is that that will figure.

Q316 **Karin Smyth:** Thank you. We have the thresholds, but we do not know what the criteria are within the thresholds. In your next stage of publication, will we be able to understand—for example, if we are using

case rates—what case rate will lead to what tiering or what action?

James Bowler: Yes. We took a deliberate decision not to give absolute hard thresholds that would absolutely trigger things moving from tier A to B or 2 to 3, for example. That was a deliberate judgment so that the analytical framework that we use, via the Joint Biosecurity Centre, could consider local circumstances in its decisions. There were all sorts of examples of where, if you used a very hard set of thresholds, you might get perverse results. We set out the five indicators, but we asked the Joint Biosecurity Centre to give us its advice, through a fairly formal structure, on its assessment of which tier should be done. That worked well. DHSC colleagues can fill you in on the details there.

There are dangers in setting absolutely precise triggers for each of these elements. For example, if you had an outbreak in a particular Army camp, which you could contain and stop, or a prison, for example, would the whole of that area be put into a higher tier, or not if you felt it was contained? Those are the types of issues that we use so as not to set absolutely hard triggers.

Q317 **Karin Smyth:** I understand, and I will come to Ms Swinson in a moment so that I am clear. Therefore, when the Government approach the next round of tiering decisions, we can expect that that information, in terms of what is contained in those thresholds—the criteria or whatever you want to call it—will be clearly understood and it will be communicated to local people so that we understand why these decisions are being made. Is that right, Mr Bowler?

James Bowler: Yes, we will try to set out—

Karin Smyth: Thank you. Ms Swinson, is there anything you want to add at that point?

Clara Swinson: Thank you. Just one example of the difference between the five tests in the spring and those set out in the winter plan was that PPE levels were a huge issue in the spring. Fortunately, we are now in a position where the PPE levels are such that we are confident in them for the foreseeable future. That is one difference and one change, because the conditions changed between the spring and the autumn.

Then a little bit about the five indicators as set out. As James said, it is a judgment and a balance between those. It is both the overall rate and the rate of change, and it is the pressure on the NHS, which will differ according to the amount of capacity, the amount of non-Covid work and so on. That is why there are not set thresholds for each of the five. It is a balance between them.

Q318 **Karin Smyth:** I understand. I am going to come on to the pressure on the NHS in a moment with Ms Whately. I think I am hearing two slightly different things, so if you can be entirely clear. We all understand outbreaks in Army barracks, things that are unusual, a major factory. We all understand that, but, Ms Swinson, I am hearing from you a bit more

hesitation about this openness around the numbers, for example case rates and thresholds. Can I be absolutely clear? In the next phase of the strategy, will that be communicated to local people? Crucially, given my last point, local directors of public health are managing this. Will they understand and be communicated why each area is in which tier and what data is driving that decision? Will you be sharing that with them?

Clara Swinson: Absolutely, and no hesitancy on that. My point was that there is no threshold for each of the five. The JBC publishes what is called its transparency report every week. That sets out these indicators for each local authority area. Through its contain framework and its regional teams, it is in regular discussion with local areas about the rates and the numbers.

Q319 **Karin Smyth:** To keep it simple, if people see a case rate of 90 that will equate to tier A. Let's call it a different thing. For example, we can see roughly that case rate 90 will put you into tier A, with a variance of between plus or minus 10%, say.

Clara Swinson: There will not be a set threshold. It is those five indicators and there isn't a set threshold. It is a judgment and balance between those five areas that are set out.

Q320 **Karin Smyth:** Who is making this judgment and balance?

Clara Swinson: It comes to the Local Action Committee, which is chaired by the Secretary of State for Health with input from the Joint Biosecurity Centre and the CMO, and then it goes to the Covid-O Committee and—

Q321 **Karin Smyth:** Going forward, will we be any better off than we were last July, in that local leaders will still not be clear as to what is defining these decisions around tiering? I am hearing a bit of row-back here. I am hearing that we are going to be no clearer in the next few weeks about how the Government are making decisions about tiering than we were last July or last November.

Clara Swinson: There is no row-back. Compared to the winter plan, those five indicators will be taken into account.

Q322 **Karin Smyth:** We may pick that up later. Ms Whately, one of the tests is about tiering pressure on the NHS. Can you be clearer now what pressure on the NHS is going to mean in the future as we try to start returning to some sort of normal?

Helen Whately: As Clara has just been setting out, those are the five criteria that we have been using to inform the tiering decisions. Particularly fundamental to those has been the pressure on the NHS. It was the pressure on the NHS that triggered us to go into the highest Covid alert level, where there was a risk, if we did not take action to slow the spread of the virus, of the NHS being overwhelmed. Now what we are seeing, through this national lockdown, is a reduction in the case rate and we are now seeing admissions into hospitals falling and we are also now beginning to see a reduction in patients with Covid.

Q323 **Karin Smyth:** Yes, we understand that. Will that information be shared and discussed with local bodies as to what the definition is of pressure on their local NHS providers?

Helen Whately: There is already substantial sharing between local authorities. In fact, the Joint Biosecurity Centre has a strong regional structure where there are nine regional leads who work closely with the nine regional public health leads, who in turn work with directors of public health.

Q324 **Karin Smyth:** I would echo the Chair's point at the beginning that we have a lot of data. No one is disputing how far we have come in the last year in terms of data, and it is being shared better. What we are not clear on is who is making those local decisions and what part of that data is being used, without a clear definition of what pressure on the NHS means. Will you be publishing more information about that, or do you think there is enough done already?

Helen Whately: A large amount of the data that is considered by the Joint Biosecurity Centre is already published in many places, and the data packs that the Local Action Committee specifically looks at have been regularly published as well, so a lot of that data is available.

Q325 **Karin Smyth:** There will be no change in the next few weeks about defining pressure on the NHS? We will not expect anything different. Is that fair?

Helen Whately: I cannot see into the future.

Q326 **Karin Smyth:** You are the Government who are going to be making these decisions in the next couple of week, so it is not that far into the future, with respect.

Helen Whately: A process has been set up publicly as to what is going to happen in the next few weeks, particularly that we are going to look at the impact that we have seen in the national lockdown—

Q327 **Karin Smyth:** I am talking specifically about pressure on the NHS. That is not going to be defined differently, or anything differently published, in the next couple of weeks as we come out of this lockdown.

Helen Whately: As we have made clear—

Karin Smyth: If it is not, that is fine. Just say so.

Helen Whately: You can speak to Clara in a moment.

Karin Smyth: Just quickly because I am conscious of time.

Helen Whately: These are not hard and fast thresholds.

Q328 **Karin Smyth:** It is a straightforward question: is there going to be anything different in the next two weeks or not?

Helen Whately: Clara, I will bring you in.

Chair: If I may bring people in, with respect, Minister.

Helen Whately: My apologies, Chair.

Q329 **Chair:** That is absolutely fine. Could I pose hypothetical questions in terms of defining NHS pressures. Might that be to do with ICU capacity, might it be to do with waiting-list times, might it be to do with staff fatigue? Could Ms Swinson answer that?

Clara Swinson: Yes, I think all of those indicators that you have talked about are relevant. There is bed occupancy. There are new admissions. There are those on mechanical ventilator beds, which we publish. There are those in critical care. There are staff absence rates. This is why the medical director of the NHS and regionally will be making those decisions, looking at it in the round.

Chair: Therefore, all Karin Smyth's questions go with that.

Karin Smyth: Yes, I have finished, thank you.

Q330 **Rachel Hopkins:** Penny Mordaunt, this Committee has taken evidence from representatives from the hospitality and leisure sectors. We heard from them that the decision to close hospitality in tier 4 was made on gut feelings rather than evidence. Is that fair?

Penny Mordaunt: Again, you will probably need to ask Health and James that question, as I have not been involved in the decision-making or preparation of data. What I can tell you is that I know the Central Office of Information in Government at the start of the lockdown had done a piece of work to improve engagement with particular sectors. We are very conscious that it was rather ad hoc as to how particular Government Departments were communicating with particular sectors, largely luck, about what businesses were on what forums and so forth. There was a piece of work done very early to rationalise that, which paid dividends throughout the pandemic, but the prime motivation for which had been to ensure that we were consulting properly with regard to the preparations for the end of the transition period and Brexit.

