

Science and Technology Committee Health and Social Care Committee

Oral evidence: Coronavirus: Lessons learnt, HC 95

Thursday 10 June 2021

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Science and Technology Committee: Greg Clark (Chair); Aaron Bell; Dawn Butler; Katherine Fletcher; Rebecca Long Bailey; Carol Monaghan; Graham Stringer; Zarah Sultana.

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

Questions 1241 - 1508

Witness

I: Rt Hon Matt Hancock MP, Secretary of State for Health and Social Care, Department of Health and Social Care.

Examination of witness

Witness: Rt Hon Matt Hancock MP.

Greg Clark took the Chair

Q1241 **Chair:** The Science and Technology Committee and the Health and Social Care Committee are conducting a joint inquiry into the lessons that can be learnt from the response to the Covid pandemic, and, in particular, lessons that can inform further decisions yet to come. We conclude our oral evidence sessions today with the Secretary of State for Health, Matt Hancock. We are pleased to welcome the Secretary of State.

As in our last hearing, Jeremy Hunt and I will alternate in the Chair, covering four themes. The first is the initial response to the pandemic. The second is the lockdown measures, the non-pharmaceutical interventions as they are called, and the Test and Trace system. The third is the development of vaccines. The fourth is the decisions taken in the autumn and winter 2020-21 and current policy issues. We will pause briefly between sessions to change over in the Chair.

We took oral evidence from the Prime Minister's former adviser, Dominic Cummings, on 26 May. Mr Cummings agreed at the hearing to provide written evidence to substantiate various verbal claims that were made at that hearing. Mr Cummings was asked to provide this evidence to the Committee by Friday 4 June in good time to inform our questions today to the Secretary of State. We have not received that evidence, nor any explanation as to why it has not been available. As Jeremy Hunt and I both said in our last hearing, it is important that, if serious allegations are made against an individual, they should be corroborated with evidence, and must be counted as unproven without it.

Most of this hearing will be about learning lessons, but I think it is only fair to the Secretary of State for him to be able to have his say about the allegations that have been made against him. I am going to begin with some questions drawing on the accusations that have been made. I want to stress that these are suggestions and allegations that Dominic Cummings has made; they are not the Committee's charges to investigate.

The first is, did you ever say anything to the Prime Minister that you knew not to be true?

Matt Hancock: No.

Q1242 **Chair:** Thank you. Specifically, in terms of the particular points that Dominic Cummings raised, first, did you say that everyone who needed treatment got the treatment that they required, when you had been told by the chief scientific adviser and the chief medical officer that people did not get the treatment they deserved?

Matt Hancock: I did absolutely say both in private and in public that everybody got the Covid treatment that they needed. I am very proud of the fact that, with the NHS, we delivered on that during the pandemic, because it was critical. There was no point at which I was advised—I have

taken the trouble to check with the chief medical officer and the chief scientific adviser—that people were not getting the treatment they needed. On the contrary, one of the things that we succeeded in doing through the entire response to this pandemic has been to protect the NHS, so that people have always had access to treatment for Covid.

Q1243 **Chair:** Thank you. The second allegation that was made was on PPE—personal protective equipment. In April, did you ever say or brief that the shortages, such as they were, were “the fault of Simon Stevens; it is the fault of the Chancellor of the Exchequer. It is not my fault—they blocked approvals”? That is what Mr Cummings told the Committee. Is that true?

Matt Hancock: No, that is not a fair recollection of the situation. Getting hold of PPE was always a huge challenge and, as the National Audit Office has shown in their report into this when they went through all of the details, there was never a point at which NHS providers could not get access to PPE. But there were huge challenges. We first opened the stockpile of PPE that we had in the event of a pandemic in January. We started buying new PPE in February. In March, China brought in export restrictions. You will remember that at the time there was a huge global demand for PPE. Aeroplanes were being turned around mid-flight. The European Union put out calls for PPE that went entirely unanswered.

We had to remove a piece of bureaucracy that was in the way that put a limit on the price that could be paid for PPE. We took a policy decision that we should pay at the top of the market. That required the Treasury to make that change. The Chancellor was incredibly helpful in driving that through, and we managed to get to the position where, despite the local challenges, and I do not deny at all there were challenges in individual areas, there was never a national shortage of PPE because of the action that we took.

Q1244 **Chair:** Thank you. We will come to more detail on that. Let me just check that I have understood correctly what you are saying. You are saying that there were blockages to the procurement of PPE. You objected to them, you requested that they should be removed, and they were removed as a result of that.

Matt Hancock: That is correct. Also I will say this: I take and took, and have taken throughout, full responsibility for all of the areas that I am responsible for. The Chancellor played his part in resolving those blockages and getting them out of the way so that we could buy PPE, and Sir Simon Stevens has worked incredibly hard throughout this crisis. My whole approach has been that this is a team effort. You can’t respond to a pandemic just by pointing fingers. You have to respond to a pandemic by bringing people together, trying to provide leadership, and by having a positive attitude to teamwork, because that is the only way through it.

Q1245 **Chair:** Were you aware that Mr Cummings then said that there was an investigation into whether there were blockages, and he alleges that that investigation by the Cabinet Secretary concluded that there were not?

Matt Hancock: I can't recall that, but what I can recall, and I know for a fact, is that there was a cap on the price paid for PPE. Because the global price had shot up, we had to remove that cap. I requested its removal. It was removed and after that, combined with bringing in Lord Deighton, who did a brilliant job in this area, we could buy PPE more easily. We are now in the happy position where we have got huge amounts of PPE and 70% of it—other than gloves—is made on shore here in the UK.

Q1246 **Chair:** Who was responsible for that cap?

Matt Hancock: You will have to go through the records, but that was a condition on the budget that we had for PPE. It was set somewhere within the machine. I think it was a Treasury condition, which is why I went to the Chancellor. I am pretty sure that the Chancellor was not aware of it until I raised it with him, because the moment I raised it with him, with the Prime Minister, he got into action, and got it removed.

Q1247 **Chair:** It was a Treasury condition or Treasury block on your Department, so you did not have the unilateral authority to procure in the way you wanted.

Matt Hancock: No, but I am not blaming the Treasury. It is absolutely standard practice that the Treasury puts in place conditions when you have been given a big budget, when you are given a multibillion-pound budget for buying PPE. On 11 April, one of the conditions of that budget was that there was a cap put on the price that we paid. The problem is that the cap was set in terms of the market price, but the market moved upwards massively, so we had to remove that particular piece of bureaucracy. I asked the Chancellor to remove it, and he did very rapidly and then we could buy at the top of the market, which was one of the reasons that we managed to resolve the challenges of getting PPE into the country.

Q1248 **Chair:** Absolutely. To be clear, I am just trying to establish the facts, given the allegation that was made. Given that this is a lessons learnt inquiry, it may be that the fact that you had to change procurement policy may be a lesson for our response in an emergency, so it is important.

The third charge that Dominic Cummings specifically made orally against you was around testing in care homes. Specifically, did you tell the Prime Minister in March that people in hospitals would be tested before they went back into care homes?

Matt Hancock: We set out a policy that people would be tested when tests were available, and then I set about building the testing capacity to be able to deliver on that. We can go through in more detail, and perhaps we will, the reasons for the clinical advice. The clinical advice set out three different reasons why we took the approach we did. On care home policy throughout we followed the clinical advice. The challenge was not just that we did not have the testing capacity, but also that the clinical advice was that a test on somebody who did not have any symptoms

could easily return a false negative, and therefore give false assurance that that person did not have the disease. That was the clinical advice.

At the same time, the clinicians were worried, because it took four days to turn a test around, that if you leave somebody in hospital in those four days they might catch Covid, and therefore go back to a care home with a negative test result but having caught it. The advice was that the most important thing was infection prevention control in care homes. The evidence has shown that the strongest route of the virus into care homes, unfortunately, is community transmission, so it was staff testing that was the most important thing for keeping people safe in care homes. Obviously, again for that we needed the testing capacity. Those are the reasons for the decisions that were taken. That is the clinical advice that we received. We accepted this clinical advice.

But, in relation to what I told the Prime Minister, of course the relationship between the Secretary of State and the Prime Minister is often that I make commitments to do things, I get on and do them, and then they are delivered. That is how the relationship works, as you probably know.

Q1249 **Chair:** Indeed. We will come on, as you anticipated, to more detail in the second section of this morning's evidence. You have been very clear in your answer that what you told the Prime Minister was that people would be tested or discharged from hospital when tests were available. That was always clear in terms of what you said and, as far as you know, what was understood by the Prime Minister and others in Downing Street.

Matt Hancock: I will take you to it. It is worth going to the precise language of the testimony that you are referring to because that is in fact what was said—that people would be tested. My job was to build that testing capacity and, with the team, we absolutely did.

Q1250 **Chair:** I understand. As I say, we will come to the policy questions and lessons learnt during the rest of this morning. I wanted to get your response to those charges that were made. Is there anything you want to add as a right of reply to the oral evidence that you heard from Dominic Cummings?

Matt Hancock: Well, it is telling that no evidence has been provided yet, but there is a reason for that, I think, which is throughout this I have got out of bed every morning with the view and the attitude that my job is to do everything I could to protect lives and to get this country out of the pandemic. I have approached that with a mission-driven determination to make it happen. I have tried to do that with an approach of honesty and integrity, and, critically, answering questions, both in public and in private, to the best of my ability. Sometimes, you have to say you don't know because you are operating in a world where huge judgments are being made, with very imperfect information, often at great pace.

The approach I have taken, not least in public and to Parliament and Select Committees like this one, and in private to the Prime Minister and everybody else, has been to be direct sometimes, yes. And I can be quite

forceful when I am trying to get something through if it needs to happen, but that is what you have to do. Crucially, you have to bring the team with you. There are a lot of people doing the biggest job they have ever done in their lives. You have to build confidence that people can go ahead and do what needs to be done and that they are going to be supported in the judgments they take.

We will go through no doubt lots of difficult judgments that were made, and it is very important that we learn the lessons on which of those judgments could have been improved. Indeed, like on care homes, we did manage to improve the system over time. The attitude and the approach was always to be direct, and as straightforward and honest as possible. In a way, I welcome this opportunity to tell you the truth of what happened, given the discussion that there has been over the past couple of weeks.

Q1251 **Chair:** Given the discussion, why do you think it was Dominic Cummings chose to be quite so withering? Did you have bad personal engagement over the time? Was it a sincere difference of policy view, whether policies or operational decisions? What is the origin of this dispute?

Matt Hancock: I have no idea. I worked directly with the Prime Minister from the start of this, and of course I worked with his aides and his team as well. I have no idea.

Q1252 **Chair:** Did you know that he wanted the Prime Minister to fire you?

Matt Hancock: Yes, because he briefed the newspapers at the time, or somebody briefed the newspapers. I now have a better idea of who it was.

Q1253 **Chair:** Did you raise an objection to that?

Matt Hancock: Yes of course and I had the Prime Minister's wholesome support all the way through.

Q1254 **Chair:** And was it problematic in the discharge of your duties in Whitehall that this was happening in the newspapers, in the public prints, but also reflecting discussions that were taking place in Downing Street?

Matt Hancock: I think the best thing to say about this is—this will be corroborated by lots of people in Government—that government has operated better over the past six months.

Chair: I turn to Jeremy Hunt for the first series of questions.

Q1255 **Jeremy Hunt:** This inquiry is about lessons learnt for the future. I want to look in a bit of detail at the scientific advice you received at the early stages of the pandemic. Test and Trace is a very established key plank of our response now, but the original four-point plan that was announced on 13 February last year—Contain, Delay, Research, Mitigate—said that community testing should be stopped after stage 1. That is what happened three weeks later on 9 March. In South Korea and Taiwan, we now know that test and trace was used right the way through the

pandemic, and, as it progressed, they scaled up their testing rather than scaled it down.

My first question is, when was the first time that you as Secretary of State were advised that South Korean-style test and trace was a potential option for controlling the pandemic in the UK?

Matt Hancock: I will answer that, but just before I answer the direct question I want to correct something in the question, which is that testing was at no point scaled down. On the contrary, we were driving up testing capacity all the way through. If you look at the record of the testing numbers, we spent January devising the test—

Q1256 **Jeremy Hunt:** I understand, but community testing was stopped. That was the announcement that was made in Downing Street on 9 March. There was still testing going on in hospitals and some in care homes, but for the community element, which is what carried on in South Korea and Taiwan and other places, it was part of the strategy to stop that. I am just wondering at what point you were advised that that different approach could be a sensible approach for the UK.

Matt Hancock: I thought it could be a sensible option throughout. This is what I was explaining.

We were ramping up testing capacity all the way through. At first, in January, PHE devised the test. We were one of the first countries in the world to devise an effective test. Then in February, we got that test up and running in practice. We got to about 2,000 tests a day by the end of February. We multiplied that by five times over March. In the middle of March, I took personal authority over the driving up of testing because it wasn't going fast enough. What I would say is that at the time PHE was brilliant at the science and the development, but simply had not had the experience or the capacity to scale. This is important because what happened was that the growth in the demand for the tests for people who were symptomatic happened exponentially, whereas the growth in the testing, although very rapid, was in a straight line. This meant that we had to prioritise the testing.

Q1257 **Jeremy Hunt:** I understand that argument, but I am really trying to talk about the advice you received. Dr Jenny Harries was very clear. She said community testing was "not an appropriate intervention." She said that was scientific advice that had been around for several weeks. I want to look at the exact evidence. The week before the big national lockdown was announced on 23 March, Imperial published a paper on the modelling they had done. They had two options in that. One was what they called suppression, which was, effectively, a lockdown approach, and the other was what they called mitigation, which was, effectively, allowing the virus to spread but protecting the most vulnerable people. There was no South Korean test and trace option in that paper. It was either lockdown or let the virus spread.

Matt Hancock: There is no country in the world that uses only testing and does not have some form of lockdown as well. So, absolutely what I was up for—

Q1258 **Jeremy Hunt:** But there is: South Korea. South Korea has not had a lockdown. This is really what I want to ask you. Why were you not advised of that middle way, which would involve not stopping community testing, as we announced on 9 March, but expanding community testing? You were not advised that in the run-up to the first lockdown that was an option.

Matt Hancock: I was not, but I am also trying to explain that I think there are a couple of points in the premise of your question that are wrong. The first is about capacity. Unlike other countries, we did not go into this with a testing capacity. One of the reasons that we had to reduce the use of community testing is that we did not have a big enough capacity and we had to target the testing where it was clinically most needed.

Jeremy Hunt: But—

Matt Hancock: Hold on. The second point, which is really important here, is that the clinical advice I received was that testing people asymptotically would lead to false negatives. In fact, there was a SAGE decision on this, SAGE advice, on 28 January, saying that it would not be useful to test asymptomatic individuals. That advice was later changed. In fact, maybe we can come on to a wider discussion about asymptomatic transmission because that is a very, very significant part of what we have learnt. The problem was that we were advised you should not test people without symptoms because you will get a set of false negative results, and, secondly, that when you only have a relatively small testing capacity, compared to, say, Germany or South Korea, you have to target it at the people for whom it might be life-saving. That is the basis on which I—

Q1259 **Jeremy Hunt:** I understand. I am not questioning that you followed the clinical and scientific advice. I accept that.

Matt Hancock: In this area.

Q1260 **Jeremy Hunt:** I am trying to understand what that advice was. SAGE did not model South Korean test and trace until April. They did not actually discuss its impact until May. I cannot see any evidence in the papers that you or the Prime Minister were offered that South Korean style approach as an option at that first stage before the first lockdown was announced, and I just want to check that is correct.

Matt Hancock: That is my recollection, yes.

Q1261 **Jeremy Hunt:** A lot of this is Captain Hindsight, but it is important to learn from Captain Hindsight because we might have pandemics in the future. We did not know at the time that Korea and Taiwan were going to have some of the lowest death rates in the world, but we did know that Taiwan had experience of SARS and Korea had experience of MERS, and

being nearer China they both had cases of the pandemic before we did. Why do you think it took until May for SAGE to discuss the approach taken in Korea and Taiwan?

Matt Hancock: I don't know.

Q1262 **Jeremy Hunt:** Okay. Let's look at someone else who was a bit closer to us who was also talking about the same kind of thing: Dr Tedros at the World Health Organisation. He said on 16 March, so this is before our first lockdown, that Test and Trace needed to be escalated.

Matt Hancock: Yes.

Q1263 **Jeremy Hunt:** At that time, Taiwan, Australia, New Zealand and Korea had already started closing their borders. They have all kept their cases to below 2% of the population. Do you think we had a blind spot about what was happening in east Asia at that time, because there does not seem to be any evidence that it was fully considered?

Matt Hancock: I think there are a significant number of lessons from this. One is that the need for a rapidly scalable testing operation must be part of pandemic preparedness, and this country did not have one. If you think about the areas where we were strong in our response to the pandemic, they are areas where we had prior strengths.

The NHS response was very strong: it built new hospitals and delivered care to everybody who needed it. The science response was very strong. We have a centuries-long science tradition. We did not have a major diagnostics industry or capability, and the tracing and isolation system was, essentially, built for very important but very small outbreaks. As Health Secretary, you are dealing with these sorts of outbreaks all of the time. I am currently dealing with a monkeypox outbreak and cases of drug-resistant TB. That is absolutely standard. The lack of that capability at the start meant that the options that we had were fewer.