There had been some work done generically to try to ensure that we were engaged properly, as a Government, with business. I am afraid I do not have any direct knowledge of the particular decisions that you are talking about.

Q331 **Rachel Hopkins:** Thank you. James, can you take it through from there?

James Bowler: Yes, I think it is not fair that that was the case. The aim of the restrictions is to reduce or, indeed, stop household mixing, and the decisions were taken based on a whole set of evidence of what has happened in previous lockdowns to reduce household mixing and, therefore, case rates and prevalence of the disease, and a set of evidence from SAGE and the chief medical officer and the chief scientific adviser. They have given evidence, particularly to the Science Committee, on

hospitality, at length on that front. Certainly it is not a gut decision. That would be unfair.

Q332 **Rachel Hopkins:** Pushing on that slightly, on some of the information we received around the 10 pm curfew, publicans I have spoken to in my constituency said it seemed very arbitrary to say 10 pm, particularly the point you say around trying to avoid household mixing. What was the evidence used to make that 10 pm decision, for example?

James Bowler: It was a policy decision based on attempting to reduce household mixing, and our understanding of how best to do that. It is probably worth saying—because this is key throughout this year—that obviously you learn from what you do. You look at it and you look at the evidence subsequently. You will know that that was changed thereafter because there was some evidence of people gathering outside pubs and outside shops and, therefore, having the reverse of the idea of what we were trying to achieve with a 10 pm curfew. That was changed to last orders at 10 pm.

The original decision was based on evidence of what we could try to do to reduce the time spent mixing. The scientific advisers will give you the proper thing, but the longer you spend together with other households the more you are likely to spread this virus. The idea was to reduce that time, but in the face of the fact that that was leading to behaviour—and behaviour and compliance is a big part of everything we do—that was likely to shift some of that from inside the pub to outside the pub, we changed that policy. We are obviously completely and utterly not afraid to listen and learn throughout all of this and, indeed, we must do that.

Q333 **Rachel Hopkins:** The industry and the hospitality sector would want to know why the Government did not share a lot of the information that underpinned these decisions with industry leaders.

James Bowler: As the Paymaster General said, there are large but now much improved communication channels between all sorts of people, but business sectors. Minister Scully, and BEIS in particular, now runs an open channel of information with the hospitality sector. That said, we are doing a set of incredibly difficult things that have a very clear impact on people's lives, the economy and jobs. I can absolutely assure you that those decisions are taken with eyes wide open and with as much information and evidence as we can muster. We are also looking at what works in each case as we do that but, hopefully, our communications are better, our evidence is better and our data are better.

Q334 **Rachel Hopkins:** Your commitment to sharing all of that with the relevant sectors is also improved?

James Bowler: Absolutely.

Q335 **Chair:** Could I follow that up? We talk here of evidence and data, and following the empirical method and everything. Is not some of this simply anecdotal, and is there not perhaps a reluctance for the Government to

admit that when there should not be?

Penny Mordaunt: Perhaps I can give you a couple of examples. For example—and I am sure Health will concur with this—the data and information that Health has on certain aspects of health and social care is vastly different from when it started. Minister Whately, for example, has done a lot of work to gather information from a very fragmented social care sector to deal with everything, from making sure people have enough PPE to the vaccination programme.

There has been, first, a massive change in the tools that we have to gather information throughout this, and similarly with the economy and business sectors, too. I also think that public health—again, Health may wish to come in on this—has had to take decisions with the best data possible, and subsequently it has commissioned research to improve that data. Curfew is one issue. We had the same issue with beer, takeaways and so forth.

You are right, Chair. People have had to make the best decisions possible with the data that they had, but what they have done is try to improve and commission research—healthcare does it all the time—to improve the information that we have.

Q336 **Chair:** Minister Whately, do you want to come in on that point? Sometimes data does not exist in the strictest form that we might wish it to and, therefore, you have to make decisions on the basis of anecdotes.

Helen Whately: Can I first say that I very much appreciate what the Paymaster General just said about the work we have done to improve and increase the amount of data that we have? I thank her for that. I do not agree with you that decisions are made on the basis of anecdote. What I will say is that we draw on a wide range of data sources. It is not as simple as having the exact data that information A leads to decision B.

Generally, on the non-pharmaceutical interventions, we know that transmission is through social interactions, through social contact, so we know that we need to take steps to reduce that contact in order to reduce transmission. Then we also have some additional data that points to some of the places where transmission is taking place, and we have to do contact tracing. We have that outbreak information to go on, as well as insights from SAGE and also, of course, insights from local authorities and directors of public health who feed into the process.

Q337 **Chair:** I am going to move on very quickly, but on the 10 pm curfew. If you cannot give me an example of the data or any number of pieces of evidence immediately now, could you please write to the Committee? What was the evidence that underpinned that?

Helen Whately: What I know is that the things we did before that included looking at things that other countries were doing and, also, some local experience. There was some experience in Bolton to do with restricting access to hospitality, where there is evidence that that was part of a contribution to slowing down the growth in the case rate.

Q338 **Jackie Doyle-Price:** To follow up on that last set of questions, I am not satisfied—coming back to James Bowler's point—that those measures have delivered the outcome that you have just suggested was the intention, which is to reduce household mixing. When you write to the Committee, could you also pick up what evidence you have to show that that has been effective? Because from where I am sitting, we have just moved household mixing from Covid-secure premises to non-Covid-secure premises in people's homes. I would appreciate some reflection on that, please.

Coming now to my set of questions, Penny, who exactly should this Committee and Parliament hold to account for ensuring lockdown decisions are underpinned by data?

Penny Mordaunt: In terms of the quality of the data, and also how it is presented, and to ensure that Ministers taking those decisions have the whole picture—so they have the economic impact and other aspects that might impinge on the strategy being successful or not—the quality of that sits with the Cabinet Office, and specifically the taskforce that is the secretariat to that decision-making process.

To give you an example. If there was a gap in that information, the Cabinet Office is the outfit that would say, "We need to fill this information gap. Ministers should be being given this briefing," and ask the relevant Department to commission that and push back.

Each Department is responsible for its own commissioning of that information and the quality of it, but you would expect, if there was ever a disagreement about that, it would be resolved in discussion between the centre and that Department. Again, it will sit with the Department, or the bodies that sit underneath it, about how and when that information is put into the public domain. Ultimately, the responsibility for the decisions taken is with Ministers, with the Government.

Q339 **Jackie Doyle-Price:** You put the Cabinet Office very firmly at the apex of making sure that there is enough holistic data, because obviously we are looking not just at health data but also the economic and social consequences of any Government action in this space. You would definitely put Cabinet Office at the heart of ensuring that we have all the right data to make those decisions?

Penny Mordaunt: Yes, the Cabinet Office is responsible for the good functioning of Government. It is a Cabinet Office responsibility if Ministers were not being given the right information. Clearly, there may be some questions Ministers might have to which data is not available because it requires a three-year-long piece of research. There may well be understandable gaps—speaking hypothetically—but identifying what those are and continually trying to improve the quality of the information and how we make those decision processes is with the Cabinet Office.

In the short time that I have been standing in occasionally as the chair of Covid-O, I could give you examples from that about how Ministers have given feedback on what they have got—they have not been shy about

asking for particular things to be done or sequenced in a different way—and the secretariat responding very rapidly to that.

Q340 **Jackie Doyle-Price:** You have neatly brought in Covid-O, which is obviously of interest to us in terms of governance and response to this. However, according to Government policy, for a level-3 emergency you would expect the Prime Minister to be overseeing all of this. To what extent has Covid-O introduced a new system of governance for dealing with something of this magnitude?

Penny Mordaunt: It is built on the quite standard processes that have long existed in the ministerial handbook. Clearly, Cobra meetings are a slightly separate issue, but you would normally have strategic meetings that might be taken in a smaller group chaired by the Prime Minister. That drumbeat of meetings happens in many other areas as well. We had EU Exit Strategy and EU Exit Operations. It would be at the strategic level that you would have the Prime Minister's involvement in that.

Covid-O was a mechanism where you could take decisions swiftly, enhancing the normal right-around processes that you would have normally to clear business. It was also critical in keeping people informed about what was happening on a real-time basis. They would be happening extremely regularly, and they still happen extremely regularly. Sometimes we have had them happen twice a day. That drumbeat still continues, but there will be smaller groups that are taken there.

As you know, the decision-making structures have evolved and changed as the pandemic has changed. At one stage earlier on, we had very formalised subcommittees of Covid-O. For example, Minister Whately would have chaired the one on social care and there would have been one on the economy and one looking at the foreign affairs picture.

Again, you can see that, as well as data improving, there has been a constant reflection about: do we have the right structures to support the right decision-making? The adaption of that as the pandemic has rolled on is evidence that people have been thinking about that.

Q341 **Jackie Doyle-Price:** I can see the advantage of that in terms of being fleet of foot. If you want to take decisions in a timely way, but also make sure that they are proportionate, that obviously relies on having the right data. There is also an accountability issue there. We are sitting here trying to interrogate how the Government have come to take the powers they have, where looking for data to inform them is not always clear. Ultimately, the fact that the Prime Minister would sit at the top of these level-3 emergencies to make those decisions made the accountability clear. It feels a lot more opaque. Why do you think that is?

Penny Mordaunt: I do not think the accountability is opaque. Government are responsible for decisions that have been taken. I understand that the Committee is not looking for someone to blame. You are looking to work out whether we have this right and how we improve it.

Jackie Doyle-Price: We are looking for good governance.

Penny Mordaunt: The accountability is clear. The Prime Minister said at a press conference the other day that he is responsible. The Government are accountable for those actions.

We are also clear what decisions are taken. Minister Whately gave the example earlier of the tiering decisions, which were taken by a Committee chaired by the Secretary of State for Health, and the Covid Operations meetings, which have a clear agenda and tend to focus on specific issues that normally would have had a right-around clearance process. It is complicated, but to every decision that you might raise there is an answer about what forum would have taken it.

Q342 **Jackie Doyle-Price:** Coming back to the issue that these decisions are being made fleet of foot, often being made without reference to Parliament in the normal way, beyond statements. We have not had much opportunity to scrutinise legislation, rules and so on. In the absence of those normal scrutinising procedures—accepting your point that it is quite clear where the accountability lies—ultimately, without the ability for democratic scrutiny, transparency is everything. Can you tell me how satisfied you are that we are presenting the right data to justify these decisions?

Penny Mordaunt: James might be able to tell you how things like the dashboard have evolved, repeating points that have already been made. Much of the data and the decision-making packs that are informing these decisions, particularly in Health, are published. I know there are very clear views that people want them to be published in a timely way. My understanding is that the only thing that would prevent that is if there was some commercial or national security situation that would cause them not to be put out in a timely way.

I do not know whether James can talk a bit more about the evolution of some of the data that is in the public domain. It is not just the information; it is the format that it is in as well. It needs to be intelligible and relevant.

James Bowler: We are at a level—having grown through the year—of incredible transparency, and in some different formats, too. There is the dashboard with over 100 metrics, over 60 local postcode checkers and up to 1 million users a day, which I think is important. There is the whole communication of how we do that, making sure we use the same statistics over time and explain them simply, press conferences and the like.

There are two big different things that would not normally happen with usual policy. There is the advent of the Joint Biosecurity Centre to pull all this analysis together, to work with local people and really to engage and provide a professional service, and there are all the SAGE, Scientific Advisory Group for Emergencies, things going on here. With over 500 papers now published, the public and anyone, politicians or members of the press who want to hold the Government to account are seeing virtually

everything that the Government are receiving on evidence on this pandemic. You would not normally see that in everyday decision-making.

I say things are very transparent. We have been on a journey, but as we find ourselves, there is a high level of public transparency and data released that underpins the decision-making here. There is a convention that minutes and attendances of Cabinet Committees are not published. That is not particularly a Covid issue, but I can absolutely assure you that the whole Cabinet and collective decision-making structure has not fallen by the wayside despite things being fleet of foot. As the Paymaster General has said, the numbers of meetings are extremely high to ensure collective responsibility and collective decision-making continues to be made, even though decisions are being made quickly. I hope that is reassuring.

Jackie Doyle-Price: It is not, because the volume of information being put in the public domain is one thing. From the perspective of openness about the facts that is transparent, but if there isn't transparency about the weighting that those various factors are being given in each decision that is not transparent. I will leave it there.

Q343 **Ronnie Cowan:** I want to challenge you, Mr Bowler, on what you said there about transparency. The Scottish Government wanted to publish figures that would not only show how much has been allocated to Scotland but also the vast majority of supplies either already in people's arms, drawn down by health boards or sent to GPs to vaccinate members of the public. The British Government did not want that published. What transparency are you talking about? We are trying to give members of the public confidence in the figures that we are showing to them, but we are not allowed to show them the figures.

James Bowler: I think you are referring to the vaccine supplies going forward. There are three things to consider there. First is commercial confidentiality, second is security and third is uncertainty. As evidenced by recent events over the last week or so, the advice I would be giving is that it would not be sensible to publish the future allocation of supplies of vaccines, with that being in mind.

Q344 **Ronnie Cowan:** Is that because we do not want to make it appear or we do not want to show—because we do know the numbers—that we have plenty of vaccines but we do not want to give them to other countries?

James Bowler: No, it is on the grounds of commercial confidentiality, security and uncertainty.

Q345 **Ronnie Cowan:** I am at a loss to see why it is commercially confidential to know how many vaccines we have.

Chair: Ms Mordaunt or Ms Whately might want to answer that particular question so as to relieve the civil servants of political questions.

Penny Mordaunt: Helen might wish to answer with the specifics of the vaccine, but the two charges laid against us—if I have understood the question correctly—is that we are somehow being ungenerous and

unhelpful to other nations with regard to prioritising and wanting to hang on to—

Q346 **Ronnie Cowan:** No. That is a decision to be made. What I am asking is: why are we not putting the data out there? One of the reasons that has been given for that is it would attract that sort of scrutiny. My question is: why are you not allowing the data to be published?

Penny Mordaunt: I do not think that is the case, because there is enough information in the public domain to answer any type of charge of that nature. You only have to point to the commitments with COVAX, the commitments with Gavi and the historic investments there. Health may wish to come in on this, but there is clearly a programme of work to improve information about the vaccine programme across the UK, down to how we are doing at a very local level. Very understandably, there is a time lag because the data always has to be verified and checked as to when that will start coming through. However, as parliamentarians, you will have been briefed about that coming online very shortly.

My colleague James is absolutely correct that there are—it is difficult to talk in this forum—some very good reasons why we do not talk about where particular things are stored, where stocks are and those sorts of things. We just need to be careful of that. This is a UK-wide effort. We all want every part of the UK to be benefiting from the massive efforts that are being made by all sorts of organisations to get these vaccines out. The UK can be very proud of the responsibility it takes, as a wealthy nation, to ensure that the rest of the world is vaccinated. We are the most connected nation on earth, and we take our responsibilities there extremely seriously.

Q347 ***Ronnie Cowan:*** Can I just say that if you are not prepared the figures, you cannot politicise them as well? You cannot hide behind them, and you are clearly doing that.

Penny Mordaunt: Through you, Chair, and I apologise, I do not think that I or anyone else who is a witness here is doing that. I think, if you do not mind my saying so, you are.

Chair: Thank you. That leads us neatly on to Mr Mundell.

Q348 **David Mundell:** Penny, can I ask you about the statistical infrastructure that exists? This Committee has heard that statistical infrastructure is far too fragmented, and that this has hindered decision-making. For example, we have heard that different Departments have their own statistical and analytical teams, and that within Health there are national statistics. There are local statistics. Then, of course, the devolved Administrations have their own statistics. Is that issue being taken on board, and what is being done to overcome that fragmentation to ensure better and more informed decision-making?