Q1264 **Jeremy Hunt:** Let's just look at what you did in April very successfully, which was ramping up testing capacity to 100,000 a day. That was a big change. If you had been advised in January or February, "We're going to need more testing capacity if we want to go South Korea, and let's start this right away"—

Matt Hancock: But we did. In January, I was driving the system to drive up testing capacity. In fact, in preparation for this meeting I was looking at the minutes of one of our internal meetings on 27 January when I was calling for the driving up of testing capacity. PHE's response was excellent on the science, but there was simply not the experience to drive up the capacity. We got to 2,000 a day by the end of February and it was still rising, but by the middle of March it was not rising fast enough, we were not doing enough to bring in private sector capacity, so I took personal charge of it, and then, a couple of weeks later, set the 100,000 target. That 100,000 target was essential in galvanising the whole system and building a diagnostics organisation and ecosystem in this country, and now we are doing about 6 million tests a week and I'm very proud of that.

Q1265 **Jeremy Hunt:** That was a very important step in our pandemic response, but the strategy at the time was clear that, when we got through stage 1, community testing would stop. On 16 March, when Dr Tedros said we needed to, "Test, test, test," the week after we had stopped community testing, did you challenge officials, and say, "Why do we appear to be doing something that is completely different from what the World Health Organisation is advising?"

Matt Hancock: I entirely agreed with Dr Tedros at that point, but the challenge was the scale of the capacity. I had driven that as hard as I could within PHE, with my indirect hands on the levers, and then in the middle of March we had a meeting. I remember very clearly we had a meeting in Downing Street at which we had an array of the test providers. We had the PHE team who were doing the testing, and I took personal charge of the testing project.

Q1266 **Jeremy Hunt:** I know you wanted to expand the capacity. I am just trying to understand the strategy. You have confirmed that you were not offered South Korean style test and trace as an option in the run-up to 23 March.

Matt Hancock: As far as I can remember.

Q1267 **Jeremy Hunt:** Did you ever ask SAGE to analyse what was going on and do the modelling for South Korean style testing?

Matt Hancock: Yes, and I had calls with South Korean Ministers myself in order to understand what they were doing.

Q1268 **Jeremy Hunt:** So why did that modelling not happen until April and why were there no discussions until May, because this could have been a big emergency?

Matt Hancock: Essentially, because of a lack of capacity.

Q1269 **Jeremy Hunt:** No, I'm talking about discussions in SAGE. I understand the lack of capacity was a problem, but in terms of the strategy, SAGE did not discuss this until May. If you requested them to look at it earlier, why did it take that time?

Matt Hancock: I'm not sure that I did directly. What I was doing was asking around the world for who's got the best response. All of these questions are predicated on the idea that we simply could have had more tests. We could not. We drove—I drove the system as hard as I could, including having to go in and essentially take executive authority over delivering it. And then we brought in Dido to pick that up because it was such an enormous task.

Q1270 **Jeremy Hunt:** I need to ask you one question similar to what Greg asked you about Dominic Cummings's allegations, which again we have to stress he did not substantiate when we asked him to, but I want to give you a chance to comment on the record. He said that you used the whole "we are following the science" line as a way that meant you could always say, "Well if things go wrong, we'll the blame the scientists and

it's not my fault." He said he saw you discuss that with the Prime Minister. Is that true?

Matt Hancock: I don't think so, no, and I'll tell you why, and we have discussed it at the Select Committee before. My approach throughout has been that we are guided by the science. I try not to say that we are following the science. There are examples where Ministers make decisions different from the scientific advice. One example is that, when we brought people back from Wuhan in January, I was advised that they should be asked to go home and isolate, and I said, "No, they need to quarantine." We used the NHS facility at Arrowe Park on Merseyside, you will remember, and we took people directly from the planes and put them in Arrowe Park and made sure that they were quarantined. That is an example of the scientific advice saying you can be more relaxed about things and me being tougher.

When it comes to the decisions around lockdown, we did accept and implement the scientific advice, and I am sure we will come on to that, in the early March period, but I take full responsibility for the decisions not only that I take but those taken in my name as Secretary of State across the health family, in the NHS, Public Health England, in the Department. I know the Prime Minister feels very strongly the same. Of course you are guided by the science.

Q1271 **Jeremy Hunt:** Looking forward, my last question on this area is, how do we improve the quality and the diversity of the advice going to Ministers from SAGE and the scientists in the future? Do you think there would be merit, for example, in a pandemic situation, rather than normal times, in publishing that advice immediately so that we can get the benefit of instant peer review from the entire scientific community?

Matt Hancock: Yes, and, thankfully, we do publish the evidence now and the minutes of those meetings, and I think that the public debate around this is generally healthy.

Jeremy Hunt: Thank you.

Q1272 **Chair:** Following up Jeremy's question about Korea, in March, the Science and Technology Committee took evidence from Public Health England, and one of the officials there said an evaluation had been made, a formal evaluation of the South Korean model, as to whether we could learn lessons from it in that early phase of the pandemic, but try as we might, that paper seems to have evaporated; it disappeared. It has never been produced to us. Did you ever see it?

Matt Hancock: I have no recollection of that. That is not to say no, because in prepping for this Committee I have gone through a whole load of things and there are some things I have discovered that I had forgotten that I did. So it is not a no, but I have no recollection of it.

Q1273 **Chair:** The 100,000 target that you set when you had gripped the problems that you saw was the subject of some quite bitter criticism from Dominic Cummings. He said it was criminal that you should have set that

target. It was notable during that time, again the Science and Technology Committee took evidence, and no one who came before us, including your officials, wanted to associate themselves with that target. Even your testing tsar, John Newton, when we asked what was the derivation of the 100,000 said, "You'll have to ask the Secretary of State; it was his target."

Matt Hancock: It was my target.

Q1274 **Chair:** Evidently. Why was it the case that even your own advisers and the whole of Whitehall seemed to be running away from it and not wanting to associate themselves with it?

Matt Hancock: I don't know whether the testimony you are talking about was before or after we hit the target.

Chair: Before.

Matt Hancock: There you go.

Q1275 **Chair:** Can you explain what is in your mind there?

Matt Hancock: We did not know we were going to hit it. Sometimes you have to put yourself in jeopardy. You put yourself on the line. In this case, I knew we needed a radical increase in testing capacity—a radical increase—and that incremental increases would not do, and so I set the 100,000 target. I set it on the advice of my team who were doing the ramp-up. I asked them what was the best they could do by the end of the month. The advice they gave me was just over 100,000. But 100,000 is a good number for a big target.

The purpose of the target was to galvanise the system, and it worked. If you ask anybody involved, including many of those who have been mentioned during this Select Committee process, they will say that the 100,000 target mattered because it galvanised the system, not just in the Government but the whole country. We needed the diagnostics companies to come to the table. We needed the NHS labs to step up further and expand. It said to everybody, "We are going for it big time," and it worked. Within Government, the whole of the Department involved in testing was focused on this, on the goal, and I am delighted to say that we hit it. There were others, it turns out. I had no idea at the time that there were others who were working who were not as supportive as I might have hoped.

Q1276 **Chair:** You didn't know that Dominic Cummings, for example, at No. 10, as far as he spoke for them, was against the whole enterprise of 100,000 tests.

Matt Hancock: I was a bit surprised by the testimony that he did not think we should have a target, or that we shouldn't—I was a bit surprised—

Q1277 **Chair:** But you didn't know at the time? That hadn't been communicated to you at the time?

Matt Hancock: No, and I will tell you why, which is what I was just coming on to. The Prime Minister was absolutely four-square behind me and gave me his full, wholehearted support in hitting the target, because he, like me, knew that we needed a radical increase in testing. It is a tried and tested method. In fact it turned out afterwards, I was told, that this is an absolutely standard business school methodology. I have never been to business school, but it turns out you set a big goal, you galvanise the team, you give everybody confidence to do what is needed to build this capacity, and it worked. I also saw some testimony from some people saying we needed to get to a higher number. Absolutely, but you cannot get to a higher number without going through a lower number first, and that is what we did.

Chair: Thank you.

Q1278 **Laura Trott:** Good morning, Secretary of State. Dominic Cummings said that on 25 January he contacted you about pandemic preparedness and you said to him, "We've got four plans up to and including pandemic levels regularly prepped and refreshed, CMOs and epidemiologists. We are stress testing now. It is our top tier risk register." Is that your recollection of what you said? With hindsight, what are your thoughts on the level of pandemic preparedness that was in place at that time?

Matt Hancock: Yes, I think the record is actually slightly wrong because that is all correct, except I said the CMO is an epidemiologist. The question was, are we ready for something like Ebola or a flu pandemic? And, famously, the preparations and the plans that were in place were for a flu pandemic.

The honest truth is that this was a completely novel virus and, in fact, as we will come to when we talk about asymptomatic transmission, it is different even from the previous coronaviruses, including SARS and MERS. It is true that the countries that experienced SARS and MERS were better prepared than we were, partly because of that experience, but it is also true that Covid 19 is very different from SARS and MERS, and the No. 1 difference is that it has asymptomatic transmission.

Those plans that were in place, the flu preparedness plans, were incredibly useful in some areas. They meant that we had a draft Bill which became the Coronavirus Act. It meant that we had plans ready for infection prevention control, and, in fact we published our first infection prevention control data—sorry, not data: guidance—on 10 January. So those plans were important. But of course when you have a novel pathogen, it behaves differently from what any plans could possibly set out. What really mattered is the capabilities that we had. There were some areas where we had strong capabilities. As I said to the Chair a moment ago, in some areas like the NHS, like science, we had strong capabilities. There are other areas where we had weak capabilities, especially testing.

On vaccine, there was a big difference with flu preparedness because we had vaccines ready to go on flu, and we had antivirals—we've still got a

big stock of them—but for a coronavirus there was no vaccine, and there aren't any proven antivirals either. What I said is absolutely true in response to the question. He asked me, "Are we ready for Ebola or a flu pandemic?", and I said we had full plans for those things. Of course at that time, 25 January, in the Department, we were working incredibly hard on responding not just to Ebola or a flu pandemic but to what we knew of what became of Covid 19.

Q1279 Laura Trott: How many of those deficiencies were predictable? Do you think we should have learnt more from SARS and MERS? Do you think that the lack of diagnostic testing was a predictable failure that we should have addressed pre-pandemic?

Matt Hancock: It is a very good question. Some of these things we would have done better to have learnt from SARS and MERS. Other things were not predictable. For instance, I first started the push for a vaccine in January. In fact, I had a meeting on 25 January pushing for a vaccine in which I was told that it would take a long time, that it would take normally years and typically, if we accelerated everything and if everything went right, it would take a year to 18 months. I said, "I want one within a year and we will throw the full resources of the state at making that happen." We tasked Jonathan Van-Tam with leading that project, and it was obviously hugely successful. It was predictable that we did not have a vaccine for a coronavirus, so as soon as we knew this was a coronavirus, which was relatively early in January, we knew that the gap in the vaccine armoury would be a significant gap. There are other things that were far harder to predict.

Q1280 Laura Trott: If you think about the function of pandemic preparedness, if we are trying to make changes in the future, do you have any reflections on things that we should do to make sure that those predictable deficits are addressed?

Matt Hancock: Yes, absolutely. We need a standing testing capacity so that we can stand it up immediately. We need an at-scale contact-tracing capacity so that we can contact trace even when the numbers get big. The reason that community contact tracing stopped was because the number of infections was so big and the capacity, again, as with the other PHE capacities on the way into this, were great on the science and small scale, but could not scale. We need in good times to retain capacity so that, as and when a new pathogen hits that could become a pandemic, we are ready to pounce on it.

I think another huge learning point is borders. I do not know whether we will come on to that later, but, on borders, the position that we took was based not just on World Health Organisation advice but on their international health regulations, which stipulate that closing borders is not an appropriate response in a pandemic. That is the international regulation. The clinical advice we received was that unilaterally taking action at the borders would only have a small effect in terms of delaying the response, of about a week. Indeed, early in the pandemic this was proven by both the United States and Italy taking direct action at the

border and still the disease went rife. If everybody takes action on their borders and restricts movement, clearly that can have a big impact, so we have strengthened our border policy throughout, and now we have one of the strongest border policies in the world.

But my reflection on it at the time, and this is very important for lessons learnt, is that the only way the world could have stopped this virus getting out of China is if China itself had stopped people leaving China, because as soon as people were allowed to leave China to go to one place, unless the whole world took action on borders as they have now, it would only have delayed to a degree. That was the clear clinical advice, and it is one of the things that we absolutely must change at the global level—that part of the response to a dangerous pathogen needs to be health action at the border.

Laura Trott: Thank you, Secretary of State.

Q1281 **Rebecca Long Bailey:** Mr Hancock, you have said that testing was at no point scaled down; you were ramping up testing capacity all the way through and you wanted to scale that up, certainly in February, but you had to prioritise testing. Just before the first lockdown, what was the plan for the prioritisation of testing?

Matt Hancock: Yes, this is important. I think it was published but, if not, I will write to the Committee with the full clinical details. This was a clinical document that set out the prioritisation according to what use of tests is most likely to save lives. If I recall correctly, the top item was use of tests in intensive care, because in intensive care, if somebody has breathing difficulties, the difference between knowing that this is Covid-19 or not can be a life-saving difference. You start with intensive care and then work through, but it was a clinical prioritisation.

Q1282 **Rebecca Long Bailey:** A whistleblower reportedly stated to the media yesterday that in March 2020 Public Health England internal advice was to ensure that any patients newly discharged into care homes had to be tested for Covid 19. The whistleblower allegedly said this initial advice was signed off by two PHE officials, Dr Éamonn O'Moore, director of health and justice, and Dr Julia Verne, head of clinical epidemiology, and that that was the case up to the period just before the first lockdown.¹ Would you say that was correct?

Matt Hancock: I have no recollection of that. That is not my recollection of the clinical advice, and I have not seen anything on that.

Q1283 **Rebecca Long Bailey:** The whistleblower goes on to say that even though officials were fully aware of Covid-19 outbreaks in care homes at this time, allegedly, one of your Health Ministers leaned on Public Health England to alter the advice being published, because your Department believed that they needed to empty space and get people out of hospitals. The whistleblower says Dr O'Moore and Dr Verne were therefore pressured to sign off on published guidance that was softened

¹ Public Health England have provided [written evidence](#).

to allow care homes more freedom to take residents in. Was discharge testing advice softened at the instruction of your Department?

Matt Hancock: Not that I am aware of. If I can, I will set out the clinical advice that we were given, because we followed the clinical advice throughout on this, and it is a very, very important topic. If you think about it, right from the start we knew that people living in care homes were among the most vulnerable, and we did all that we could to support them. We knew that, because we know that Covid-19 has a bigger impact on people the older they are, so this was obviously a very important topic from the start.

The clinical advice at the time had three parts. First, if you take somebody who has had a test, and given that it took about four days for the test result to come back, and they stayed in hospital therefore for those four days, that test could come back negative but the person could have caught Covid in hospital in that time. That is obviously bad for that individual, but it is also bad for the care home because they would be going back to a care home with a negative test result—people thinking they tested negative—but having Covid 19.

Secondly, the biggest challenge in this space was that the clinical advice at the time was that, if you did not have symptoms and took a test, it was likely to give you a false negative result. That clinical advice stayed all the way through this period and then was changed later.

The third point is that the most important thing to do, which is what we did in the advice that we gave to care homes, starting in February, is to make sure that there is infection prevention and control in the care homes. In fact, the data published since all of this has shown that the best estimate from Public Health England is that 1.6% of the transmission into care homes came through this route. In fact, what that tells you is that, sadly, the biggest route of Covid 19 into care homes is through the community. It is through people who live in the community and work in the care home. The most important thing for protecting people in care homes was staff testing, which we introduced as soon as we had the testing capacity to be able to do so.

Q1284 **Rebecca Long Bailey:** Certainly there seems to be a lot of confusion here. The allegations suggest that Public Health England advice was initially to test on discharge, and certainly, as we have heard, Mr Cummings told this Committee that No. 10 had been specifically told that was happening. To clarify this, would you provide copies to this Committee of all internal advice and communications between your Department, Public Health England and your ministerial team on hospital discharge and care home testing, certainly for the period from January to April?

Matt Hancock: I am very happy to ensure that the clinical advice and the clinical testimony is provided to this Committee, yes. In particular, if you actually look at the testimony to this Committee about the commitments that I made, the commitment was that we would introduce

this testing when we had the capacity to do that, and given the other pressures on testing, which is a life-saving resource, we did that.

Q1285 **Rebecca Long Bailey:** Just to be clear, you are happy to publish all clinical advice from PHE, your Department, and your responses and your ministerial team's written responses, to the Committee so that we can analyse the same?

Matt Hancock: I am absolutely happy to provide the clinical advice on which these decisions were taken, yes.

Q1286 **Rebecca Long Bailey:** But not your responses, Mr Hancock.

Matt Hancock: I am sorry, I don't understand. This decision was—

Q1287 **Rebecca Long Bailey:** Would you be prepared to publish your written responses to that advice and the written responses of your ministerial team, so that we can be clear on what direction public health officials were given?

Matt Hancock: Yes.

Rebecca Long Bailey: Thank you.

Q1288 **Chair:** On the point that Rebecca Long Bailey raised, she mentions what she has described, or what was described, as initial advice at the beginning of the pandemic just before lockdown, which is the period we are looking at in this section. That was signed off by two PHE officials, we are told: Dr O'Moore and Dr Verne. Will you provide the Committee with that initial advice?