Penny Mordaunt: There are two points I would make with regard to this, and James again might want to come in with some of the detail. The criticisms that could have been levelled at us at the start of the pandemic—

this has really changed beyond measure. It is not just the fragmentation that was there, but, clearly, producing good information on which to take decisions requires the fusing of quite different disciplines, from behavioural science through to more traditional data that would be produced by Health. There have been some very clear changes, which James can run through.

The second point I would make, which is very important—and I would cite examples I have already mentioned, such as the data on social care that have been produced—does give us, as a Government, some opportunities for better decision-making not just in the pandemic but hopefully once this is all behind us on how we properly use datasets in order to better run public services. Through you, Chair, James might wish to come in on the detail.

James Bowler: It is a good point, because the statistics are generated where they lie, in different Departments, and the risks the Committee has talked about are real. There are three things we are trying to do to overcome it, as you asked. My analytical and data directorate is directly trying to bring it all together in a cohesive way, and we have embedded within us people including the ONS, and there are some ONS people in No. 10, to try to help us do that and provide the firepower to do it.

Secondly, we try to overcome the fragmentation by this dashboard, which, as the Paymaster General says, is possibly something we should look to do more widely outside Covid, because the response is that people like it and use it and it does bring everything together. Thirdly—and Health colleagues might want to talk about this—the setting up of the JBC from June was precisely to give us the firepower to make sure that these things can be brought together, analysed and used for decision-making at a local and national level.

Q349 **David Mundell:** Are you able to give us an example of what has changed? The Paymaster General indicated that things had changed from the start of the pandemic. Are there decisions that have been taken recently that would not have been able to have been taken in such a well-informed way if those decisions had been required eight months ago?

James Bowler: A good example would be the new variant. The ONS now does 15,000 swabs a week. It was doing 3,000. It can get much more precise data and it can pick up whether people have the new or the original variant, and it publishes data on both accounts. We were able to use it in our decision-making on going into and coming out of lockdowns to trace very closely where the new variant had got to, its spread and its prevalence, knowing from NERVTAG and SAGE colleagues that it was more transmissible. Therefore, we should be more concerned the more the new variant was present. That is probably a good example of what we can do now that we could not have done eight months ago.

Q350 **David Mundell:** Is everything going smoothly in relation to the sharing of data with the devolved Administrations?

James Bowler: We do an awful lot of sharing at ministerial, Health and official level. We have a whole set of ministerial forums and phone calls. There are links at Health Secretary level and, critically, the chief medical officers speak regularly. The indicator level that my Health colleagues talked about earlier was triggered at a UK level. The dashboard as well is UK-wide. I think that is absolutely the case.

Only yesterday I was discussing our future strategies with devolved colleagues, making sure that we had an open line. Obviously public health is devolved, so there are different responses across the UK, as there should be, but I am positive about the engagement.

Q351 **David Mundell:** I have a question for Helen Whately. The Royal Statistical Society told us that a full review of health statistics was needed to overcome the fragmentation of health data. Can you commit to that review and tell us what it might it look like?

Helen Whately: There are a couple of things I can say on that, first that there is, in Health, a piece of work being done on a data strategy for the Department. That would be addressing questions like that. What I can also say is that what we have seen is a huge amount of bringing together of datasets and bringing together the data from different organisations. This is exactly what the JBC was formed to help do on a timely basis. That draws on public health data, NHS data, ONS data and data from other sources in order to give a fuller picture. The joining up of data has been an important part of the pandemic response and is an important part of the pandemic response. It is something we have got better at, and it is one of the things that we can take and build as we come through this.

David Mundell: You are not minded towards such a review, then?

Helen Whately: What I can say is there is a data strategy being worked on. That is work that is going forward. If Clara has any more to say on this particular point, Chair, you may invite her to do so.

Chair: We will park that matter there and assume there will be an exchange of letters between the Royal Statistical Society and you, and that you will respond in due course.

Q352 **Lloyd Russell-Moyle:** Minister Whately, the president of the Association of Directors of Public Health told the Committee that if public health teams had received testing data, which they were asking for, earlier in the summer, they would have been able to respond better to the virus. Do you think that is a fair comment?

Helen Whately: I watched some of what she said in giving evidence to the Committee, and I had some good conversations with her and have worked broadly with directors of public health in my social care role. I also know the links between JBC and the regional public health leads is an important part of the operation of that organisation.

Coming specifically to the sharing of testing data, I am aware of the conversations of—

Q353 **Lloyd Russell-Moyle:** Sorry, Minister. I am interested in whether it is a fair comment that data was not shared quickly enough and, therefore, directors of public health were not able to act as well as they could have. Is that a fair comment? Do you disagree with the comment?

Helen Whately: Let me say what I can say, which is that—

Lloyd Russell-Moyle: I want to know your opinion on the president of the Association of Directors of Public Health's comment. Is it a correct comment or is it not a correct comment?

Helen Whately: Can I share with you what has actually happened, which may be enlightening and helpful to the Committee, which is what I am trying to be? I know that in June last year testing data was shared with directors of public health and local authorities. By July, or in July, data was being shared down to an individual level so they could see individual record data exactly to help local directors of public health in their outbreak response.

Q354 **Lloyd Russell-Moyle:** Therefore, you do not think it is a fair comment because you think the Government did share data in the summer?

Helen Whately: What I have described to you is the data that we have shared, which I think is the most helpful way of responding to the question.

Q355 **Lloyd Russell-Moyle:** Why do you think directors of public health, therefore, would say that data was not passed to them in the summer for them to be able to respond on testing issues?

Helen Whately: I heard—and I recall hearing it at the time—that local authorities and directors of public health were asking for more data and the response, as part of working with local authorities, was the sharing of that data. Further detail was shared with those directors of public health by the time we got into July, so they have large amounts of information for contact tracing.

Stepping back, what I am going to say is that if you look at the whole test and trace operation, an enormous system and infrastructure was created from scratch. This time last year we were not testing thousands of people for Covid and now we are testing in the order of 600,000 people.

Q356 **Lloyd Russell-Moyle:** Yes, I am interested in data particularly at this point. We spoke to the directors of public health in November. You say there were some changes in June/July. Have there been any changes in the content, in terms of quality and granularity, of testing data that you have shared with directors of public health since November?

Helen Whately: I am not that close to our testing data, but Clara may have some further information on that, Chair, if it is okay to bring her in.

Clara Swinson: In terms of sharing with local government, one thing we have done speedily is to share the vaccine data. The rollout had not started in November when you took your evidence. I think it is fair what they said that improvements had been made, but we are still continually seeking to improve that and share. That is what we have managed to do in the last few weeks with the vaccine data for local authorities and directors of public health.

Q357 **Lloyd Russell-Moyle:** We heard that there was a two-week delay in data coming from national teams to local teams due to system issues. That lag no longer exists in terms of the vaccine, for example?

Clara Swinson: Vaccine data is being shared, not on a two-week lag. I am not sure exactly what that refers to. I am happy to look at it. There was a difference, obviously, between new datasets that are being established as they were being done for testing. For vaccines there were some datasets already set up in terms of age cohorts, but for other JCVI cohorts it will take a bit longer to get reliable data. There is a balance between the management information for direct use and then making sure that can be improved and quality assured. I am talking a matter of days, not weeks, for that quality assurance.

Penny Mordaunt: I want to clarify so there is no confusion. When I referred earlier to the two-week lag, it is not about the data being two weeks out of date. It is that, across the vaccines but also other areas, people are constantly trying to improve the information that is available, for example to parliamentarians. Right now you could drill down to a certain local level. You would probably have county information about the vaccine programme. You would not necessarily have it about a particular town or city in a vicinity. That is what I was referring to, that people are trying to improve the level of detail that people have in terms of local information. That has improved in other areas and, as I understand it, it is the situation with vaccine information as well. It is not that the information is two weeks out of date.