Matt Hancock: I don't know anything about that advice—

Q1289 **Chair:** Assuming it exists.

Matt Hancock: But I am very happy to go away and look to see what advice was given.

Q1290 **Chair:** Assuming that it exists, will you provide that initial advice to the Committee so that we can compare it to the advice that was eventually adopted?

Matt Hancock: Subject to the normal rules on disclosure. I am cautious here, but I have a reason for it, which is that in that period there will have been a lot of advice written that then goes through layers of clinical approval, so I do not want junior officials to end up having their material put into the public domain. What I am very happy to do is go through and look, especially if there is particular advice from these named individuals, and to make sure that is provided to the Committee.

Q1291 **Chair:** You said in answer to a question a few moments ago that it is transparency about the process of decision making. Everyone was operating, especially in those early weeks, in a fog of great uncertainty as to what was the right thing to do. We are trying to learn lessons that might be applied later in this pandemic, but to other emergencies, as to what the right approach is. What is obviously vital for that is not just to

see the final products, but how the advice evolved.

Matt Hancock: Yes, and also the reasons for that evolution, because there will have been a debate about it, I imagine.

Q1292 **Chair:** Precisely. Exactly. That is what I think is behind Rebecca's question and why it would be useful to see this.

Matt Hancock: Okay.

Q1293 **Chair:** Thank you. In terms of those early weeks, and talking about taking clinical advice and following scientific advice, as you say, one of the clear things that has emerged from our oral hearings and the evidence that we have had is that we did not lock down early enough. Neil Ferguson suggested quite a lot of lives would have been saved, I think he said up to half of those initial deaths, if we had locked down a week earlier. The whole question of the changed advice in the middle of March reflected that, and again, this is something that I think has pretty clearly emerged. Some people have said there was a degree of group-think round around this.

From your position, did you not see that, for all the complex modelling, the mathematics of this pandemic were pretty stark; that you have, say, 60 million in the adult population, and if two thirds of them contracted Covid and 1% of those who contracted it died, we would have 400,000 deaths, and that is unacceptable and liable to overwhelm the NHS? How did we, and you in particular alongside everyone else, miss this for so long, for about six to eight weeks?

Matt Hancock: I would absolutely say that we knew about this problem from the start, and the challenge in those early weeks of March was making a massive judgment, probably the most significant judgment that any Prime Minister has made, certainly in peacetime, based on incomplete information, and at great pace. I instructed the Department and the health system to plan on the basis of a reasonable worst-case scenario in January, in fact on 27 January. I asked for a reasonable worst-case scenario planning assumption. I was given the planning assumption based on Spanish flu, and it was signed off at Cobra on 31 January. That was a planning assumption for 820,000 deaths. I was determined that that would not happen on my watch, so throughout February we were planning for how to stop that, and how to deal with the consequences if it came true.

In the middle of February, the scientific advice confirmed that the reasonable worst-case scenario should be taken as read, that this was equivalent to Spanish flu. If you think about it, at the time, at the end of January when that was first presented at Cobra, I, like everybody else, thought of Spanish flu as something you read about in the history books, but as Health Secretary you are always worried about new pathogens. We are dealing with them all the time.

Knowing that that was the reasonable worst-case scenario, we planned for it. We did the work in February, and on 3 March I set out to Parliament what we called the action plan, which set out all the actions

that we might have to take, up to and including shutting schools. I was asked in media about lockdowns and confirmed that we would be happy to take those. At the time, on 3 March when we set that document out, setting out all the things we might have to do, and saying that we were prepared to do them, there were no deaths. Indeed, on 3 March there were 50 cases.

In the week beginning 9 March, what happened is that the data started to follow the reasonable worst-case scenario. By the end of that week, the updated modelling showed that we were on the track of something close to that reasonable worst-case scenario. I think the numbers were slightly below that, but they were of a scale that was unconscionable. Therefore, on 16 March, when there were 611 cases and 53 deaths, we took the decision, and we announced that everybody in the country should stop all unnecessary social contact.

Q1294 **Chair:** We know what happened. We have a clear view and it is all in the public domain. It is evident and everyone agrees; Sir Patrick Vallance said it would have been better if we had locked down earlier, and Neil Ferguson, as I mentioned, said that it would have a big reduction in deaths. We did not do what was necessary early enough, and it seems to me that everyone—certainly most people in the system—got bogged down in the modelling and the complexity, and did not step back to see the crude maths of it, if you like, and to take the measures that were eventually imposed, earlier.

Trying to learn lessons and thinking back, you were someone who was involved in all of those discussions. How was it that you and everyone else did not see the enormity of what was going on and took these literally incremental decisions to turn up the dial progressively week by week in terms of restrictions? Why did we miss the big picture?

Matt Hancock: The clear scientific advice at the time was that there is a need to have the tools, like lockdown, at your disposal, but also, that the consequences and the costs of lockdown start immediately, and critically, the clear advice at the time was that there was only a limited period that people would put up with it—would put up with lockdown. That proved to be wrong because the British public have stepped up to what we have asked them to do in an extraordinary way.

Q1295 **Chair:** Much of that proved to be wrong. It proved to be wrong that people would only tolerate the restrictions for a short period of time. It proved to be wrong that the level of infection could be contained within the NHS, until that had to be revised. We are aware of that. SAGE got it wrong. It is now very clear, and members of SAGE are candid enough, in the way of scientists, to concede that. This is what we are trying to learn.

Was it the case that you simply accepted that scientific consensus without challenge, because that was their business? Were you concerned about it yourself and did you challenge it, or did you think it was not your place to, and you were there to enact what was being recommended?

Matt Hancock: No, we absolutely debated and challenged that advice, but when you are faced with a decision of this enormity, and, ultimately, of course as Health Secretary with my primary goal of protecting lives and finding a way out of this and protecting the NHS, I made that argument, but, ultimately, we did not know how long people would put up with it. Now, it seems obvious that people would put up with lockdowns. It was not at all obvious. We needed the protections in place, especially for vulnerable people in the shielding programme. We take for granted that that has been a huge success, but that was not clear at the time because lots of people rely on social contact, literally, to live.

We needed to ensure that we could, for instance, support businesses to get through this. These are huge decisions. To take those decisions against the scientific advice is an even bigger decision to take. When the scientific advice moved, that became easier. I remember when the big—

Q1296 **Chair:** Do you regard it as part of your role to challenge that scientific advice, to debate it, to stress test it, to ask others, perhaps around the world?

Matt Hancock: Yes, of course.

Q1297 **Chair:** And you did it?

Matt Hancock: Yes, I was discussing this with my counterparts across the world. I had been willing to overrule the scientific advice earlier, for instance, on quarantine. I had pushed in January for a wider flight ban from China, but the scientific advice was that we should only restrict it to Wuhan.

Absolutely, challenging the scientific advice is one thing, but overruling a scientific consensus is much harder, especially when the costs of the lockdown are immediate and are obvious. I remember very, very clearly when the new projections from SPI-M came in towards the end of the week beginning 9 March; I cannot remember exactly what day it was, but towards the end of that week SPI-M came in with some new projections. I remember going into No. 10 and one of the most senior advisers saying to me, ashen-faced, "Have you seen these new projections? Isn't this awful?" I said, "I'm glad the projections are now showing what I think is happening," because you've got to remember—let me take you back to what it was like—the data was so incomplete and sparse. Even getting data out of the hospital system was very difficult. We now have infinitely better data systems than we did.

Q1298 **Chair:** How did you form this view of what was happening?

Matt Hancock: I could see from what I was seeing on the ground. I could see from anecdotes from what I was hearing. You could see it in the testing data with the testing numbers going up. You could just see it in the number of people, sadly, who were dying, but the numbers were still very low at that stage. As I say, on the 16th, there was still—

Q1299 **Chair:** That is the advantage of being Health Secretary; you were visiting hospitals, you are talking to people.

Matt Hancock: I remember the moment around the Cabinet table when I said, "We are going to have to tell everybody to stop all social contact." I remember thinking, "This is the most extraordinary thing that I have ever said." The Prime Minister said, "Yes, we are. You'd better go and tell them."

Q1300 **Chair:** As it turned out, what you said there is pretty much identical to what Dominic Cummings told the Committee—that he had come to believe that there was going to be a disaster and that the assumptions that the policy was being based on were wrong, but that he felt intimidated. He did not use that word, but from what he said in multiple answers he felt very reluctant personally to intervene to overturn what had been an established consensus. Am I right in detecting in what you have said a similar thought?

Matt Hancock: I just think it is hard when there is clear scientific advice to go against that with a decision of such enormity. There is one other example that I wanted to set out—maybe now is the moment to do it—which is about asymptomatic transmission.

One of the big reasons that we changed policy, for instance, towards care homes in April was the conclusion that there was significant asymptomatic transmission. There was a global scientific consensus, based on decades of expert work on coronaviruses, that coronaviruses do not transmit from people who don't have symptoms. This is wrong because this is a novel pathogen. It is a novel virus. It is unprecedented. I heard evidence from China that there was asymptomatic transmission in January, and I also remember talking to my German opposite number, Jens Spahn, and they had seen some evidence in Germany. I asked the scientists to look into this. In fact, I was so worried about it, I arranged a call with the World Health Organisation, and I was told on that call that, with respect to China, this was likely a mistranslation.

Q1301 **Chair:** When was that call that you made?

Matt Hancock: At the end of January. I can get the exact date.

Q1302 **Chair:** Do you have a transcript, a read-out, of that call?

Matt Hancock: We have a note of the meeting and I am happy to supply that to the Committee.

I was told that it was likely a mistranslation. After that, we did not get the evidence from China which could have proved it. I was in a situation of not having hard evidence that a global scientific consensus of decades was wrong but having an instinct that it was. I bitterly regret that I did not overrule that scientific advice at the start and say that we should proceed on the basis that there is asymptomatic transmission until we know there is not, rather than the other way round. But when you are faced with a global consensus, and you do not have the evidence that you are right and the scientific consensus is wrong, it is hard to do that.

On 2 April, the World Health Organisation was still claiming that there was no evidence of asymptomatic transmission—2 April. On 3 April, the

CDC came forward with an evidence paper, and very shortly afterwards Public Health England came forward with a further one, and the consensus scientific position changed. Then we brought in the extra, the stronger—we changed a number of policies across Government as a result. That is a story of preparedness and relying on the science, which is normally the right thing to do. Let's be clear; we are picking on two areas where it would have been better if the prevailing consensus at the time had been overruled, but everybody was operating on highly, highly sketchy information, just a lack of data and lack of information because this is a novel virus.

Q1303 **Chair:** What you said about the difficulty of challenging a scientific consensus is very frank, and I think it is very helpful for us to reflect on. We have heard from other people variations on that theme. Since you raise this question of asymptomatic transmission as not being known, and knowable, you said you had an instinct but the science was against it, it is the case, as you will be aware, in the second SAGE meeting, on 28 January, that the minutes, at point 16, say, "There is limited evidence of asymptomatic transmission but early indications imply some is occurring."

Matt Hancock: Yes. I raised the prospect of asymptomatic transmission on 27 January with the CMO and others. He took it away, and they discussed it at SAGE on the 28th. I called the WHO on the 29th and I have the quote here. I was told it was "highly likely that the message may have been confused by translation issues but that this is unclear."

Q1304 **Chair:** Okay, but SAGE, on 28 January, concluded that early indications imply some asymptomatic transmission is occurring.

Matt Hancock: Yes and the overall scientific—

Q1305 **Chair:** In the minutes of SAGE it was not recorded that the consensus is that there is no asymptomatic transmission. Quite the opposite. They are saying that early indications imply some is occurring.

Matt Hancock: But the World Health Organisation advice and the clinical advice of the most likely situation that I received remained that asymptomatic transmission was unlikely. In fact, the WHO's position was, "There has been no documented asymptomatic transmission." As I say, given all of this debate, and this is an absolutely accurate reflection of the debate, I should have stuck to my guns and said that even if it is uncertain, and even if it is relatively small, we should base policy on that. Even though the formal advice I was receiving was that asymptomatic transmission is unlikely and we should not base policy on it, I should have overruled that.

Q1306 **Chair:** This is an important point. You mentioned the WHO. You said that the WHO view on 2 April was that asymptomatic transmission was not assumed to be a possibility. But in fact the WHO, on 2 April, in its situation report said: "Transmission from a pre-symptomatic case can occur before symptom onset."

Matt Hancock: Yes, so we had this position where, essentially, there were individual instances of the evidence being presented, but the overall scientific conclusion, which was the recommendation for the policy advice, was that it was highly unlikely there was asymptomatic transmission.

Q1307 **Chair:** That is a strange thing to conclude because SAGE, on 28 January, said that early indications imply some asymptomatic transmission.

Matt Hancock: I know.

Q1308 **Chair:** The WHO, on 2 April, said that transmission can occur before symptom onset, so there certainly was not a consensus. There might have been mixed messages but not a consensus on asymptomatic transmission.

Matt Hancock: What I can tell you, and I can send you the details, is that the clear overall clinical advice was against this, despite the fact that I raised it from the start, and there were individuals in the system who were pushing this argument, and there were individual conclusions. If you look at the totality of the evidence, this was the position. As I say, I wish that I had stuck to my guns at the start.

Q1309 **Chair:** We would be grateful for that advice. It does not stand against your conclusion that, as you have just said, it would have been better if we had assumed asymptomatic transmission, even to the point of you stepping in and overriding the assumptions that some other people were making.

Finally, and then we will turn to the next theme of our questions, we heard from Dominic Cummings, as I am sure you have seen reported, that during this period in mid-March when the penny was dropping that things were on the wrong track and needed to change, the Deputy Cabinet Secretary, Helen McNamara, came into No. 10 Downing Street and, according to Mr Cummings, said, "This country is heading for a disaster. I think we are going to kill thousands. There is no plan for this. We are in huge trouble." Was there a plan?

Matt Hancock: Yes, and at that point we had published it.

Q1310 **Chair:** So Helen McNamara was wrong, or do you think she did not say that?

Matt Hancock: I have absolutely no idea, but what I can tell you is that we published the action plan of the actions that we might need to take, including these extraordinary, unprecedented actions, and the question was when to make the judgment to do it, when to put in place, if it was needed, a lockdown, closure of the schools, et cetera.

Q1311 **Chair:** So Ms McNamara, or one of her colleagues, had not communicated to you her concern that there was no plan.

Matt Hancock: I don't recall having any conversations with her at that time.

Q1312 **Chair:** Or any of her team of officials.

Matt Hancock: I will—

Q1313 **Chair:** Obviously not that conversation, but to that effect, to raise the alarm that there was no plan.

Matt Hancock: I don't understand that testimony. I also note that no evidence has yet been put forward for much of this testimony, and I find that telling.

Chair: Indeed, and part of the point of asking that question is to see whether your recollection tallies with what was said orally, and you have been clear about that.

That brings to an end this section of the hearing. I am going to hand over to my co-Chair, Jeremy Hunt. We will suspend the sitting for about five minutes while we change around.

Sitting suspended.

Jeremy Hunt took the Chair.

Q1314 **Chair:** Welcome back to the joint hearing of the Science and Technology and Health and Social Care Committees. We are going to come on to the vaccine programme later. We have talked about the decisions in the run-up to the first lockdown on 23 March. In this session we want to talk about what measures we took to prevent the spread of the pandemic in that first period—if you like, the middle of last year—before the vaccine programme had got under way.

I want to talk to you about the Test and Trace programme. Dido Harding was appointed on 7 May. I want to look specifically at the question as to why that Test and Trace programme when it was set up did not prevent a second or third lockdown as we had hoped, and, indeed, as test and trace programmes managed to in other countries. With the benefit of hindsight, and this is looking back to see what we can learn going forward, why do you think it was that that Test and Trace programme did not prevent further lockdowns?

Matt Hancock: I think the No. 1 challenge that we had was going into this without a large-scale testing programme, as we discussed in the previous session. We had a small, effective, but not easily scalable, contact tracing programme. Putting those things in place at very large scale is hard. We needed somebody who had experience both of building big retail organisations and the NHS and healthcare, and there was nobody better placed than Dido Harding to do that.

As I said earlier, I had taken on, essentially, executive authority to make it happen, but I had a lot of other things that I needed to do. In fact, one of the other things we did during this whole period was we brought brilliant external people in—Paul Deighton on PPE and Kate Bingham on vaccines and others.

The starting point is that building a plane in flight is harder than flying a plane that has been built for a while. That is central, I think, to some of the areas where this country found it more difficult.

The next thing is making sure we had a system that was rigorous enough was critical. We built that over time. There were improvements that we had to make as we learnt. For instance, one of the changes that we made in about September/October was that, if you were phoning an individual on the contact tracing side, you would ask them to tell their contacts in their household to isolate, instead of asking for the names of all those individuals and then phoning them one at a time. That change increased the efficiency of the system enormously and was something we had to improve.

When you build a huge system, and I think Baroness Harding has said that it was about the size of Tesco and she built it in six months, there are things you have to learn on the way through, whereas if you start with a system it has got all those teething problems ironed out.

Q1315 **Chair:** Five months later, on 7 October, after it had been set up, SAGE said that Test and Trace at that stage only had a marginal impact on transmission. At that point, and recognising that huge improvements have been made since then—but at that point—was that a fair assessment?

Matt Hancock: I think at that point that was probably a backward-looking assessment because by that point we had a very large system.

Q1316 **Chair:** But it was a fair assessment of what had happened to that point.

Matt Hancock: It is SAGE's assessment.

Q1317 **Chair:** But is it yours?

Matt Hancock: No.

Q1318 **Chair:** So you think they were wrong on that.

Matt Hancock: I think that it had had an impact, but it clearly had not had an impact big enough to bring R down from the R-0, which is R in the natural state of around 3, to below 1. There is evidence now, as of today, that the surge testing and tracing and isolate system that we have in place is working. If you look at the case rates now with the Delta variant, the places where over the last month we have put them into surge testing, starting with Bolton, but it is also true in Bedford, in Hounslow and other places, their case rates are coming down.

Q1319 **Chair:** I totally accept that, and it is fine to mention it, but I am really looking specifically at why we did not manage to stop a second and third lockdown.

Matt Hancock: Sure.

Q1320 **Chair:** I take on board what you have said. I would like to go through some of the other reasons people have suggested as to why Test and

Trace was not as successful as we had all hoped. You said earlier this morning that one of the reasons was that by the time we set it up we already had around 2,000 cases a day, which is much higher than the levels that test and trace was having to cope with in Korea and Taiwan, so that simple scale was one of the reasons.

Another reason people have suggested is because the people who were asked to isolate by Test and Trace did not actually do so. In February this year, Baroness Harding gave evidence to the Science and Technology Committee, where she presented two bits of evidence, one that said that 20% of people were not fully isolating when they were asked to, and another that said that 40% were not fully isolating when asked to. Do you have a more up-to-date number as to what numbers of people more recently are fully complying with the isolation requests?

Matt Hancock: I do not have an up-to-date figure. I am very happy to write to the Committee with whatever we have. I am afraid I did not prepare on that topic. What I would say is that we can see it working, and since Baroness Harding said that in February we have done two important things. One is that we have strengthened the isolation payment so that in the targeted areas anybody earning less than £26,000 gets the £500 isolation payment. We have strengthened that element of it. The second thing is we have increased the size of the isolation assurance service, which is the team of people who phone up and knock on the doors of those who are meant to be isolating to make sure, essentially, that there is stronger enforcement of isolation.

Q1321 **Chair:** Thank you. That is very welcome news, but the very specific thing we are trying to understand, because this is a lessons learnt exercise, is why in that middle period of last year we were not successful in preventing the second and third lockdowns. When Baroness Harding gave evidence in February, we were in the middle of our third lockdown.

Just on that point of financial support, some people say that one of the reasons why people did not isolate was because we did not give a simple promise that, "If you isolate because you are asked to by Test and Trace, we will make up as the state any salary loss that you have." Would that have helped?

Matt Hancock: The challenge that we had with that proposal is the extent to which it might be gamed, because, after all, a contact gives Test and Trace their contacts—that is what contact tracing is made of. You would not want a situation in which if you tested positive you could then list your entire friendship network, who all get a £500 payment.

Q1322 **Chair:** But that friendship network would be more reassured and you might have been more willing to give their names if you had known that any salary they lost in the 10 days or two weeks they were asked to isolate was going to be made up. Just with the benefit of hindsight—I appreciate not all these things were known at the time—is that something we should have been more open to?

Matt Hancock: I think it is fair to say I am glad that we have made the change now.

Q1323 **Chair:** I think we can interpret from that, perhaps, what your private position is. I want to go on, because there were lots of other reasons that were put forward. One of them was that we did not have enough involvement early enough of local authorities on the contact tracing side, and, indeed, some people argued on the testing side as well.

We know that they have been very involved recently, so I do not want to use the recent examples. This is simply about that period in the middle of last year. Knowing what we know now, do you think there is an argument that someone is more likely to comply with an isolation request if they are called up by someone locally who can potentially check up locally, rather than someone in a call centre 300 miles away?

Matt Hancock: Of course, and the fact we have changed it to have that dual approach is testament to what I really think, because I think that is the best way to do it.

Could I explain for the record, since this is a lessons learnt exercise, some of the reasoning? You have to have the national and the local system. We know that because, internationally, where systems are local only, we know that when there is a serious outbreak they get overwhelmed. I remember distinctly a phone call with my Spanish opposite number in which I said, "And tell me how your test and isolate and tracing system is going." He said, "Oh it's terrible. It's fallen over in...", and then he named a number of parts of Spain. I said, "What about the national system?", and he said, "No, we have no national system." In countries that have only a local system they pine for a national system. In this country where we had an essentially national system at the start, the critique was you need more local engagement.

The honest answer is you need both. This comes to data flows. Data flows have been strengthened enormously in this last 18 months, all the way through from the dashboard that the Prime Minister and I look at most days on what is happening, through to the management information that the Department has about the whole health and care system. You will remember from your time in the Department that getting data out of the NHS used to be a huge struggle. We now have common dashboards that we look at, making sure that there is free flow of data between organisations, in a way of course that protects privacy but allows for decision making and allows for targeted activity, for instance, between local and national. This is absolutely critical. It has been improved no end, but by God was it a problem at the start? Absolutely, it was.

Q1324 **Chair:** I think we can understand now that you would need some national contact tracing capacity for surge capacity.

Matt Hancock: Yes.

Q1325 **Chair:** But would you say looking forward that the primary engine of contact tracing should be local, with national surge capacity ready to step in where necessary?

Matt Hancock: I think that is simplistic. The way that we have tried to optimise it is not just according to surge, and therefore the scale of need,

but also according to those who are being contact traced. There are some people for whom a national call centre system is the easy way of most efficiently gathering the data quickly and then acting on it. So speed matters here, and a national call centre system can be much faster. Then you need the local boots on the ground, especially for the hard-to-reach cases.

What we have put in place is a system that is as smart as it can be, and it is improving all the time, on optimising which case and which positive goes through the local system and which goes through the national system, and when. If you can't reach somebody after a number of calls, it gets switched to the local system, and they can send somebody round to knock on the front door. You would not put all contacts into the local system straightaway because you need, essentially, to deal with the easy to reach, who can most efficiently be dealt with nationally. It is about optimising a joint system with data flows that are unhindered and a team who work together cohesively. That is the way that I think this is best done.

Q1326 Chair: A final reason that some people say we may still have those very large numbers of people who were not isolating when we needed them to, which meant that we could not prevent those second and third waves, is that perhaps, again looking back, we were shooting for the wrong target. The whole system during last year was geared around testing targets—first 100,000, then 500,000 and then a million. Sure enough, if you give a big system a target, ultimately, they hit it. Should the real target in a pandemic not be a process target like testing, but the proportion of people whom you need to isolate who actually do isolate? Do you think looking back we hit the target and missed the point?

Matt Hancock: No, because we absolutely had those targets for the number of people who isolated and the number of people whom we successfully contacted. We publish as much of that data as we can. The challenge in running a very large system is that, if you have a target that is only indirectly reachable, you also need goals on the way—process targets—that are measurable. So the answer is both.

If you think about it, just one more comment on this, we learnt a huge amount from this experience that I have just described of improving the contact tracing and testing system for the vaccine roll-out. On the vaccine roll-out we have local and national data integration. We have the local systems going and finding people who are hard to reach. We have the national system for the big numbers, for the people who are enthusiastic and willing to drive and queue up. That integration is something we actively took from the learnings from the Test and Trace system and ensured that it was embedded in the vaccination system from the start. We have been doing our own lessons learnt all the way through this. One of the lessons is this data integration and ensuring that you get the right activities happening at the right level.

Q1327 Greg Clark: I would like to go into a bit more detail on the question of care homes. We know, and I think we have agreed already this morning,

that the decisions, especially in the early days and months, are taken in a kind of fog of war; urgent decisions have to be taken without all of the information, but that fog is dispersing and some things are becoming clear. I think it is fair to say that during this inquiry we have established pretty clearly that we were too late to lock down sufficiently vigorously and that many people—SAGE, Dominic Cummings, yourself—agree that, if we had either known more or perhaps acted earlier, that would have been better. I think we have learnt that. We have also established that we had inadequate testing capacity during the early phases of the pandemic. Are both of those prospective conclusions ones that you would agree with?

Matt Hancock: I absolutely agree that, if we had had that greater testing capacity at the start, of course, it would have been better. But I am a practical man. We didn't. My job was to build it, not just to feel sorry for myself that we didn't have it; we had to get on with it.

Q1328 **Greg Clark:** Absolutely. We want to be practical and learn lessons that can be applied in the future. I want to establish whether we should add a third of these lessons, which was that discharging infected patients into care homes was—for many, perhaps understandable, reasons—one of the major faults in the first steps to handle the pandemic. You said, Secretary of State, "Right from the start, we tried to throw a protective ring around our care homes." What was that protective ring?

Matt Hancock: I think the most important words in that sentence are "we tried to." It was very hard. All of these deaths in care homes, each and every death in a care home, weigh heavily on me, and always will. We knew from the start, from very early in January, that the impact of this disease was most significant on the oldest, and therefore care home residents were going to be a particular risk. This was a problem that we had across the whole of the UK, and, indeed, there were some other countries that had really difficult circumstances. We put in funding. We made sure that PPE was as available as possible. It was a challenge, because we did not have a distribution system. We had to build one. We set out guidance for care homes. The first guidance was on 25 February.

Later, when we had the testing capacity, in July, we brought in the weekly testing of staff, which is, I think, the single biggest improvement in terms of protecting residents. Now, of course, we put care homes, both the staff and residents, in the top priority for vaccination. That is what I meant. But it was very hard for a number of reasons, some of which are fixed and some are not. I am Secretary of State for Health and Social Care, yet at the start of this pandemic the powers I had over social care were extremely limited. The formal powers rest with local government, and, formally, social care is a responsibility of local government, but I feel it keenly. We did not have the data. When I first asked for a list of all the elderly care homes, we did not have one, which I find it totally extraordinary saying, but it is true. We simply did not have the levers, and we had to invent a whole series of them. We now have far better data, but some of these problems still need to be fixed. We need to reform social care, and we need to make sure that we put into law the

ability of national Government where necessary to come in firmly, whether it is to issue guidance that is binding or put in place funding. We had to funnel funding indirectly through local authorities as well, because we had no vires to fund care homes directly. There is a whole series of things that have been improved and there is a whole series of things that we still need to do.

Q1329 **Greg Clark:** Let's go into some of decisions to know whether you had levers yourself or whether you were denied them. We know that on 17 March, NHS Providers were instructed by NHS England—I have the letter from Sir Simon Stevens to all NHS trusts ordering them to urgently discharge all hospital in-patients who were medically fit to leave. It is a very famous instruction.

Matt Hancock: Yes.

Q1330 **Greg Clark:** Was that a unilateral instruction on the part of Sir Simon Stevens and his colleagues at NHS England, or was that, as it were, a co-decision that he took with you?

Matt Hancock: Of course, that decision was discussed with me and the Prime Minister before it was executed. If I take you back to the time, we had just had the scenes from Lombardy showing what happens when a health service is overwhelmed. We knew that the death rate would increase dramatically—we did not know how much, but dramatically—if NHS services were not available, and we needed to make sure there was NHS capacity because the number of cases was going up, at the time, exponentially. We protected the NHS.

One of the things in the lessons learnt exercise that is really important for us all to remember is that, while there were absolutely challenges in some areas, there were some things that this country got right, and the provision of care at all times to Covid patients is one of them. That instruction actually led to a reduction in the number of people who left hospital and went to care homes, because the vast majority of people went home to their own home and we put in place social care packages.

One of the other things that we did as part of that decision was that we agreed to pay for the discharge. In normal circumstances, when you leave hospital, the local authority has to arrange the social care package, and sometimes individuals have to pay for that and sometimes the local authority does, as you well know. Because the central Government, through the NHS, decided to, and the Treasury provided the budget to, pay—what is called discharge to assess—for those discharges, it meant that we could get more discharges to people's own homes. In fact, one of the reforms we need to make to social care is that more people should be discharged to their own home with a care package as a proportion than into care homes.

The result of that letter, ironically—I know it is counterintuitive—was a reduction in the proportion of people who were discharged to care homes. I am sure we will come on to the testing around them, and, in fact, we

have already discussed it to a degree. Yes, that letter was a policy that was agreed at the highest level in Government.

Q1331 **Greg Clark:** Absolutely. That is very clear and very helpful. You also said in that answer that the motivation was a concern—looking at Lombardy—that our hospitals might otherwise be overwhelmed and that that galvanised the action that that was a reflection of.

Matt Hancock: Yes, but I do not want to imply, and it would be wrong to conclude, that that is because we somehow favoured the need to protect the NHS. As well as the scenes from Lombardy, I still remember—it is burned across my soul—a news report from Spain in which the military were sent into care homes, and in one particular case the care home had been abandoned because the staff were ill and all of the residents had died. Many had died from Covid, but many had died because they needed care in order to live. There were care homes in France where every resident died as well.

This was a problem that everybody struggled with, and we talked among my colleagues across the continent and, of course, with my fellow Health Ministers across the UK about how best to protect the most vulnerable. In fact, in England, the proportion of people overall who died who lived in care homes is lower than in many European countries. Yes, this was incredibly difficult, but I think you have to look at the whole picture. The No. 1 fact, if you like, that matters in this is understanding how Covid gets into care homes.

Q1332 **Greg Clark:** We will come on to that. The motivation, you said, was to certainly protect the NHS and avoid a Lombardy situation, but you have been clear that that did not mean that you were unaware and unconcerned at all about what was a threat to care homes.

Matt Hancock: On the contrary.

Q1333 **Greg Clark:** You said that very clearly. Is it the case that, when you had that discussion with the Prime Minister about what I guess was the proposed advice from Sir Simon Stevens at that point, you were clear that the testing capacity to test people leaving hospital going into care homes would not be there immediately, and for at least a number of weeks?

Matt Hancock: I don't recollect directly, but I know for a fact that the testing capacity at that time—the letter was dated 17 March—was around 1,000 a day, because 17 March was the date on which we had the Cabinet Room meeting where I took direct personal charge of the testing system.

Q1334 **Greg Clark:** So you knew there was not the capacity there to do it, but did you communicate that to others who were part of the discussion about this new policy?

Matt Hancock: I would be amazed if that was not part of the discussion. I have not seen the minutes of that discussion recently—in fact, I don't think I have ever seen them—but I know that it was agreed and signed

off across Government. There is no doubt that the testing capacity would have featured, but also remember that the clear clinical advice at the time was that testing people asymptotically might lead to false negatives, and therefore was not advised and was seen as not a good use of the precious few tests that we had at that moment.

Q1335 **Greg Clark:** This is an important point of contention in our last evidence session, as you know, because the evidence that we had from Dominic Cummings was that people in that meeting felt assured that the testing capacity would be in place. At the opening of the session, when I put this to you, you said you were always clear in your mind, and as far as you know in the way that you communicated this, that you were talking about a plan to get to that capacity. Thinking back, was there any possibility for ambiguity there? Do you think in that discussion you could have thought you were talking about future capacity and people like Dominic Cummings—we do not know what the Prime Minister thought—could have thought that it was available now?

Matt Hancock: There are two responses to that. The first is you have to remember that we were taking huge decisions under imperfect information and against a completely unprecedented situation. The recollection I have is that at that time the clinical advice was clear. In fact, I checked this with the chief medical officer in the last couple of weeks. This was his recollection as well. The recollection was that the clinical advice was against asymptomatic testing for the reasons that we set out, and for the clinical reasons that I have reported to the Committee, but they were not my reasons; it was the clinical advice—

Q1336 **Greg Clark:** In terms of the misapprehension that—

Matt Hancock: I have no idea—

Q1337 **Greg Clark:** But you were clear in your mind that the capacity was not there, so it would have been strange for people to assume that it was.

Matt Hancock: That's right.

Q1338 **Greg Clark:** But you do not have any positive recollection of others who were part of that discussion conceding and agreeing that.

Matt Hancock: I don't have any recollection one way or the other.

Q1339 **Greg Clark:** Again, in the evidence that we heard from Dominic Cummings, he said that when the Prime Minister returned from his illness—in other words, in April—he came back alarmed at what was going on in care homes and asked, "What's happened with all those people in care homes?" Dominic Cummings said he used a less polite version of, "What on earth are you telling me?" Did the Prime Minister, when he came back from his illness, have a conversation with you that indicated he was surprised to find out what was going on in care homes?

Matt Hancock: Not that I can remember.

Q1340 **Greg Clark:** I see. In terms of the numbers—in your initial answer, you talked about the numbers—how many people were discharged before

testing was available for people being discharged?

Matt Hancock: I don't have that figure with me. I think it is in the public domain. If it is not, I will get you the best estimate that we have.

Q1341 **Greg Clark:** The NAO says it is about 25,000. Presumably—

Matt Hancock: I would not dispute the NAO.

Q1342 **Greg Clark:** You would not dispute the NAO. That reflects your feeling.

Matt Hancock: I wouldn't dispute that figure.

Q1343 **Greg Clark:** Okay. You said that the number of discharges actually going into care homes fell compared to the previous year. I think I remember you saying that.

Matt Hancock: The figure I actually used was that the proportion of discharges fell.

Q1344 **Greg Clark:** The proportion. Is that from that NAO analysis? Is that where you got it?

Matt Hancock: That is from an NHS analysis that I think we published at the time. If we have not published it, I will make sure we get it to you.