Q358 **Lloyd Russell-Moyle:** Is it ever the case that Ministers see local-level data that directors of public health do not? Of course, Ministers will see national-level data, but is there ever a moment where the Minister can see local-level data and the directors of public health cannot?

Helen Whately: You can see that I am genuinely trying to think of examples of datasets that I am familiar with. For instance, as Penny and I have both mentioned, we have built up data for social care using a tool called the capacity tracker, so that we now have far greater insight into social care and particularly care homes than at the beginning of the pandemic.

We built up a national dashboard that gives us data at an England level and then can drill down into regions and local areas. We have then shared access to that with local authorities and directors of public health so they can see that. There may have been a period when that was being rolled

out to those areas where we had it until they had it, but that was a matter of deploying a rollout across 151 local authorities.

Q359 **Lloyd Russell-Moyle:** Are you now confident that every single local authority or director of public health can look at and see the same data in terms of all the datasets in the same time, real time, as you can?

Helen Whately: I do not think I am in a position to say that for every single dataset that we look at, obviously bearing in mind that quite a lot of the datasets that we look at are externally owned, but we bring them together and analyse them in, for instance, JBC. I would not want to say every single dataset. I do not have oversight of every dataset in my role as Minister of State for Care. What I know is that we work to make sure that directors of public health have access to the kind of data that we have nationally, and that has been part of the effort during the course of the pandemic.

Q360 **Lloyd Russell-Moyle:** You mention private data, which is quite interesting. The testing was set up outside of the existing public health data systems. Why was that?

Helen Whately: I did not mention private data, I said different datasets, like public health—

Lloyd Russell-Moyle: Sorry, I misparaphrased. You said some of the data was not owned by you, it was not your data.

Helen Whately: No, it is not Department of Health data as such.

Lloyd Russell-Moyle: The testing data was set up outside existing public health data systems. Why was that done?

Helen Whately: I am pausing because I am definitely straying beyond my brief as Care Minister and oversight for JBC, but I notice Clara putting her hand up. She may be able to give you more insight into the establishment of NHS Test and Trace.

Clara Swinson: I do not think it is right to say it was set up outside the local systems. Health protection teams in local authorities are of a certain size, and they needed to be supplemented due to the pandemic. I know that Baroness Harding has spent a lot of time—including yesterday—in front of Committees talking about the balance between national and local. Local government was integral to the setting up of test and trace, including a seconded local authority chief executive, right from the start.

Q361 **Lloyd Russell-Moyle:** I suspect it will be a surprise to many local authorities that had to set up their own test and trace systems that they were integral to it at the start.

What I want to know is: why weren't the existing NHS record systems, the existing systems that we have for public health data in terms of sexual health—I am an honorary president at BHIVA, which is the association for HIV consultants. They told me that never once were they asked what kind

of datasets they use that could be carried over and used in this, what kind of data systems they already had in use.

I want to know why the systems that existed already, the public health data systems, which are used by numerous different agencies already, and the public record system, which we are using for the vaccine rollout, were not used for testing. Maybe the question is: why did you decide to abandon the separate system that you had had for testing and go back to the public health data system for vaccinations? Was it because the testing system was not very good?

Clara Swinson: As I have said, there is a difference between setting up new types of data systems—and there is a balance absolutely, as you have said—and using existing systems, whether they could cope with the scale that was required. Obviously, when you set up new systems it is then harder to share them and put in sharing agreements and so on.

For vaccines, fortunately, there is the existing NIMS system and other systems and sharing between GPs, primary care and local authorities, which again need to be at a bigger scale and of course very fast, which I think are being used effectively.

Directors of public health also have a direct line into their regional directors, and professionally into their chief medical officer. We try to make that a two-way conversation as far as possible. CMO speaks to them regularly. Of course, if they are flagging things that mean that they cannot do the job on the ground, we will listen to that and respond to it so that they can do.

Q362 **Lloyd Russell-Moyle:** Minister, we know the testing data was found to have overstated the number of tests carried out. What broader lessons—not just for the testing system—have been learned from this that can be applied to the communication of the vaccine data to make sure that we do not overstate that?

Helen Whately: Looking back at the testing data, what you can see, I hope you would acknowledge, is that a huge amount of data has been published. Compared with the normal time lag that you might have between the collection of data, the validation of it and putting it in the public domain, there was an extremely rapid transition from the collection of data, establishment of the system and communicating that data publicly, and in quite some level of detail. I have heard that we are seen as world leading in the amount we have shared and the transparency of this system. There is always a challenge to make sure that you are timely and have good quality data.

For vaccinations what you have seen is that we have moved rapidly to share the data for the vaccinations, initially sharing it at a countrywide level and then, almost week on week, putting out more detailed data, down to regional and then ICS STP level, and looking at what is the most useful level of data that we can share for the system. We will continue to look at the best way to use data to support the overall vaccine rollout process. It is not job done; it is work in progress.

Q363 **Lloyd Russell-Moyle:** Why are we not recording people who refuse to take the vaccine?

Helen Whately: What I know is that our overall approach to the concern, and what people are calling vaccine hesitancy, is to educate, encourage, inform and enable people to take the vaccine.

Q364 **Lloyd Russell-Moyle:** It is no good if I do not know. Even, let's say, at a local level. It is no good at a local level if I do not know what population. It might be that they are not responding because mobile phone text messages or paper letters are not an appropriate level of communication but they would be willing to take it up, compared with a group of people who have been contacted and actively responded to say, "I do not want the vaccine." My understanding is that we are not currently recording that data, the difference between someone who has not responded compared with someone who has responded negatively. Surely that is a real gap in the dataset that we need to fix relatively quickly.

Helen Whately: Let me come in on that, and then Clara may be able to add further detail. I can say that the overall approach is to encourage the greatest possible uptake of the vaccine. We need to be thoughtful about how we do that, and understanding, where some people have a concern about it, why they may have that concern. That is something I am looking at closely for the social care sector, working with NHS colleagues and our colleagues in the vaccine—

Q365 **Lloyd Russell-Moyle:** I had to get my director of public health to ring around individual care homes and, on a piece of paper, calculate the number of care home staff who have agreed to take the vaccine or not agreed to take the vaccine. That does not seem a very organised way of doing this. It is great that local directors of public health and local CCG chiefs are doing that, but that does not give you a national picture of where we are on the key problem that you just mentioned.

Helen Whately: To that specific point on social care and care homes, as demonstrated by the director of public health, it is a collaborative effort with local authorities, with care providers and with the care workforce themselves to come forward and get the workforce vaccinated. We already have much higher levels of vaccination than we normally have with the flu vaccine.

Q366 **Lloyd Russell-Moyle:** That does not provide any data, does it? It does not provide good data. It might eventually get some people vaccinated, but it does not provide the data for us to be able to drill down and look at it in real time or post-time.

Clara Swinson: You are exactly right that the reasons people may not be taking up a vaccine are varied and, therefore, the action to take would need to differ. This is an example where we need both national and local action. Your example is a great one for what can be done locally. We will definitely be collecting uptake data, and this is probably something that

will become more of an issue as we come down the age ranges. We need to collect what that uptake is.

We know, from other vaccine programmes and flu, the types of reasons why people do not come forward. There may well be some additional ones for Covid, but we know the types of categories at a national level. Therefore, use of specialist media, trusted community leaders, faith groups and so on is what we can try to do at a national level. Then it is the expertise at a local level about those who are hardest to reach—either for this vaccine programme or other health services—and a way of encouraging people to come forward, whether that is about specific reasons why they do not want this vaccine or if they are fearful of the state. There are a range of reasons that people can address.

Q367 **Lloyd Russell-Moyle:** I am seeking assurance that we have a system, or a system is being developed, to be able to record all those amazing reasons—or varied reasons, all of them I wish would not exist—that people would not take up a vaccine, because, you are quite right, we need to target them.

Of course, the other important thing is to get that at a granular level. The county and CCG level that we have at the moment is not granular enough to target communities, when it is doctors who are often having to do the follow up. If you are not getting it at the PCN level, it is not very useful.

Minister, I want to ask one further question about a report that the head of data at Sky News told this Committee. Ed Conway said, "During the initial period of test and trace…the data was just being collected on pieces of paper. Some was just being entered into spreadsheets in Whitehall offices." Did this happen, and why did it happen? Why did we not have the systems to do it digitally?

Helen Whately: I was not involved, and I am not involved, in the test and trace operation, so I cannot tell you how data has been collected by test and trace. Clara may have more information about that or, alternatively, I will have to find out from Lord Bethell, who is the Minister with oversight of the test and trace operation, and let the Committee know

Chair: If you would do. Briefly, Mr Bowler.

James Bowler: I was looking at Ed Conway's evidence, and he also charted the progress we made over the year and said, "The sight we have at the moment is so much better than it was before." I thought a little bit of balance, that being the case.

Lloyd Russell-Moyle: He said that it is now even better than the European data and is world leading. Let's give credit where credit is due, of course, but I want to find out whether the initial report is correct, because it is fair to put that in balance.

Chair: We accept there is balance and we are a nit-picking Select Committee, for which I am sure our witnesses will forgive us entirely.

Q368 **Mr David Jones:** Penny Mordaunt, how important is the clear communication of data to the public during the pandemic?

Penny Mordaunt: This is absolutely critical. First, the public's behaviour and confidence in what they are being asked to do by their chief medical officers is the biggest tool we have to control the spread of the virus. Understanding what they need to do and, also, understanding why it is necessary that they do it is fundamental.

As we said similarly in other questions we have been asked, there has been an evolution in how that has been presented. The slide decks that people see on a daily basis have improved, both in terms of the content and messaging that they are trying to get across but also the presentation. Early in the pandemic we had slide decks being cut off when they were being broadcast and so forth. That is very important.

I know the central information team has done a lot of work—it has always done a lot of work—to understand how messages are being understood and cut across. Over the last 12 months, in particular, it has also done a huge amount of work to improve communications with particular groups. If I can give you one example, it now has a group set up with people who have a learning disability, to advise them on how to present information, what language to use and what works. There is still a lot of improvement in areas like that that we need to make, but a lot of attention has been paid to that because, ultimately, it is the actions of the public that are going to help us stop the spread of the virus.

Q369 **Mr David Jones:** You clearly believe that you have learned lessons during the course of the pandemic as to how to present data. What would you say are the most important lessons?

Penny Mordaunt: For me, it is ensuring that you have good two-way communications and that you are understanding at a local level where the gaps are that might be driving particular behaviour. To give you an example, a lot of the breaches—not necessarily breaches of the rules but people undertaking activity that they do not need to undertake—were people driving to areas to go for a walk, for example. Getting people to understand that a car journey, although you might feel safe because you are in your car and you are not getting in anyone's way, is still a risk because the more petrol you use the more times you are going to have to fill up and so on.

Trying to take that localised information, which the COI will do through focus groups and feedback—including feedback that parliamentarians give—and feeding that in and shaping and constantly adapting how we are communicating messages to find those gaps and fill them.

One of the key things has been that the simplest messages are the ones that have cut through. Yes, messages will need to change, but it is how you can try to have some consistently so people understand what it is they need to be doing and why.

Q370 **Mr David Jones:** By what metrics do you assess if your presentation of data has been successful and effective?

Penny Mordaunt: There are a huge number. Again, it will be the COI that looks in terms of the public's perceptions and whether messages are cutting through. It will look at whether those messages are landing, whether they are understood. It will have disaggregated data, so it will be looking at particular audiences. It will also look at the information that has been gathered about behaviour, about where there have been breaches and where there are hotspots around the country, and it will be looking at doing some particular information analysis about why messages might not be cutting through with particular audiences. That is extremely thorough. It will always do focus groups, both to test how things are working and also in the design of those messages as well.

Q371 **Mr David Jones:** Over the course of the pandemic, are you finding that there are improvements in terms of the effectiveness of the message?

Penny Mordaunt: I think there are. The volume of work this has been for that team is quite immense, but it has been a real opportunity for it to improve how it does things, especially for groups that have not been historically well served. We obviously have sign language at press conferences. When that initially started, it was not available on all channels. There was a lot of work done to try to improve that.

There are still improvements that can be made in that respect, but people have focused on ensuring that everyone we are trying to reach has the capacity to understand what they should be doing, and has confidence in the data on why they need to be doing it.

I also think that one of the most powerful levers we have to get people to behave in particular ways is that people can see the effect it is having in their own local community. It is not that my behaviour is going to impact on someone up the other end of the country; it is going to impact on my next-door neighbour and on the staff working in my local hospital.

Communication at a local level to get those messages out, and the links between central Government, the LRFs and local authorities and their communication teams, has been strengthened tremendously throughout the pandemic. Real-time information, huge weekly meetings with all the communications teams together to ensure that we are all singing from the same hymn sheet and that we are capturing the sense of their local feedback.

Q372 **Mr David Jones:** You mentioned that part of the aim was to persuade people to change behaviour. Is that right?

Penny Mordaunt: It is to follow the advice of their chief medical officers.

Q373 **Mr David Jones:** We have had evidence—which I am sure you have read—including from Professor Spiegelhalter, who outlined the principles of good data communication and said, "First, it should be to do with informing

rather than trying to persuade or manipulate people. It should offer balance, the pros and cons, rather than just one side and not false balance." Do you believe that our use of data has accorded with what Professor Spiegelhalter said is the way that data should be used?

Penny Mordaunt: My experience of dealing with my own local community, and also of the evidence that I have seen collected by the COI from its focus groups and from the other tools that it has to look at compliance with the asks of public health, shows that the real difference that is made is when people have a clear understanding about what they should be doing.

One of the challenges that we have had has been the speed at which someone in a particular location might find themselves under different sets of rules. My local area, in the space of a week, was in four different types of tiering as we went into lockdown. With that comes stress. With that comes confusion. One of the biggest challenges has been about the clarity that we need to give people about what they can and cannot do. The great British public like rules. They like to understand what they need to do. They like fairness. That has been the most important thing in terms of compliance with the chief medical officer's advice.

Q374 **Mr David Jones:** Would you accept that the handling of the test and trace statistics was not the Government's finest hour?

Penny Mordaunt: That may be a question for Health.

Mr David Jones: Perhaps I can ask Helen Whately if she would like to answer that one.

Helen Whately: I am thinking back to the time last summer, in the early summer, when we were building up the capacity of the test and trace system and the Government were setting quite audacious targets, such as to reach 100,000 and then 200,000 tests a day. That focused minds and resources on a huge expansion of our testing capability. Reflecting where we are now—where we have now done over 70 million tests—setting ourselves targets, although it produces a lot of challenges and a lot of questions about whether you have hit your target or not, has helped in the fact that we have had this huge expansion of the testing system.

Q375 **Mr David Jones:** Forgive me, I understand that, but could we wind back to last summer? Would you accept that the handling of the test and trace statistics at that time was rather poor?

Helen Whately: I know there was some correspondence between the Health Secretary and the statistics regulator, and the outcome of that correspondence—

Q376 **Mr David Jones:** The ONS was highly critical of the Government, wasn't it?

Helen Whately: Yes, and I know that some of the concerns were addressed and a position has been reached where I understand it is much

improved. In fact, NHS Test and Trace has now been praised for its transparency and presentation of data.

Q377 **Mr David Jones:** Yes, but if we could rewind to the summer, would you accept that the Government's handling of the statistics resulted in a loss of trust on the part of the public?

Helen Whately: I do not know that I would accept that. I would accept that there were criticisms made, and improvements have been made, as has been reflected in the correspondence I just referred to.

Q378 **Mr David Jones:** You say you do not know that, but surely you would have carried out studies to ascertain whether or not trust had been lost as a consequence of that.

Helen Whately: I am not aware of any evidence along those lines. Can I bring in Clara to see whether she has any further insights?

Mr David Jones: Yes, please, if the Chairman will allow it.

Chair: Naturally.