Q1345 **Greg Clark:** I think it is the same analysis, and that talks about a period between 17 March and 15 April, but it misses out the crucial period at the beginning of March in which it was the case that, actually, the number of people being discharged from care homes was higher than it was in the year before. Were you aware of there being an escalating problem that required you in the middle of March to put the brakes on it?

Matt Hancock: I wouldn't be surprised. The recollection I have of that chart, if you like, of that data series, is that it was, essentially, flat and then fell—the proportion of people who were discharged into hospital. You can see a clear policy reason why that would change on and around 17 March, and that is because we put the funding in to fund the NHS to buy the care packages, which are more likely to be care packages in people's own home. I am sure that we will go through the full detail of exactly what those numbers are.

Q1346 **Greg Clark:** In terms of the steps that were taken, you said that the transmission into care homes was not predominantly from people coming out of hospital but it was from staff. Is that right?

Matt Hancock: Yes. Public Health England made a recent publication of this and found that approximately 1.6% of the cases going into care homes came from people leaving hospital. There are two reasons that it might be so low. The first is that of course there were infection, prevention and control—essentially isolation—rules around how people went from hospital into care homes because they were not tested, because the testing capacity was not there and the advice was not to test, for the reasons I have set out. Therefore, there was already an isolation process in lieu of knowing whether somebody was Covid-positive

or not, and, anyway, if people were Covid-positive, there needed to be an isolation arrangement for them.

The second reason is that, just in terms of the numbers, the proportion of people who go into a care home is much higher each day from staff. That is inevitable. In any care home, the number of people who are residents who move in and out of a care home on a daily basis, even in normal times, is a fraction of the number of staff and indeed other professionals like GPs and other health professionals. If you think about a care home and who physically goes in the door, the number of times that that person going through the front door is a resident is really quite a small proportion of the total.

I understand why people feel very strongly about this point of residents going into care homes, but, in terms of the volume of human movement and interaction with a care home, you can understand once you think of it that way, because this virus transmits between humans of whatever type, whether you are a staff member or a resident; the virus does not know or care. It is, therefore, the staff testing regime that was the big change that we brought in over the summer, and then we learnt all of these lessons and did a review with the care home providers, the CQC and others and came up with the care home winter plan. In the second peak, throughout the winter, the proportion of deaths that we have had in care homes is far lower, and that is one of the many lessons that we have been learning as we go through this.

Q1347 Greg Clark: Let's go on to the staff transmission in a second. That Public Health England report, which I have read, essentially relates a positive Covid result in a care home to whether that person has been in hospital before. They call it a data linkage approach. That is the way they approach it. That's right, isn't it?

Matt Hancock: The methodology is the best methodology they have. It is a difficult figure to put a number on.

Q1348 Greg Clark: But it is made difficult, is it not, by the fact that people were not being tested in care homes and, therefore, the chances of finding someone with a Covid-positive test and then linking that back to a discharge from the hospital is very low indeed, because the whole point that we have been discussing is that testing was not available in care homes? Isn't it, to put it most politely, a stretch of the imagination to believe that 1.2% of cases and 1.6% of outbreaks are attributable to hospital transmission into care homes, when we simply do not have the data because people were not tested there?

Matt Hancock: It brings me back to the central point about the challenge of responding to this pandemic, which is that we were having to make these judgments—sometimes very big judgments—based on imperfect information, and getting better information is vital. I think that that study is the best assessment that can be made, given the facts on the ground in terms of what is and is not measurable. It is always a challenge to measure these things—

Greg Clark: It is.

Matt Hancock: —and estimates are estimates. I think I described it as an estimate rather than a fact partly for this reason. However, once you think about the number of people who go into a care home, and think about that in terms of staff and residents, you can see why a figure of that amount might be appropriate. There are reasons to explain it. Anyway, that is the best estimate that we have, but, of course, it remains an estimate.

Q1349 **Greg Clark:** But that is a bit of a danger for a lessons learnt inquiry—for us and for you and colleagues in the Government and the Department—because that study was a look back at what happened during the period; it was an attempt to learn lessons. You drew a pretty important conclusion, which was that infections from hospitals were a small—in fact, a tiny proportion—of deaths in care homes. That conclusion then has very important policy consequences for the future, to look, for example, at staff transmission rather than so much hospital transmission. But it is not possible; we do not know what the answer is, because people were not being tested in care homes, so it is completely impossible to say that less than 2% of infections in care homes were attributable to hospitals, is it not?

Matt Hancock: No, because, first, we did test in care homes throughout when people were symptomatic, and then we brought in the Vivaldi study in care homes in the late spring, after the first peak, but, nevertheless, we brought it in. This is not based on no data; it is based on the data that we had. But I keep returning to this point, that you were working on imperfect information. I also disagree with the idea that, because that figure is low, therefore it should not matter. It does matter.

Greg Clark: Absolutely.

Matt Hancock: Each one of those transmissions matters. Absolutely, the discharge protocols now require testing and isolation until there is a comprehensive test result. Of course, that matters.

Q1350 **Greg Clark:** But the care home providers are very clear. We all know that there was limited testing in care homes—

Matt Hancock: Yes.

Q1351 **Greg Clark:** So to attribute the deaths of the positive cases in care homes to hospital discharges without a representative study cannot have the weight that you are placing on it. We don't know, and it is important that we find that out. No?

Matt Hancock: Of course, it is important that we find out as much as we can, but there are some things about that first peak that we will never know because we did not have the information-gathering capabilities that we have now. I will also argue, and I will always believe this, that it is best to make your best assessment of these things even if you have to recognise that these assessments are imperfect. The search for perfect information in a pandemic is a vain one.

Q1352 **Greg Clark:** Indeed, and we should, therefore, open these things up to scrutiny.

Matt Hancock: Absolutely; like publishing the PHE report so that the Chairmen of esteemed Select Committees can read them.

Q1353 **Greg Clark:** Quite so. Has it been peer reviewed?

Matt Hancock: I don't know.

Q1354 **Greg Clark:** It would be normal for an important publication like that to be peer reviewed.

Matt Hancock: Yes, I am sure it says it on the top of the document, but the—

Q1355 **Greg Clark:** It doesn't even say who the authors are.

Matt Hancock: I will go back and find out if it is peer reviewed. There is a different principle—in a slightly different part of the forest. There is far more pre-peer review publication now because you have to get the best information you have with all of the caveats, including the ones that we have discussed, out into the public domain, rather than waiting for perfect information that may never come.

Q1356 **Greg Clark:** A final question picks up on the point that you made about the possibility of infection from social care staff in care homes. You recognised that as an important potential source. Obviously, the weekly testing of staff was not announced until July, and I think was rolled out from July onwards.

Matt Hancock: Yes.

Q1357 **Greg Clark:** Obvious question: why, if that was thought to be the prime way of infection getting into care homes, was it not possible to do that earlier?

Matt Hancock: Again, this comes down to the prioritisation of tests.

Q1358 **Greg Clark:** Right. You went as far and as fast you could, given the testing capacity.

Matt Hancock: And given the clinical prioritisation of the use of tests, yes.

Q1359 **Greg Clark:** In essence, what you are saying is that this question of infections within care homes comes from a combination of an understandable and perhaps necessary requirement to avoid a Lombardy situation in the NHS, combined with what we have previously talked about, which was an inadequate testing capacity. They are the components of the problem in care homes, as you see it.

Matt Hancock: And a presumption that testing people who have no symptoms would lead to false negatives, which turned out to be wrong, but was the clear clinical advice for some time, until we had a better assessment of that in April.

Greg Clark: Thank you very much.

Q1360 **Dr Davies:** Thank you, Secretary of State. I would like to return, if I may, to the success of certain countries in south and south-east Asia—South Korea, Singapore, Taiwan and so forth. We have already touched on their pre-existing testing capacity. Were you given advice not to follow their strategies in other respects?

Matt Hancock: No, I don't think we were advised not to follow their strategies. I cannot remember being formally advised to follow their strategies, but we did have discussions with them.

Q1361 **Dr Davies:** In retrospect, you would agree that there should have been more focus on what was going on in that part of the world and their success.

Matt Hancock: There was a huge amount of focus on what was going on in China, although one of the things that hindered our early response was a lack of transparency from China, and that must be put right in terms of future preparedness for future pandemics. It is absolutely vital for the world that China is more transparent about its health information as soon as it understands that there are problems in future.

With respect to the rest of south-east Asia, we would benefit a lot from ensuring that our future pandemic preparedness learns from different strategies that were pursued right around the world. The strategies different countries pursued, in my view, followed, essentially, two things. One is their recent history. It is standard now to say that the countries that had experienced MERS and SARS were better prepared, partly because their body politic had had a shock a decade earlier, and, here, that shock, in around 2009, was not heeded as much as it should have been.

The second is in terms of their capabilities and, to an extent, their geography and history. It is harder in a democracy to take some of the steps that some of the authoritarian countries took. Geography matters. Britain is an island, and we have the benefits of being an island in terms of borders, but we are a highly interconnected island that has a tunnel, and a huge amount of our freight comes accompanied. Other islands, like Australia, New Zealand and Taiwan, were able to be more absolute at the border, whereas completely shutting the border here is not something that we are structured to do because a very serious chunk of our daily imports comes accompanied. History is also about the capacities you have at home, and we just did not have the testing capacity in particular and the contact-tracing capacity that others had.

Q1362 **Dr Davies:** We did not have the capacity, but was it discussed that British people would not accept east Asian testing and tracing methods?

Matt Hancock: There was a debate about how much people would accept it, but I was always of the view that people would go for it. My view on the use of data was that, because the mission and the motive

was so important, people would be willing to allow their data to be used and give consent to that because the justification was so clear.

The story that I told at that time is that over 95% of people are willing to give their iris scan to the Home Office in order to have a queue that is maybe five minutes faster at Heathrow when they go on holiday, and if you are willing to give your biometric data to the Home Office, you are likely to be willing to allow your data to be used to save lives and try to stop a pandemic. My view on the public's approach to consent for the use of their data for these purposes is that my experience is that they are very enthusiastic so long as there is a proper mission, and there was a clear mission here. I was up for action in this space. I personally did not think that would be a problem so long as we articulated it properly and we got all the privacy rules, et cetera, right.

Q1363 Dr Davies: Dominic Cummings alleged that there was a lack of urgency in our approach to the pandemic in February and March because we believed ourselves to be lower down in the pandemic curve. He also said that the implementation of measures was delayed because there was a lack of planning and preparations in place. How would you respond to those two points?

Matt Hancock: The first is true and the second is false. It is absolutely true that we thought, and the advice we had was, that we were earlier in the pandemic curve than our European neighbours. As it happens, we now know from genomic testing, and the huge genomic testing capability we now have, that there were thousands of individual incursions right across the UK. We did not have an outbreak in individual areas; we had an outbreak, essentially, everywhere at once. That was one of the reasons that we had a tougher first wave, along with, frankly, the fact that the population is not as healthy, and we know that obesity is a significant risk factor. That was true.

On the second point, the idea that we did not have a plan, the evidence that I can best point you to is the fact that we had at that point published a plan.

Q1364 Dr Davies: Fair enough. In terms of face coverings, SAGE discussed in late April the fact that there was some evidence, albeit weak, for the use of face coverings, and on 11 May they issued advice for their use in enclosed spaces. Then the UK Government mandated their use on 15 June in public transport settings, 24 July in shops, and 24 September elsewhere. For the record, here in Wales, that was six weeks later for each change. Why was there a delay, first of all, in implementing what SAGE was advising, and also, why were we, as a country as a whole, behind other countries in the world?

Matt Hancock: There was a rigorous international debate about the use of face masks, and there were very significant divisions in the science on this. I think that it is one of the clear lessons from the pandemic. It comes down to disagreements about the most likely route of personal transmission of the virus from one person to another. There is now a

common understanding much more about aerosol transmission from one person, and how face masks are therefore more important than was the initial advice.

There is also a practical consideration, that we did not want people to take face masks away from where they were absolutely vital, within health and social care settings. When we did introduce rules around the public's use of face masks, we introduced them saying that you should wear a face covering, as many people in this room are, because in that way it did not take away from the provision of PPE. Now, that is not a problem; we have huge stockpiles of it, but it was a problem at the time.

Dr Davies: Thank you.

Q1365 **Anum Qaisar-Javed:** Thank you for joining us, Secretary of State. Whether it is policy implementation or the general workings of the UK Government, or even in your role as Secretary of State for Health, public trust is of paramount importance; getting those key lines right, ensuring that communication is clear and maintaining that trust so that the general public have faith in the leadership of the country. Would you agree with that statement?

Matt Hancock: Yes, I would very strongly agree with it.

Q1366 **Anum Qaisar-Javed:** Why then during the pandemic do you think that the Prime Minister had lower approval ratings in comparison to his counterparts of the devolved nations?

Matt Hancock: I do not think it is about approval; I think it is about, as you say, public trust. We worked very hard to ensure that we had the support of the public. In fact, when you look at the proof point of that, the consequence of that, the public have been incredibly strong in supporting the measures that we asked them to support, and, ultimately, that is what you need the trust for. Perhaps the most important factor when it comes to having the trust of the public is to make sure we get very high vaccination uptake, and we have extraordinarily high vaccination uptake. That is true across the whole of the UK. In fact, I think it is stronger in some parts of the UK than others, but this is not a competition. It is important that it is high everywhere.

Q1367 **Anum Qaisar-Javed:** Going back to the idea of how the public view their leadership, that is something that is taken into consideration, whether that is by the media or by Government or by other members of the public. In November, an Ipsos MORI poll found that 74% of the Scottish public believed that Nicola Sturgeon had handled the pandemic well in comparison to 19% who thought the same of Boris Johnson. There could be differences there because the NHS in Scotland is devolved, and there is NHS Scotland. What lessons do you think the UK Government are learning in terms of their communication?

Matt Hancock: I don't have the latest figures on me, but I notice that to prove your point in your question you picked figures from November. I have already said that I think that the operation of government has

improved very significantly since November. The public have definitely noticed that. In fact, the public trust across the UK in the measures that the Government have taken has increased significantly. I have noticed, as Secretary of State, that it is now more efficient and more effective; there is better communication inside Government. There is a better sense of teamwork, and that is so important in a pandemic. The public have undoubtedly noticed this improvement over the past six months or so.

Q1368 **Anum Qaisar-Javed:** Do you think that the public trust you, Secretary of State?

Matt Hancock: You can judge that for yourself, and there are—

Q1369 **Anum Qaisar-Javed:** I am asking you. What would you say?

Matt Hancock: All I can say is that the approach I have taken throughout this is to try to answer questions as directly and straight as possible. I am a big team player. I am willing to say difficult things if necessary. That is the best approach you can take in the pandemic—answering difficult questions and answering questions that are easier to answer. When difficult things happen, my approach is to go to the Dispatch Box or have a press conference and explain why there is a difficult thing. I think that is important in a pandemic in particular. At the same time, I am a huge team player, and I think it is very important that we operate as best as we can as a team.

Q1370 **Anum Qaisar-Javed:** Yes, I completely agree with you: team player and ensuring that all four parts of the UK are heard loud and clear. Rewinding back, in the session we had with Mr Cummings a couple of weeks ago, he claimed while I was questioning him on borders that the Prime Minister and the UK Government prioritised the economy over people's lives. That is quite a damaging allegation, but that allegation was made. I will not question you on the validity of that, but what I will ask you is this. Statements like that have been made; what actions will the UK Government take to maintain or regain trust from the public?

Matt Hancock: The honest truth in response to that is that we have some of the toughest border measures in the world, and people can see that we are willing to take difficult decisions on borders, based on the data, if that is what is needed. For instance, just last week we had to remove Portugal from the green list of countries, despite the fact that that was very uncomfortable and there were lots of people, especially who were on holiday or out in Portugal on business, that had a significant impact on. But when the data changes, we are willing to make those difficult decisions, because we have a tough approach at the borders.

Q1371 **Anum Qaisar-Javed:** Do you think those decisions were made in a timely manner?

Matt Hancock: Yes, absolutely. In fact, when we took Portugal off the green list, I was criticised for acting too quickly. But when you see a new variant, it is incumbent to act.

Q1372 **Anum Qaisar-Javed:** Many in ethnic minorities, during the Covid

pandemic, have sadly passed away. What steps did your Department take to engage in those communities who, for example, maybe have English as their second or third language or traditionally do not engage with the NHS?

Matt Hancock: This was and is incredibly important throughout. To be honest, I think it is something we have got better at. We have got better at working alongside local authorities in terms of engagement, and we have taken those learnings, a lot of which we learnt through the use of the testing programme, and deployed them in the vaccination programme. Although the vaccination rates now are lower for some ethnic minority communities, we are seeing those rates rise up, which I am really pleased about.

Q1373 **Anum Qaisar-Javed:** Sorry, the question I asked was, what steps did your Department take? You are saying you worked with local authorities.

Matt Hancock: Yes.

Q1374 **Anum Qaisar-Javed:** Anything else on top of that?

Matt Hancock: Yes, huge amounts of work.

Q1375 **Anum Qaisar-Javed:** What are they?