Clara Swinson: ONS tracks not just all of its infection surveys and so on but a whole range of data, including: public understanding of the rules; understanding of isolation; and whether people say they are complying or not. As the CMO has said, there has been a high level of compliance. That does vary over time, both in how worried people are about the virus and their individual action. Of course, test, trace and isolate is a tough thing to do, to isolate for 14 or 10 days.

There definitely is research, and ONS puts this together in its regular publications. In terms of the impact that has and how we can make it easier for people to isolate and understand the reasons for it, that is something we have tried to do better on throughout the autumn.

Q379 **Mr David Jones:** Ms Whately, I am sure you will be concerned about the prevalence of Covid denial or anti-vaccination sentiments that appear chiefly in social media. Is that right?

Helen Whately: I would counsel against overstating that, in the sense that we know that, in general, our country and our citizens are positive about the vaccine and getting vaccinated, more so than people in other countries. Overall, we are in a good place on people's willingness and enthusiasm for getting vaccinated, as I have seen very directly in the uptake among care home residents.

Of course, there is work being done to reassure those who are worried about getting vaccinated and to encourage particular communities and groups of people who may be more worried, to assure them about the safety and efficacy of the vaccination.

Q380 **Mr David Jones:** Presumably, you are employing data in that exercise?

Helen Whately: I know there is a great deal of work being done on this, involving both NHS England and the Cabinet Office. They are drawing on the expertise, insights, local knowledge and huge amounts of experience that, for instance, NHS England has in reaching out to communities for other areas of work, which can all feed into that. Others may be able to add further.

Q381 **Mr David Jones:** Penny Mordaunt, we had a discussion a few moments ago about the attempt to get the public to change its behaviour. Was it the Government's approach to create a sense of anxiety about the virus, or was it simply to present data in a balanced manner and allow the public to make up its own mind?

Penny Mordaunt: I do not think it was the intention to create anxiety at all. Both in terms of the data produced and also the manner in which it was presented, it was to be very factual but, also, to leave people in no doubt about why it is in their interests and the interests of their family to follow the chief medical officer's advice.

Chris Whitty, Sir Patrick Vallance and others who are not politicians—the Children's Commissioner, for example—have been incredibly important in leading some of those communications, as well as in getting those voices out there, without spin but simply stating the facts and going back to good, old-fashioned public information.

Part of the reason for that, and it has been incredibly important over the last few weeks, is that public morale is also very important. Unfortunately, we are in a lockdown situation. We know that there are consequences to that for people's wellbeing and mental health, and we want to keep the nation as resilient as possible, so there is a great deal of consideration in how these things are presented. The public are a sophisticated audience and they want the facts. That is what they are interested in. We know from our mailbags—not just about the health aspects of this, the other impacts—the strategy that we are setting out results in.

Q382 **Mr David Jones:** You say that there is a great deal of care in the way that data is presented. A few days ago the Prime Minister said that the new variant of the virus might be associated with higher mortality, but NERVTAG has said that there are limitations on the extent to which the impact on mortality can be opined upon at the moment. Do you feel that the Prime Minister's statement was clear enough about that, or was the Prime Minister jumping the gun and, again, simply trying to change behaviour without having sufficient data for presentation to the public?

Penny Mordaunt: Clearly, in part because data are published and are out in the public domain, both by Government and other organisations, and especially if you have a daily press conference, people are going to be asked questions to which you need to give an answer.

Q383 **Mr David Jones:** He could say, "I don't know."

Penny Mordaunt: If you do know about something, the public would want you to answer.

Q384 **Mr David Jones:** Quite clearly the Prime Minister did not know that, because NERVTAG said there was insufficient data to enable him to express such an opinion.

Penny Mordaunt: The Prime Minister and others can caveat things that they say. You are also very conscious about things that might be discovered further down the line, and you are trying to retain public confidence. I cannot comment on every single statement that every single Government Minister has made.

Q385 **Mr David Jones:** That is an entirely reasonable point to make, but here we have the Prime Minister, on primetime television at the daily press conference, making a statement that appears to have been unsupported by any scientific data, saying that this particular variant might be more deadly than the original one. That is inevitability going to cause alarm among sections of the public, I would have thought. I quite appreciate that every Minister has to answer a question, but isn't it better to answer a question in a balanced manner and say, "I am unable to say whether or not this is more dangerous than the original variant"?

Penny Mordaunt: Health may wish to come in on this but, from my understanding of that particular press conference, from memory that story was already running in the media and, had he not addressed it and given his view and what he had been briefed, it would have perhaps been odd. I was not involved in the preparation of that statement or the press conference, so I cannot—

James Bowler: Just some facts. NERVTAG had produced a paper that provided some evidence, with caveats. The Prime Minister and Government had received that paper. The Prime Minister—very much through Sir Patrick Vallance and the chief medical officer—communicated it with full caveats. It was precisely because, having received that information, as the Paymaster General has just said, it is difficult not to share some information that you have received.

It was very much nothing to do with raising anxiety but, having received that information, there was a need to communicate it. I think the Prime Minister did it with both the chief medical officer and the Government chief scientist in a measured, very measured, way. The original part of this is a Committee having done a whole set of analyses and coming up with the conclusions that were then published.

Q386 **Mr David Jones:** Thank you. Penny Mordaunt, as you probably know, we have taken evidence from behavioural scientists who told us that, in many respects, the Government see the public as the weak link and part of the problem rather than the solution. Do you think Ministers have focused too much on rule breaking and not enough on the majority of the public who do comply, and building more trust and more compliance among those who

are rule breaking?

Penny Mordaunt: As a member of the Government, I can tell you that I do not think that. The stoicism of the public in this has been phenomenal. They are the frontline of this fight, and it is only because of their good will, their compliance and their sense of duty and care towards each other that we are now getting the numbers going the right way. I do not wish to speak for all of my colleagues, but that is understood and we cannot thank them enough for what we have done.

I have always thought that it was that sense of solidarity in a local community that is the biggest driver in people following the advice. I do think that is how the public feel. They feel a responsibility to the doctors and nurses in their local hospital. They feel a responsibility to people in their neighbourhood. I was always very keen to stress to the COI that that was one of the main levers we had and that, by thanking people for what they were doing, that was one way we could reinforce that.

Understandably, the media focuses on the egregious breaches. They generate stories. They are obviously in vastly the minority, but they do have a disproportionate amount of attention.

Q387 **Mr David Jones:** What do the figures tell us about the level of compliance with regulations and rules that are published by the Government?

Penny Mordaunt: That it is extremely high and has been throughout the whole pandemic. We can give you information to support that.

Q388 **Mr David Jones:** Could you write to us about that?

Penny Mordaunt: Yes, I am sure we could give you some good information on that. As Members of Parliament, if your mailbag is like mine, we know that there are lots of questions, every time new restrictions are announced, about what you can and cannot do, "Is it okay if I do this?" People feel this very keenly. They want to do their bit and they feel very responsible. As I say, we have a huge amount to say thank you for.

Q389 **Mr David Jones:** Presumably, the Government take advice regularly from behavioural scientists?

Penny Mordaunt: Yes. As well as the hub of information that James's team fuses together, with the behavioural scientists inputting in to that data team, we will also be taking information from the COI, who as a matter of course regularly have real-time information about how people are feeling, how people are complying, what messages are landing, what messages are not landing and how they are feeling about the Government response and so forth.

Q390 **Ronnie Cowan:** Could I quickly ask Helen Whately a question? It is a response to something you said earlier to David Jones. It was about proof of public confidence, which is hugely important throughout this entire crisis. We do not want to govern people by fear. We want them to come on this journey with us. You said proof of public confidence is the uptake

of the vaccine in care homes, which is great, absolutely fantastic, but what is the percentage of uptake in care homes? How many people in care homes in England have actually had the vaccine in their arm?

Helen Whately: I know that data is due to be published today, because it is Thursday, by NHS England on the uptake of vaccination. It either is or will imminently be in the public domain. If that is not available to you, I am sure we can let you know.

Q391 **Ronnie Cowan:** Do you know the percentage of people who have taken the vaccine into their arm in care homes in England? Do you know that number?