Matt Hancock: For instance, the Minister, Nadim Zahawi, on the vaccine roll-out, has undertaken a huge amount of work over the last six months in terms of engagement with communities of all sorts across the whole country, the whole of the UK, to make sure that we tried to get the messages across. For instance, ensuring information is available in the language that people commonly use is so important. From the point of view of the attitude that we take, some people say, "You've got to do better at reaching hard-to-reach communities." I don't think about it like that because that implies that somehow it is their problem. It is about making services more accessible to people and making sure that we make it as easy as possible to access services. You have to make sure that you reach out. That has been a big part of the plan all along.

Q1376 **Anum Qaisar-Javed:** Okay. I have one last question. Mr Amjad Al-Hourani was an ENT specialist at University Hospitals of Derby and Burton and died on 28 March 2020. He was the first doctor to die due to Covid. A lady called Nasreen was one of the first nurses to pass away, sadly. You are sitting here with your NHS badge on. It was one of the first things I noticed. Do you think NHS staff have trust in yourself and the Government in the way that you have handled the pandemic and will lead us out of the pandemic?

Matt Hancock: Yes, I do, and it is something I put a lot of effort into. Right across the UK, making sure that the health services we provide are there for everybody is incredibly important to me. The NHS, across Great Britain, is our most valued institution. The people who work in the NHS work incredibly hard and have faced some of the toughest situations of their lives over the last 18 months.

It saddens me enormously that around 1,500 people from health and social care lost their lives in this pandemic. I know that the first four doctors who lost their lives were all from ethnic minority communities. In fact, at Eid I went to Brent Central Mosque to thank them and, through them, everybody who works in the NHS from all different communities, and especially to mark the sacrifice of those who have come to this country to offer their services and to work in the NHS, and who gave their lives in that service during the pandemic. It is something that has moved me a lot.

Q1377 **Anum Qaisar-Javed:** Would you say that you protected NHS staff?

Matt Hancock: Absolutely. We did everything we possibly could, Not only that—we protected the NHS so the provision was there for patients as much as was possible. We provided the PPE, as we have discussed. We have worked together right across the UK, including with the Scottish Cabinet Member for Health, Jeane Freeman, whom I worked very closely with, to make sure that everywhere in these islands people got the support they needed and the treatment that they could, as much as possible.

Anum Qaisar-Javed: Thank you.

Q1378 **Barbara Keeley:** Thank you, Secretary of State. In the Chamber on Monday this week, you said that nobody was denied treatment for Covid and people got the treatment they needed. You repeated that earlier.

Matt Hancock: Yes.

Q1379 **Barbara Keeley:** I would just like to draw your attention to two things: first, the widespread reports of the use of “Do not attempt resuscitation” notices, which I know has been challenged, but was widely reported both last year, this spring, and is reported again today in the *Telegraph* in terms of people with mental illness and people with a learning disability. The second point is the refusal of some hospital trusts to admit Covid-19 patients from care homes. Bearing those two things in mind, are you really still saying that everybody with Covid-19 got the treatment they needed?

Matt Hancock: Yes, that is the medical advice that I have. I totally agree with you about the inexcusable nature of any attempt to use do not resuscitate orders without consent. When there were concerns raised at blanket consent being put in place, we stopped that immediately. Yes, making sure that that provision was there was absolutely critical. We did succeed. It was not me on my own; it was a huge team effort that everybody was involved in, because part of the action that we took to suppress the virus was in order to protect the NHS. If you think about it, my strategy through this was to suppress the virus until a vaccine could make us safe. I always believed a vaccine would come through, and I drove that project hard. The clinical advice that I have, and I checked again on this recently, as I said earlier, was that that provision was always available.

Q1380 **Barbara Keeley:** I had cases of this happening to a constituent of mine. I had a case on 3 April of a constituent in a nursing home. Her daughter was contacted out of the blue by an NHS hospital staff member who told her that her mother would not be admitted to hospital if she contracted Covid. That was a battle that I took up on her behalf with the local hospital. My constituent said this: "My mum's life was made insignificant because she is old and has dementia." I understand from a colleague that this also happened in Hove and Portslade. As I have said, it is still being reported.

In my view, this was a serious impact of the policy of discharging patients from the NHS to care homes. In my view, it led to a mindset in parts of the NHS that it was okay to deny treatment to vulnerable and older people. Were you aware last spring that some hospitals had gone out to care homes and told them they would not be admitting their residents?

Matt Hancock: I immediately insisted on the issuance of very clear and strong guidance, which is that this approach is completely unacceptable. It has never been acceptable. It has never been policy. When I heard reports—in fact, you have raised reports with me of this before—I immediately took action to reiterate the position that do not resuscitate notices require informed consent. There are proper procedures around how you can go about giving and recording that consent; decisions must be made on an individual basis.

Q1381 **Barbara Keeley:** Indeed. I really want an answer to the question, though—why we kept having reports, why this kept on happening, why there were patterns of this happening up and down the country, and we are still getting reports of it. There have been a couple of surges of reports of do not resuscitate notices for people with learning disabilities. The *Telegraph* includes today reports of people with mental illness. It certainly happened in parts of the north-west for people in care homes. That was reported to me, and I have reported it in the House. Why were questions not asked about a policy with such wide-ranging impacts on vulnerable people? I understand it has been challenged and you put guidance out, but it kept on happening.

Matt Hancock: The guidance we put out was absolutely crystal clear. The idea that a DNR notice should be put on without the individual consent process and the correct decision being taken, with clinical advice on an individual basis—it is completely unacceptable for the guidance not to be followed. In a system as big as the NHS, it is very important that, when people see problems like this, they raise them and then we can address them. The availability of treatment was always there. Treatment was available for these people in all circumstances because we never ran out of that capacity, in part because of the action that we all collectively took.

Q1382 **Barbara Keeley:** You are not willing to accept from these reports and, in fact, from myself as an MP that this was happening; that there was a denial of treatment to some people. I understand, and I have said that you challenged it, but the problem is it carried on happening.

Matt Hancock: I have seen the reports, and it is totally unacceptable.

Q1383 **Barbara Keeley:** How can you stop it though? It is not as if it just happened once.

Matt Hancock: The strongest thing I can do is ensure that the NHS issues guidance to make the rules around this absolutely clear; and that is what I have done. The point about protecting the NHS is that the capacity to treat all people for Covid was always there throughout, even in the highest peaks. That treatment was always available at all times. I am very proud that we managed to build that capacity. In fact, the NHS themselves did a remarkable job in building the Nightingale hospitals, for instance, so—

Q1384 **Barbara Keeley:** It is not about that, though, Secretary of State. It is about a cast of mind, a mindset, that treated vulnerable people, people with learning disabilities and people with mental illness in a particular way. Let's leave the point now.

I want to raise the question of expert advice to the Government. You mentioned earlier clinical advice on testing on discharge to care homes, and you said it was advice from SAGE. I think you quoted that a couple of times. SAGE had almost 100 advisers, including experts from health, epidemiology, criminology and psychology, statisticians, environmental and behavioural scientists, but no social workers and no input from care providers.

Care England told me planning prior to the pandemic did not involve social care; it was all focused on the NHS. The British Association of Social Workers chief executive, Dr Ruth Allen, said, "SAGE would be strengthened enormously by input from social work, and it is shocking that we have none." Some of the biggest care home operators have said that they repeatedly warned in March 2020 about the dangers of discharging people into care homes without testing, and they warned you both directly by email and via representatives of Care England. Given the terrible excess mortality in care homes, partly driven by actions that the care sector had warned could be damaging, do you recognise that this failure to include expertise from the care sector was a mistake?

Matt Hancock: The way that clinical advice reaches me as Secretary of State, properly, is that the chief medical officer who co-chairs SAGE listens to the scientific views—because SAGE is a scientific body—and then also takes into account the operational considerations from social care, from the NHS and from others, and then puts an assessment and recommendations to me and to other Ministers, including, of course, the Prime Minister. The chief scientific adviser—

Q1385 **Barbara Keeley:** Do you think that advice was strong enough? Do you think that listening to the care sector was strong enough? I have to say, right through the pandemic, but particularly in the early stages, there was the view that the care sector was being treated as an afterthought.

Matt Hancock: I think that we strengthened the way that we got advice from the care sector through the pandemic. When we wrote the winter

plan and published it, I think in August 2020, we took several weeks to ensure that we worked closely with the representative organisations of the care sector to make sure that that winter plan was road tested with them in advance, learning as many lessons as we could.

Q1386 **Barbara Keeley:** But that was in August. That was not in March, April, May, June or July. That was in August, well past the first wave.

Matt Hancock: Thank you. I was coming on to that. We had then, over the summer, the time to be able to write a draft and then to be able to circulate it and take on board comments, which is the normal way, of course, of developing policy within Government.

In the first peak, we were operating with these huge decisions based on, as I have said, imperfect information but also at remarkable speed; we had to move very fast. Of course, we took on board views of the care sector and the experts on social care we were engaged with, but we were not able to undertake the full public consultation that we normally would do with development of policy of this significance, simply because of the time that it took. If you think back to those times, it was a matter of acting as fast as we could to keep people safe, and that meant that you could not go through the normal formal channels of consultation that you would for something of this huge significance.

Q1387 **Barbara Keeley:** What is important, though, in terms of the lessons learnt that we are trying to gather today is the point about what impact that lack of knowledge about the care sector had on the decision making of the time. We had Professor Whitty say to the Health and Social Care Select Committee in July that the risk of agency staff travelling between homes and spreading the virus was not recognised early on during the outbreak. He admitted that in retrospect it is obvious, but that it was not obvious early on, which really does show that there was no input, no listening and no expertise from the social care sector in that early stage, which was so important because decisions were being made that caused the excess deaths.

Let me just remind you of this. My colleague, Peter Kyle, raised this set of issues in the House at PMQs on 25 March. He wrote a letter about it to the Prime Minister, and he copied you, on 31 March. He described a care home in his constituency with a serious Covid outbreak involving residents and staff, making clear the staff who had Covid were agency staff who had been working in other care homes. I wrote a letter to you on 1 April, jointly with Jon Ashworth, pointing out the lack of PPE in care homes, concerns about care staff unable to access tests, and the need for testing patients being discharged to care homes. I also raised the issue that care homes had said they were unable to transfer sick residents to hospital due to a lack of beds, and that hospitals would not admit patients from care homes.

Care England has told me that at the start of the pandemic several care providers offered brand-new care facilities that had not been commissioned and could have been used for the isolation of patients, potentially with Covid, discharged from hospital, and they received no

response from the Government. Having no expertise on social care in your group of advisers, why did you not heed the warnings about dangers to the care sector raised by MP colleagues, the care sector and Public Health England?

Matt Hancock: You didn't only raise these concerns in a letter to me; you also raised them with me in the House of Commons. Making sure that we got feedback from MPs who are expert in particular areas, including in social care, was a critical part of the response, and it led to us strengthening the guidance throughout. In that period, after you wrote on 1 April, I think it was, we strengthened the guidance to care homes on 15 April. I remember discussing it in the House of Commons, I think in an exchange with you Chair—the other Chair, the Member for Tunbridge Wells, for the record—about the attitude to listening to concerns and the need to constantly feed that into how we responded. I was completely open about that. You raised the issue of care homes in the House of Commons. We took into account those concerns as we updated the guidance. But it was inevitably an iterative process because we were operating at such pace in the face of unprecedented circumstances.

Q1388 **Barbara Keeley:** Earlier, you said, on your discharge policy to care homes, that tests took four days to turn around, at which time a patient could have contracted Covid. But on 11 March 2020, the NHS said approximately 1,500 tests had been processed every day at PHE labs, with a great majority of tests being turned around within 24 hours—1,500 a day—with most turned around within 24 hours. I just want to reiterate the point that Care England has told me that several care providers offered the use of those brand-new care facilities that had not yet been commissioned for use to isolate discharged patients. They received no response from the Government. Why?

Matt Hancock: I was not aware of that letter. On the turnaround times, what matters is—

Q1389 **Barbara Keeley:** You weren't aware? Could we just be clear about this? You weren't aware of the offer from several care providers of care facilities that could be used to isolate patients? That is actually pretty important in terms of life and death.

Matt Hancock: A better answer is that I cannot recollect that letter. What I can tell you, though, is that the turnaround times sometimes were fast, but sometimes not. If somebody is left in a hospital setting when they have been tested, they can catch Covid.

Q1390 **Barbara Keeley:** You made that point. You are repeating the point.

Matt Hancock: Sending somebody to a care home with Covid with a negative test result is very dangerous.

Q1391 **Barbara Keeley:** You are repeating a point that you made earlier. I am repeating that Care England has told me several care providers offered brand-new care facilities that had not been commissioned and could have been used for isolation. If tests had not come back within 24 hours, they could have been used in that way. It could have been a combination of

prioritising discharges to care homes for testing, and if the testing had not come back they could have gone as an interim step to those care facilities that were offered. Why didn't that happen?

Matt Hancock: As I say, I do not have a recollection of that correspondence.

Q1392 **Barbara Keeley:** You'll admit that that would have been a solution, though. In fact, I think it was adopted as a solution later on in certain parts of the country that step-down facilities were used from hospital. Clearly, we are talking about thousands of deaths in care homes. This is important. You were taking clinical advice on your policies that did not include advisers from the care sector.

Matt Hancock: No, that is not quite right. I just want to correct the point there. The scientific advice from SAGE—because SAGE is the scientific advisory group in emergencies—

Barbara Keeley: I understand that.

Matt Hancock: —is then combined with the operational advice from the Department and others in the clinical advice that comes to me. I know that might sound technical, but it is inaccurate to say that because SAGE did not have operational experts therefore that was not taken into consideration in the advice to me. SAGE is a scientific body, not an operational body, and that is how the advice is structured.

Q1393 **Barbara Keeley:** Yes, but it is a scientific body on whose advice you were relying for the discharge policy into care homes. Leave it there. You don't seem to want to accept the points I am making.

Matt Hancock: I just want to give accurate answers. Can I also add a further point to my answer on the DNRs, because I think this is such an important point?

As well as issuing the guidance, we also asked the CQC, which regulates the care home sector, to make sure that they reiterated this point. If there are further levers that are available to stop people wrongly using DNR notices, I am absolutely open to it. I have sought to use every power at my disposal to stop the inappropriate use of DNRs, while allowing people who want to express a wish that they should not be resuscitated to do so.

Q1394 **Barbara Keeley:** Indeed. Before we leave this point about the lack of expertise from the care sector, or operational knowledge, as you call it, you said earlier about the care sector, "We did not have levers. We did not have data. We did not even have a list of who the providers were."

Matt Hancock: Yes.

Q1395 **Barbara Keeley:** I just point out to you that there are organisations like Care England and the National Care Forum that are perfectly capable of providing lists of providers and perfectly capable of advising the Government. As I say, it very strongly came across to me, both in my own constituency and nationally, that the care sector felt they were

treated as an afterthought. It would be advisable now to think about how to take their advice better into account so that we do not get into the decision making and the issues that we got to in this particular pandemic.

Matt Hancock: Well, absolutely we were in contact with those organisations throughout, and indeed the CQC, but none of these lists is comprehensive. This is the problem that we were facing, which we have now addressed.

Q1396 **Barbara Keeley:** You are saying that Care England does not have a comprehensive lists of its members, of care providers.

Matt Hancock: No, I am not, but I—

Chair: We have to move on to the next section, but we will definitely be making recommendations in this area in our report.

Q1397 **Graham Stringer:** Can I just say, Secretary of State, I have not always agreed with the decisions you have made in this area, but I do appreciate the number of times you present yourself on the Floor of the House of Commons and to these Committees and other Committees? Can I take you back about two hours, I would think, to—

Matt Hancock: A long time.

Graham Stringer: —back in Greg’s questions where they were asking about the information that they believed had not been presented yet when PHE changed their advice. Are you aware that a Dr Cathy Gardner is taking the Department to judicial review?

Matt Hancock: The Department is engaged in judicial review on a number of aspects.

Q1398 **Graham Stringer:** According to the *Byline Times*, which I think is what Becky was referring to—that report—you, or the Department via you, had not provided the emails, advice and other information that had been asked for in that case. I do not want to make a clever point, but if one was to apply to that lack of evidence the interpretation you put on Dominic Cummings not supplying us with supportive evidence, we should be very worried. Will you provide all that evidence that has been asked for in that case, and has been asked for by this Committee to the Committee?

Matt Hancock: Of course, I am happy to provide all the evidence that I have committed, as per the previous exchange. I would say this. My whole approach is to provide you with whatever evidence is needed for you to reach your conclusions, hence being open to questioning for as long as you like.

I will tell you why, Graham. It was kind of you to say about me coming to the House throughout the pandemic. I will tell you why. That is because I know, deep in here, that what I did and what my team did was what we believed to be the best thing we could on the information that we had, to protect lives and to get us out of this pandemic. We worked every day, from the moment we woke up to the moment that we fell into our beds,

on that mission for months and months and months. I know that I can face the mirror each morning. Despite my deep regret at the deaths that have occurred, I know that I did that with the right motive and being straight with people throughout. This pandemic has caused enormous pain, but the way through it is to try to bring people together as a team, which I hope I have demonstrated, and be as transparent as possible.

Q1399 **Graham Stringer:** I don't doubt your motivation, Secretary of State. I don't agree with some of the decisions you have come to. The membership of SPI-B have given an apology for their advice. They said that they regretted having given extreme advice. They thought that behavioural psychology had been undermined, and that they had given too much bad news and not enough good news. Gavin Morgan said he thought that they had not behaved ethically in doing that. Do you accept that apology, and do you accept any responsibility for the negativity and unethical nature of that advice?

Matt Hancock: I think that everybody who was in a position of responsibility in the health family was acting according to what they thought was their best interpretation of their role in helping the country to manage an unprecedented situation. I just think that, especially in a pandemic when everybody is involved in trying to get through this—every single member of the public, everybody is involved—I see the best in people, and I think that the best thing is to try to motivate people to do their best in this common mission.

Q1400 **Graham Stringer:** What they were saying was that they had exaggerated and co-operated with trying to create a climate of fear beyond the evidence. I was just asking you whether you accepted that and you regretted the over-emphasis on the negative.

Matt Hancock: I do not think there was an over-emphasis on the negative. There were thousands of people dying, and we needed to stop that.

Q1401 **Graham Stringer:** Can I ask a couple of simple questions? You mentioned Portugal and moving it into the amber list, but there were other parts of the globe where there was no infection. The best example I can think of, off the top of my head, is the Cayman Islands. As you were moving parts of the globe from green to amber, why didn't you move some from amber to green?

Matt Hancock: The evidence is presented by the UK Health Security Agency, and Ministers then take decisions on the basis of that evidence. That is how we make the decisions on what is on the red, amber and green lists. Sometimes, there are balanced decisions, when you could make the decision either way. In this case, it was very clearcut that we had to move Portugal off the green list, unfortunately—it gave me no pleasure to make that recommendation—and that is what we did. There are other balanced decisions. We will keep looking at the data and make an assessment each time we do.

Q1402 **Graham Stringer:** Can I ask a couple of questions about Greater

Manchester and Bolton?

Matt Hancock: Sure.

Q1403 **Graham Stringer:** Bolton has had both surge testing and an increased supply of vaccine, which was going to everybody, essentially. Everybody—

Matt Hancock: Everybody who is eligible.

Q1404 **Graham Stringer:** Yes. Over Greater Manchester, the results have been an increase in infections. Andy Burnham, the Mayor of Greater Manchester, has been asking for what has been given to Bolton to be given to the whole of Greater Manchester. The surge testing and the support of the Army is there, but not the vaccinations for everybody. Why is that?

Matt Hancock: We have to make sure that we use the vaccines that we have as appropriately as we can. I have been talking to the Mayor of Greater Manchester throughout this. I am glad that he welcomes the action that we have taken. It is clear that the package in Bolton has had a positive effect.

Graham Stringer: Absolutely.

Matt Hancock: The challenge is that once you get to a much wider geography, including Greater Manchester and Lancashire, and the more vaccination you put in, you have to find those vaccines from somewhere. We are working on what more we can do to get more vaccines into Greater Manchester, into Lancashire, to try to get the vaccination numbers up as well, but the immediate priority is to get as much testing done as possible, so we can break the chains of transmission. You have to remember that the vaccine takes several weeks to work, not least because if you haven't had a vaccine at all you need the second jab.

Q1405 **Graham Stringer:** There is a wonderful Radio 4 programme, "More or Less". I don't know if you ever listen to it.

Matt Hancock: A fine programme.

Graham Stringer: It is.

Matt Hancock: What did they say?

Q1406 **Graham Stringer:** They tried to understand why Wales is the country, not just in the United Kingdom, but comparable to any country in the world in terms of the number of vaccinations it has given out as a percentage. The conclusion they came to was that they had stopped holding stock and, as soon as they got the vaccinations, they got them into people's arms. England, Scotland and Northern Ireland don't seem to have been doing that. Is that not a solution to Greater Manchester and anywhere else that is suffering increased infections? The country stops holding on. There may be problems in the future in the supply line, but getting those vaccinations into people's arms as quickly as possible is a good thing.

Matt Hancock: I am grinning because I am working out whether to give you the full answer because I very much like my colleagues in Wales. Although we are different parties running the devolved Administrations and the UK Government, there is a very clear answer to why this happened. Because you asked so nicely, I am going to set it out, and then I will phone up my new Welsh opposite number afterwards.

The reason is this. We need to ensure that, whatever happens in terms of security of supply, there is enough vaccine for people to get their second doses. We ensure that there is enough of a buffer that we can be confident that people will get their second doses. It is a judgment how big that buffer needs to be. Our colleagues in Wales, as you say, decided to hold no such buffer and go ahead on the presumption that supply would come through. But they also knew that, if there was interruption to supply, England's buffer would be used to ensure nobody in Wales would miss their second vaccination. That is not a decision I could make for England because I cannot draw on anybody else's buffer.

I suppose what this demonstrates is that the value of the UK-wide vaccination programme, and the fact that we have taken a whole-of-UK approach, benefits everybody, including in Wales. It enormously benefits everybody living in Scotland because we were able to procure on behalf of the whole United Kingdom. I would argue that the vaccination programme demonstrates that the Union saves lives. In the case of Wales, the Union has helped them to have one of the fastest vaccination programmes in the world, and I wish them every luck in the delivery of it.

Q1407 **Graham Stringer:** I hope you get on well with the Welsh Government. You mentioned that at the start of the epidemic you had difficulty getting information out of hospitals in particular, to find out what was going on. It has been my experience, as a Member of Parliament trying to get information out of NHS England, that they have had a very tight control both on press releases and on the supply of information. They have played the information close to their chest. I have found that difficult. Was that your experience in the elevated position of being the Secretary of State? Have you always been satisfied that they have provided information?

Matt Hancock: You should ask the Chair his experience. The answer I give is that the supply of data and the use of data across the health family as a whole is infinitely better now than it was two years ago. We have, through this pandemic, built a system of the provision of data for decision making across the NHS, PHE, the Joint Biosecurity Centre and the new UK Health Security Agency in order to be able to make better decisions founded on the best possible data science. I think that has been one of the benefits of the work that we have done during the pandemic. It is much easier now, and I pay tribute to the team in NHS England and across the Department and the other parts of the health family for those who pulled that together. As you can see, I am a positive team player, and what I can say is this is one that is going very much in the right direction.

Graham Stringer: Thank you.

Q1408 **Dr Evans:** Secretary of State, my questions are around risk. What is your attitude towards risk?

Matt Hancock: Sometimes, you have to take it, but if you take it you should then try to manage it. To give you an example, we didn't know, at the start of this pandemic, if we would ever get a vaccine for sure, but I believed that we would and could, and was willing to throw everything at it. Then we took risks, for instance, backing six different projects, even though only some of them have come off so far. Once we took the risk on those projects, we did not just fire and forget and leave it; we then actively managed them. You should take risks. It is one of the lessons of the pandemic that you need to take risks that are worth it, but they should be—I am an optimist when it comes to making decisions like this, but I am a rational optimist, and that means you manage risks as well as taking them.

Q1409 **Dr Evans:** You demonstrated that when you said you put yourself on the line and you put yourself in jeopardy with your 100,000 tests.

Matt Hancock: Yes.

Q1410 **Dr Evans:** At the same time, on the vaccines you decided to keep some back as a buffer, and that is a conservative approach. How does that pan out when we come to having the debate about the lockdowns? From your position, you are sat in the Cabinet, you have set it well, you have realised, "Gulp. I'm going to have to set this out for the Prime Minister, that we need to shut the economy." I am interested to know what the flip side was. Throughout this pandemic, every measure is about risk management.

Matt Hancock: Yes.

Q1411 **Dr Evans:** No vaccine is 100%. No test is 100%. No mask is 100%. It is how you stratify that risk.

Matt Hancock: That's right.

Q1412 **Dr Evans:** Could you talk me through the first lockdown and how that worked?

Matt Hancock: Epidemiology is a science of risks, and it is all about the balance of different risks where the typical projection of any particular figure is exponential in one direction or the other. That leads to a particularly complicated set of metrics to understand, in order best to manage. Fortunately, I am trained as an economist. While I do not have a clinical background, economics and econometrics training, at least to the degree that I have it, allows you similar training in the understanding of these concepts.

Q1413 **Dr Evans:** There is a really important point there, because for every measure that we put in at the very start, we locked down the entire economy and switched off—there was only urgent care. All elective stuff was cancelled.

Matt Hancock: Yes.

Q1414 **Dr Evans:** Rightfully so, for the capacity and what we have seen in Lombardy. You set that out. How did that change in the second lockdown? You learnt the measures. You kept elective going, and there was a reduced impact on the economy. How were those decisions made at the top?

Matt Hancock: There are two answers to that. The first is that the answer I just gave also comes back to the discussion we had about testing. We had an exponential demand for testing, but only an essentially linear—we got a bit above linear—expansion of supply. That is why we ended up having a shortage of testing at the point when the exponential curve got above what was essentially a straight line. That is how it can be true that we continued to expand testing capacity and yet had shortages, because it is about the shape of the accelerating demand.

When it came to the second lockdown, there is a similar way of conceptualising this. When case numbers are low but rising, you can see what is likely to happen but not certain. You know when you bring in a lockdown that you have definite and immediate costs. That makes for a difficult judgment, always based of course on imperfect information.

If I take an example for this—I know we are going to come on to the second lockdown later—a really good example of this is the Kent variant. I remember having the meetings in November when we were under lockdown and saying, “Something odd is going on in Kent.” I remember being on a Gold meeting with Helen Whately, who is a Kent MP. She was saying, “There is something happening in Kent, and it’s different.” At that time we didn’t have an explanation. I remember having a conversation with the Member for Tunbridge Wells, saying, “There is something happening in Kent, but we don’t yet know.”

We then found out that it was because there was a new variant that was more transmissible. The challenge, when it came to the action that we took in December, was that we did not know exactly what the problem was. We were acting with imperfect information. For instance, in Tunbridge Wells even though the case rate was very low, we knew that if we locked down that would have immediate negative costs. You have an absolute and certain cost versus an uncertain but projected, much worse, alternative. The balance of those is an incredibly difficult judgment to strike.

The conclusion I have come to, having been round this loop many times now, is that you have to act early and you have to act firmly. That is when you do not have the tool of a vaccine. Now, we have a different calculus, which is that we have to offset what I think of as the 2020 dilemma. We now have a vaccine, and we know that we are in a race between the virus and the vaccine.

Q1415 **Dr Evans:** That is where I want you to pick it up. You pre-empted where I was going with it. We have seen it three times and we have moved on.

Of course, there is an important day coming on the 21st. This is about lessons learnt. The lessons learnt are about decision making and the economy versus Covid health and non-Covid health, and what happens to our freedoms on the 21st. How is that decision going to come about? What is being put in to drive it, and what are the lessons that you have learnt that you can take forward and that we can put in our report for the next time, should this ever happen in another hundred years?

Matt Hancock: Sadly, I expect us to have a pathogen similar to this to deal with in less than a hundred years, and we need to be better prepared. One of the things that can make the world better prepared is better data.

I have complained many times in this session—not complained but explained—that everything was based on imperfect information, and that makes the decisions much more difficult. We have far better data now than we did. We go through it each day and look at the trends.

What we are looking at right now—the most important fact—is the link from cases to hospitalisations. On the likelihood of a case turning into a hospitalisation—not the absolute of any individual but the population-wide risk—that link is falling. The question is how far it is falling and how fast. Hence, we are watching the hospitalisation data like a hawk.

It is hard to work out that function because there is a lag in there. As a former economic modeller, I am sceptical of these models, but in looking through the model it helps you to understand the data that you have. I think that decisions are best taken on the actual data that is in front of you, not necessarily the model. A model can be useful to help you think about the likely future paths of the pandemic.

Q1416 **Dr Evans:** My final question to you—and I put it to you in the House a couple of weeks ago—is about how rapidly this progressed. You were going to the G7 to discuss with the Health Ministers about health surveillance in a future plan.

Matt Hancock: Yes.

Q1417 **Dr Evans:** We do 50% of all genomic testing in the world on viruses. Is there a place for the UK to be leading that at the forefront, as a preservation plan for the future, so that we have better data and surveillance to try to stave this off before it ever happens again?

Matt Hancock: There is no doubt that the UK has an important leading role in ensuring that we have better vigilance in the future. This vigilance needs to be not just on human health, but on animal health and the zoonotic links between the two, as well as on environmental causes of pandemics or the conditions that lead to pandemics.

I think that the G7 is an incredibly important moment for our like-minded allies to come together on this view. That is what we were talking about in Oxford last week. The Leaders Summit will address this as well.

It is also critical that this is global. World Health Organisation reform is vital to make sure that we get the transparency that we needed at the start of this pandemic on things like asymptomatic transmission.

Q1418 **Chair:** We have been going for three hours, Secretary of State. I know that you are hoping it will not be another seven-hour session. We have some colleagues who want to come in, so if I could ask you to be fairly brief in your answers that would be great.

Matt Hancock: Brief, okay.

Q1419 **Sarah Owen:** Secretary of State, I have about five questions on PPE. I hope to get through all of them, and, as you have heard, time is of the essence.

I want to take you back about three hours when you told the Committee that there was "never a national shortage of PPE because of the action we took."

Matt Hancock: Yes.

Q1420 **Sarah Owen:** How can you say that when we saw, with our own eyes, nurses in bin bags instead of proper PPE?

Matt Hancock: Well, I can make that assessment because the National Audit Office came and looked at all of the details here. PPE was a huge challenge. We had a stockpile, and we released the stockpile in January. We started buying in February. From the middle of February, the British Embassy in Beijing stood up a team to buy PPE, but it was difficult because global demand shot up. We all saw that.

But when the National Audit Office looked at this in the autumn, they found: "The NHS provider organisations we spoke to told us that while they were concerned about the low stocks of PPE, they were always able to get what they needed in time."

Now, I have acknowledged throughout that there were individual challenges in getting hold of PPE, but at a national level there was never a point at which we ran out.

Q1421 **Sarah Owen:** That leads me on to my second question. Over 850 healthcare workers have died during this pandemic in the UK at a rate of 79 per 100,000 compared to a national average of 35.9 per 100,000. It is around double the death rate for healthcare workers compared to the general population. If they were, as you say, properly protected and had proper PPE, can you explain that huge discrepancy?

Matt Hancock: Yes. Sadly, so many health and social care workers have died in this pandemic. That is because they are often at the frontline. Of course, the PPE was important. I have enormous admiration for, and pride in, those in the team who put themselves in danger on Covid wards when they knew that the people they were looking after had Covid. No PPE is perfect, and many, sadly, lost their lives.

Q1422 **Sarah Owen:** Yes. No PPE is perfect, but a bin bag is certainly less

perfect than PPE.

I am going to move on to the procurement process around PPE because you have touched on that. On 31 March last year at the Health and Social Care Select Committee, I asked how PPE was being prioritised and where social care was in that list. I did not get an answer. Was it Michael Gove, yourself, Rishi Sunak or the Prime Minister who was responsible for prioritising the PPE and what went where? Mr Cummings came here and painted a picture of absolute chaos.

Matt Hancock: I am not sure how involved—well, it was a Government decision. No doubt in the inquiry we can look into exactly who was involved in the decision making, but I take responsibility for the provision of PPE to the health and social care family.

What I can tell you is that at the start of the pandemic the NHS supply chain provided PPE to around 250 NHS organisations. Because of this enormous global demand, it meant that the normal supply routes of PPE to primary care, to social care and to community care, which is normally not provided through the central NHS supply chain—that system—effectively could not get hold of enough PPE; and it took the strength of Government with our Beijing embassy, for instance, to be able to buy it. We expanded the supply route from 250 organisations to around 65,000 organisations, including GP surgeries and care homes. That was because the existing logistical system simply could not expand fast enough.

So it was a huge pressure. It was a huge challenge. The team rose to that challenge to ensure that we did the best we possibly could. As you have said—and I know, I know—it wasn't perfect, but what you need to do in a pandemic when there are difficult problems like this is to work at it as hard as you can. We brought in Lord Deighton, who provided a fantastic public service by leading this area of work.

Q1423 **Sarah Owen:** Thank you. I do not think you have really answered the question, with the greatest respect. You can write and submit the evidence to the Committee afterwards. It would be really good to know what the chain of command was when it came to purchasing PPE and distribution, because that is a key failing. I think the families of the 850 healthcare workers deserve to know why it was that their family members went to work unprotected, or not as protected as they could have been.

Matt Hancock: I think this is a very important subject, and so it is very important to get this absolutely right.

With respect to the provision of PPE to the health and social care sector, that is my responsibility as Secretary of State. The other thing I would say is that we have looked into this, and there is no evidence that I have seen that a shortage of PPE provision led to anybody dying of Covid. That is from the evidence that I have seen. What I do know, though, is that PPE provision was tight and difficult. It was difficult throughout the world, but we did manage—it was pretty close sometimes—to ensure that at a national level we had the PPE. Distribution was a challenge to all areas.

Q1424 **Sarah Owen:** Thank you, Secretary of State. That is quite a bold claim. It would be really good if you could share that evidence.

Matt Hancock: That is the information that I have, yes.

Q1425 **Sarah Owen:** Thank you. You have talked a lot about a team effort.

Matt Hancock: Yes.

Q1426 **Sarah Owen:** Procurement is usually the domain of the Cabinet Office. Where was Michael Gove during the procurement process for PPE and Covid contracts?

Matt Hancock: Procurement is not just the domain of the Cabinet Office. The NHS procures at all levels. The NHS procures at a national level, obviously, and NHS organisations, whether trusts or GP surgeries, procure. The Department procures some things. It is a huge effort. The best analysis of this, I suppose, is the NAO report, because they have looked into this process right across the board.