Helen Whately: I have some data about it, and I am expecting data to be published so that it is available more widely.

Q392 **Ronnie Cowan:** I assumed that you would know that number, if you know it is proof of confidence.

Helen Whately: As I say, I have data about it and data will be published.

Q393 **Ronnie Cowan:** I am not trying to trip you up. I just thought a good number was coming out. The reason I ask that question is that in Scotland we have had this debate about why the vaccination rates are different. I do not want to put politics into this—I absolutely do not—but when asked that same question Michael Gove said it has been offered to 100%, but he could not tell us how many people had actually taken it. Being offered means nothing at all. When I heard you say that, I thought you had that number for me, which would have been a good number.

Helen Whately: Something that has been referred to is that we have built a dataset about social care, including asking care providers to report to us the number of people who work for them and then, on that, the number of people who have been vaccinated to give us an indication so that we have exactly that kind of information.

Q394 **Ronnie Cowan:** Sorry, I just jumped to that because I thought maybe there was a number. I have been trying to get hold of updates and it suddenly presented itself to me, but clearly not. Thank you.

Penny Mordaunt, this should not take us too long; we dipped into it earlier. We have been told that data about the pandemic has been framed within political consideration and that data has sometimes been cherry-picked to tell a certain story, often one that is favourable to the UK Government. Is that a fair criticism?

Penny Mordaunt: You are right that this will not take long at all. No, that is not a fair criticism. If you look at the work done by James's team and all of the highly professional bodies, from SAGE to the Joint Biosecurity Centre and the behavioural scientists and everyone who is contributing to the information to make sure that we all make the best decisions we possibly can, you will see that is not the case. Also, there is a huge amount of information in the public domain.

It is incredibly important and, by and large, there has been so much cross-party working, immense goodwill and working across the four nations, from the chief medical officers right through to all of the bodies that are working together—this really is a UK-wide effort—and working together to help the international effort as well. That is what the public expects from us. That is what I would urge all colleagues to do, and the Government will be held to account for the actions they have taken. The Prime Minister has not shirked that responsibility at all, and people are making the best decisions they can with the best information they can.

Q395 **Ronnie Cowan:** I respectfully disagree on the Prime Minister taking responsibility. The criticism did not come from me, it came from Professor Richardson of the Royal Statistical Society. She was talking about an example from the start of the crisis. That was referred to earlier. She said, "The Government set a target to carry out 100,000 Covid tests per day and then claimed to have met the target by posting 100,000 tests a day. This is against the code of practice."

Penny Mordaunt: I will have to defer to my Health colleagues with regard to the particular data that they are using, but I would just repeat my point. Time and examination will tell. When you look at the information that is in the public domain, the information that has been used to take particular decisions, the accountability for those decisions and the working that goes across the four nations in taking those decisions with other nations—the devolved nations being part of whether it is Covid-O or other Cabinet Committees in taking those decisions—they are taken together. We understand as well, because of the points I made about having simple messages that are understood, that having consistency across the UK is also desirable in terms of that messaging.

Q396 **Ronnie Cowan:** Professor Spiegelhalter also told this Committee, "I am on record as having complained about what I call the number theatre of briefings, in which big numbers were being thrown out. That seemed to be intended to give an effect favourable to politicians rather than genuinely trying to inform the public." Is Professor Spiegelhalter wrong as well?

Penny Mordaunt: I am not familiar with the details of his criticism. What I can tell you is that it is very well understood in Government that the way you maintain public confidence is not to overpromise and under-deliver. We will be judged on how we deliver for people.

There are big numbers involved. If you look at the vaccination programme, these numbers are enormous. Our healthcare professionals and those supporting them are vaccinating enormous numbers of people every day, so they are big numbers but they are correct numbers. We very much understand that maintaining public confidence in what we are saying and what we are asking people is fundamental. We are not going to do anything to risk that.

Q397 **Ronnie Cowan:** There are big numbers: 109,000 people have died from Covid in the United Kingdom. That is a frightening number and obviously

dials down to 109,000 individuals, family members and loved ones. That is the biggest figure we should be looking at.

Just in terms of the UK and confidence in the Government, will this Government admit that they got some things wrong?

Penny Mordaunt: I think already people have—

Ronnie Cowan: It is a yes or no.

Penny Mordaunt: Already people have said that they could have done things in a particular way. People have taken decisions based on the information that they have had at the time. There are lots of lessons to be learned.

Q398 **Ronnie Cowan:** I absolutely understand and respect that, but we seem to be unable to admit that we have made mistakes. If you are going to take the public with you, and if they are genuinely going to believe you, maybe a little humanity is required to say, "Do you know what? As human beings we made mistakes." Just that statement, but I cannot hear it coming at all from the UK Government.

Penny Mordaunt: I have to say—if you will let me answer—that the answer I gave just a few moments ago did say that. That people were taking decisions on information at the time. We have obviously learned a lot about the virus in that time. Short of a time machine, you cannot alter those decisions. What is critical is that we learn the lessons from this in order that the nation can be more resilient in the future. As well as the inquiry that the Prime Minister has spoken about, we have also been very keen to have real-time improvement and learning. We have given you some examples of how that happens with data and how that happens in healthcare and social care today.

What is critical, and what the public expects, is that focus on delivery and that openness about making particular decisions. I think people do not want this politicised.

Q399 **Ronnie Cowan:** Did I catch you right? Have the UK Government committed to a public inquiry at the appropriate time?

Penny Mordaunt: The Prime Minister has made several statements on this, and I would refer you to those.

Q400 **Tom Randall:** If I could stay with you, Penny Mordaunt, on that question of public confidence and data. A lot of data has been published, but there is often uncertainty around data, what it shows and the decisions made on it. Do you think the Government have been open enough about the uncertainty of data on the spread of the pandemic?

Penny Mordaunt: The short answer to that is yes. From both the complex datasets and the information SAGE produces and the minutes of those meetings, there is clearly discussion around that and the margin of error but also in the very simple information that is presented to the general public as well. Quite often you will hear the chief medical officer and others

say, when they are presenting their slides, about the margin of error. For example, the size sample is always mentioned. People understand that. We try to explain how data has been generated as well as the headline numbers.

James may be able to give some further examples of how that is done and the evaluation that goes into it.

James Bowler: Yes, you are absolutely right, there is a huge amount of uncertainty and, therefore, using things like ranges, confidence intervals and being clear on things is important. People have increasingly done that and should continue to do so. The other uncertainty is about the future. We were saying earlier that the Prime Minister's most recent statement had that at its fore, whereby he was saying prevalence is very high and it is uncertain what is going to happen. We will look at evidence in this period, publish a strategy on 22 February and look to reopen thereon. Obviously, people are pushing hard for absolute clarity and it is important that we recognise that uncertainty limits that going forward.

Q401 **Tom Randall:** Coming back to Penny Mordaunt, officials might talk about confidence intervals and so forth. That is not something we often hear politicians use, those sorts of terms. Do you think that, when speaking, Ministers or politicians should be more open and transparent about uncertainty than they otherwise are when making statements?

Penny Mordaunt: People are trying to make statements as clear as possible, particularly public-facing statements. They are obviously trying to make them as transparent as possible in terms of how information is generated, and communicate the degree of confidence they have in those numbers.

Most of the examples—for example, to change behaviour or to emphasise the asks that are being made of the public—have been linked to very clear factual information, such as the infection rate. A great deal of effort has gone into localising that information so that, as a member of the public, you can go online and drill down to your local ward to understand what is happening in your neighbourhood. That is very critical in terms of public information.

I also think that in information to other organisations, partner organisations, to parliamentary colleagues and so forth, a great deal of thought has gone into trying to present as much information about the quality and reliability of that data as possible. The House of Commons data pack that is put together, which James and his team will be producing information for, is good in terms of framing that and giving good information that people can make a judgment about.

Chair: Thank you very much. That brings us to the end of today's session. The Committee will probably be writing to both Ministers for clarification and follow up. From me and from the other members of the Committee, I thank our four witnesses today as we conclude our inquiry.