Q1427 **Sarah Owen:** Mr Cummings explained there was chaos and a clash of egos behind the scenes at No. 10 between different Departments. How did your Department work with, say, the Cabinet Office and the Treasury?

Matt Hancock: Great. I have an exemplary relationship with Michael, who has been a stalwart of the efforts and incredibly helpful.

When it comes to the Treasury, the amount of money that the Treasury has put into this problem is unprecedented. When I had problems, I raised it with Ministers, and they were normally resolved. If they were not, that was because there was a perfectly decent reason. That is how Government works.

Q1428 **Sarah Owen:** That is a very different picture from the one that we heard. Do you think that Mr Cummings's business relationship with Michael Gove was a reason for him being perhaps less critical? He barely mentioned him throughout the testimony, but gave you, I would say, a fairly rough ride during seven hours. Do you think it is fair to say that that has perhaps clouded his judgment?

Matt Hancock: I am not responsible for anybody else's testimony, but I am really pleased to have the chance to come here and to be able to tell you the truth.

Q1429 **Sarah Owen:** Lastly on PPE, we have seen a number of British PPE manufacturers and companies come out this last year to say that they were either knocked back for contracts or were not taken up on offers to manufacture or procure PPE. They were long-established, British PPE suppliers. Why is it that they were overlooked for companies that had zero experience or had not even existed before the pandemic?

Matt Hancock: When we came to buying PPE, we absolutely looked to buy it from anybody who could offer it and offer it for delivery. We looked into lots of options that were put forward to us by all sorts of people. The BMA and the Royal College of Nursing worked incredibly hard to find

sources of PPE. The Labour Party made some proposals. We looked into all of these. The decisions on the individual contracts were made by officials, and quite rightly. My job was to make sure that we could fund it and that the funding rules—like the discussion earlier about the cap on costs—were appropriate for making sure we could get hold of PPE.

Chair: Final question.

Q1430 **Sarah Owen:** My final question relates to a question that my colleague Barbara Keeley raised. I do not think we got to the nub of the answer. You said earlier in the session that patients from hospitals were released to care homes because it took four days to test. You justified the discharge policy without testing on that. On 11 March 2020, the NHS website said that the majority of tests were being turned around in 24 hours. Which one is the truth? Is it four days or the NHS's website, which says quite clearly that the majority of tests were being turned around in 24 hours?

Matt Hancock: Yes; I answered this question around an hour ago.

Q1431 **Sarah Owen:** You did not answer it, which is why I am asking it again; sorry.

Matt Hancock: No; I answered this question around an hour ago, and I will repeat my answer. If the tests can take up to four days to come through, not all of them came through within 24 hours. Whatever the time period, the point is the same. You can catch Covid in a hospital after taking a test and before getting the result. Critically, I would say that is only one part of the reason that the decisions were taken. Those decisions were all taken on clinical advice.

Chair: Thank you very much.

Q1432 **Dawn Butler:** I will pick up from where my Honourable Friend left off. You talked about procurement and the decisions being made by officials. Were you ever involved in any procurement contracts?

Matt Hancock: No.

Q1433 **Dawn Butler:** Were you ever helpful to anyone pitching for procurement contracts?

Matt Hancock: When people came forward with potential leads, I would feed those into officials. Absolutely. For instance, I can't remember the exact date, but there was a moment when I think Rachel Reeves wrote to Michael Gove, but no matter, with a list of potential leads. We took those forward in the same way. This was a cross-party effort. Everybody was involved. So, yes, part of my job was that when I saw a lead I would pass it forward.

Q1434 **Dawn Butler:** Did you have any personal access to people or individuals?

Matt Hancock: I would pass them into the official system, and the official system would take them forward. They had a prioritisation according to the likelihood of a lead.

Q1435 **Dawn Butler:** I have an email here from Samir Jassal. He says in this email, "Matt, you have been most helpful previously." What did Mr Jassal mean by that?

Matt Hancock: I don't know. You have not given me any context, so I cannot really answer the question.

Q1436 **Dawn Butler:** It is an email sent on 6 January 2021. He talks about seeking validation. He talks about help, basically, with a procurement contract. Do you know Mr Jassal?

Matt Hancock: He has emailed me in the past, and I have replied. I have made sure that his requests were dealt with in the appropriate way.

Q1437 **Dawn Butler:** I think it is really important, if we are going to learn the lessons, to know whether people have special access. He is calling you "Matt". If people have special access to the Secretary of State, we need to know how that works in the supply chain and in terms of public procurement. There are several emails—they came from your Department—from Samir Jassal and Surjit Jassal. I think Samir was acting as a middle man. Surjit Jassal's company went from £200 in value to almost £10 million in value in the year of the pandemic. Were you aware of that?

Matt Hancock: No, but when people brought forward proposals to be able to supply PPE, I passed them on to the team, who took them forward, and decisions on individual contracts were made by officials. I think anybody—

Q1438 **Dawn Butler:** So you always passed them on. You would not have a private conversation or email exchange with, say, Mr Jassal.

Matt Hancock: It depended on the circumstances, but I would pass on an offer and then the team would look into it. That is how this worked. If you think about it, obviously, I would, because if I did the opposite and ignored likely offers of PPE, then I would rightly be criticised.

Q1439 **Dawn Butler:** I completely agree. I just wondered why you would have time to give special attention to an individual person. Can I move on?

Matt Hancock: I don't know whether I have.

Q1440 **Dawn Butler:** How do you feel about the Government's counter-fraud function proclaiming that there was a higher risk of fraud in procurement of PPE?

Matt Hancock: We were buying PPE as a Government in order to protect lives. We were doing it at a time of extraordinary global demand. I just want to put on the record, if I may, Chair, my thanks and admiration to the team who made sure we never had a national shortage of PPE. Because they come under—

Q1441 **Dawn Butler:** Secretary of State—

Matt Hancock: I will finish, thank you. They come under pressure, and in my view it is unreasonable—

Q1442 **Dawn Butler:** Secretary of State, this is a lessons learnt Committee. You can do all your thanks at the end.

Matt Hancock: The lesson I learnt is that—

Dawn Butler: Secretary of State—

Chair: Everybody has a limited time. Could we possibly let Dawn Butler continue her questions?

Q1443 **Dawn Butler:** Dr Evans mentioned earlier about your attitude to risk. Do you know what the risks were in regard to procurement of PPE?

Matt Hancock: Yes. I knew the risk was that, if we did not buy enough, people would not have enough PPE. Thankfully, because my team did such an excellent job, we never had a national shortage of PPE.

Q1444 **Dawn Butler:** Your Department is one of the few Departments that has not estimated the risk of fraud and what that looks like in its Department. Why is that?

Matt Hancock: We have a very significant counter-fraud agency in the NHS that does a huge amount of work to make sure that we tackle fraud and the problems that come from it.

Q1445 **Dawn Butler:** Why has your Department not given evidence as to what that fraud might look like in the department of health? Other departments have said, "This is what fraud might look like in our Department. This is our attitude to risk." Your Department has not done that. Why?

Matt Hancock: I am not aware that that is right. I am very happy to write to you with details.

Q1446 **Dawn Butler:** We need details of what the risk looks like in the department of health, and what fraud would look like in the department of health.

Matt Hancock: Yes; and I will set that out in the context of the fact that there was a global scramble for PPE and the Department desperately needed to get hold of PPE—and succeeded in doing so.

Q1447 **Dawn Butler:** I understand that, but it is public money and so we do have to account for risk of fraud in that regard.

Matt Hancock: Indeed.

Q1448 **Dawn Butler:** There is lots of paper trail to this. Most people can find it. You are aware of the Good Law Project, obviously. The Government lost a case just this week. This case cost £600,000 to defend. The Government spent £600,000 defending unlawful conduct in a contract, which was more than the contract was worth. Do you think that is value for money?

Matt Hancock: That was not in my Department. It was not a judgment that I made or know any of the details of. What I would say is that the judgments that we made at the time were based on what we needed to

do to deliver at pace in very difficult circumstances. The team really drove that through because they had to.

Q1449 **Dawn Butler:** Thank you. Actually, lots of the emails are on the Good Law Project's website and Twitter address. I put that on record so your Department can look them up.

You spoke earlier about people being very enthusiastic to give their data. I think you are overexaggerating how enthusiastic people are about giving carte blanche access to their data.

Are you aware that Palantir and Faculty have links to the discredited Cambridge Analytica?

Matt Hancock: I do not think I am aware of that, no.

Q1450 **Dawn Butler:** I think it is really vital that you should be aware of that. Palantir reportedly taught Cambridge Analytica how to scrape the data. That means that you are putting at risk everybody's data in the country and giving it to organisations such as Palantir. It is really important that you get to grips with that. I will give you this little book of "Data and Democracy", and some information for you to help inform yourself, Secretary of State.

I have just a couple of questions that need quick yes or no responses. Do you have any other agreements with companies that will help supply data and analyse voting intentions?

Matt Hancock: I have no idea what you are asking about.

Dawn Butler: In our previous session when you came in front of the Committee, I asked you about unsolicited questionnaires that were being sent to people, asking them how they intended to vote in the next election. You said you did not know anything about that. Now we know more about Palantir's and Faculty's involvement in the NHS, it seems like that this could all be used as part of a way to get data about how people are going to vote and to encourage people to vote a certain way.

Chair: This is a Coronavirus: lessons learnt inquiry. We do need to make sure that the questions are on that topic.

Dawn Butler: It is, Chair. The lessons that we must take from this pandemic are that, in a pandemic, we cannot use it as a shield to be able to get people's data, and to do with it whatever a Government want to use it for.

Chair: Okay. Do you want to ask your final questions?

Q1451 **Dawn Butler:** Secretary of State, are you 100% sure that Palantir, Faculty, Cambridge Analytica or any other offshoot companies are not supplying public data, voting intentions or anything like that to the Conservative Party?

Matt Hancock: What I would say is that this is absolutely nothing to do with it. Where your accusations are unfounded and wrong is when you said that companies involved in improving the way that we use data in

Government, and we have made huge positive strides in doing this in the last year and a half, would have carte blanche. That is not true, because all of this work is done within strict and careful protocols to make sure that we can use data to save lives. That is what I was doing.

I know that there are various theories in this space, but—

Dawn Butler: Secretary of State—

Matt Hancock: No. You have asked me the question and I will answer it.

Q1452 **Dawn Butler:** This is not a theory, Secretary of State.

Matt Hancock: There are various theories in this. What matters is, can you use data better to save lives, ensuring that it is properly and appropriately protected? That is what we do.

Chair: Last question, if we may.

Q1453 **Dawn Butler:** Secretary of State, 100% you can use data to save lives. Of course you can. You can also use data to manipulate people and manipulate lives. That is not where we want to go as a country or as a Government. This is not about theories. These are factials. It is about how you use data.

Chair: Please ask your last question.

Q1454 **Dawn Butler:** Have you visited the Covid Memorial Wall?

Matt Hancock: Not yet, but I very much hope to.

Chair: Thank you.

Q1455 **Dean Russell:** Thank you, Chair, and thank you, Secretary of State, for attending today. My question builds on data and the importance and role of technology over the course of the pandemic. It seems to me that we are quite rightly talking about the positive aspects of the vaccines and of testing. Data seems to be at the very heart of much of the work we have done.

Could you explain what lessons we have learnt over the course of the past year or so in terms of the growth of how we have used and collected data to save people's lives?

Matt Hancock: We have used data, I think, better in the health and care system over the last year than ever before. We have proven the point that you need high-quality and rigorous use of data and data architecture that protects privacy, to make sure that people can be reassured that some of the conspiracy theories are just that, while making sure that you can improve care.

The proof point of this argument is the success of the vaccination programme—both its operational success, because we drew up very high-quality data architecture right at the start, learning the lessons that we had learnt during the crisis, but also in terms of how that is applied on the ground. We use data to be able to target groups who need an offer of

a vaccine brought closer to home, for instance, and to make sure that they get the opportunity to have a vaccine and the opportunity to consent to do that. That is just one example of how this has improved. There is so far to go for the NHS to really get the value out of the data that it holds.

Q1456 **Dean Russell:** Outside of the pandemic, and obviously moving forward, we have a real, rich sense of data. The country has got used to dashboards now in a way that perhaps they would not have even considered a year and a half ago. That is from the daily briefings and from what the public can interrogate. How do you see that playing out, moving forward, outside of the pandemic? Do you think that sort of information will continue to be available?

Matt Hancock: We have made huge strides forward and we have to keep pushing: for instance, using data for research purposes so that we can find new treatments and get them to people fast. We can use data to make sure that we can better manage things and have better co-ordinated delivery of care, for instance. We can use data to take preventive action to stop people from getting ill in the first place.

We are going to launch a data strategy for the Department that will set all this out in detail.

Q1457 **Chair:** When are you planning to do that?

Matt Hancock: In the next few weeks. We have made big strides, but there is a lot further to go.

Q1458 **Dean Russell:** Would you say, moving forward and especially as a lesson from the pandemic, that data is going to be a part of the NHS?

Matt Hancock: I very much hope so. The opportunities here are huge. There are opportunities to save lives, opportunities to improve care and opportunities for the UK to be at the forefront of research.

I have just one small example before we move on. The recovery trial based out of Oxford University led to the discovery that dexamethasone could save lives from Covid. Over a million people are alive today who would have died—that is the latest estimate—because of that discovery based on high-quality NHS data in the recovery clinical trial. That is a really good example of the sort of thing we can do if we get this right.

Q1459 **Dean Russell:** From a personal perspective, in terms of one's own health data, so many people now wear Apple watches and track everything with their apps and phones, and so on. It seems to me that in the nineteenth and twentieth centuries people donated organs. There is an opportunity, moving forward, to save other people's lives. There is an opportunity to save more lives by effectively donating data, anonymously and securely. Do you see that as being part of that ability to potentially find cures for cancer?

Matt Hancock: Yes, of course. My view is that every citizen should allow their data to be used, as you say, anonymously and carefully, for

research purposes. We have seen that happen during Covid. Huge numbers of people came forward and signed up for that approach. I think it is something we can learn.

The public as a whole in the UK, and everybody in the UK, has got far more used to dealing with data, and their health data in particular.

The final thing I will say on this, because I know you want to move on, Chair, is that the data on your personal health and your health record belongs emphatically to you, in my view. It does not belong to your GP; it does not belong to the NHS. That is your data. People should be able to care for you based on that data. If you want it to be used for research purposes, that is your decision.

Q1460 **Dean Russell:** I will ask one very small question, if I may. When you look at organisations like Apple, which are excellent at collecting data and have the tools and facilities to do that, do you see an opportunity to partner more with those sorts of big organisations who are already tracking people's heartbeats to say, "Look, could we find a way to help improve people's health as well?"

Matt Hancock: Up to a point. What really matters here is that we maintain people's trust and consent in the process. Personally, I would be very happy to do that, but we need to bring people with us on this one.

Chair: Thank you. I think you may find that the predecessor Health Secretary had the same view about who owns your personal data.

Q1461 **Aaron Bell:** Thank you, Chair, and thank you, Secretary of State. I have the topic of vaccines. I will try to be as quick as I can, but I fear we may not get it all done today. On behalf of the Chair of the Science and Technology Committee, perhaps you might come and speak to us at further length about vaccines in the future.

Obviously, they have been the triumph of the whole thing. The development, procurement and deployment has been world class. That does not mean that there are not lessons we can learn. It has also been a personal triumph for you.

I wanted to ask you about a quote from 17 October by Katie Balls. "Matt Hancock is the only person here who thinks there is actually going to be a vaccine", said a Whitehall source. "It's a running joke with other departments."

Is that an accurate reflection of your position in Government with the vaccine, and who do you think that quote may have come from?

Matt Hancock: I have no idea who said that. Others may speculate. It was a view that was held among some, but the whole health family was absolutely determined to get a vaccine over the line. We first talked about it in January. The advice was, and I said at the start, that it would take a year to 18 months if everything went well. I set the team the target of getting one within a year, and we delivered on that. I am incredibly proud of the team who have pulled it off.

Q1462 **Aaron Bell:** Dominic Cummings told us that the vaccines were actually taken out of your Department to ensure that it was done successfully with the Vaccine Taskforce. Do you think that was the right move?

Matt Hancock: There was a big team effort on the vaccines. Alok Sharma played a vital role in this. The industrial side and the science budget are in BEIS. The deployment, of course, is on my side of the fence. Ahead of the deployment, we just worked together as a team. There were some people who were not very involved in vaccines and never believed that they would happen. I would say, partly because we just got on with it and we did not have interference, that that is one of the reasons why the vaccine project was so successful. We brought in Kate Bingham, who did an amazing job. One of the reasons Kate did such a good job is because she brought with her a huge amount of talent as well and had the same team attitude.

There were times when I had to make big calls and was happy to do that, but most of the time I let the team get on with it.

Q1463 **Aaron Bell:** On that point, did you, as was reported, overrule your officials on the Oxford-AstraZeneca order and increase it from 30 million to 100 million? Was that the personal interference that you made?

Matt Hancock: Yes, but it is unfair to say that that was overruling. The advice was to buy 30 million doses. I said that we needed to make sure that we had enough for the whole adult population, even if other vaccines came off. I decided that we needed 100 million and then got agreement for that across Whitehall.

There were other areas. For instance, Oxford University—who of course have done this brilliantly—were initially lined up with a different vaccine company. I was determined that we would have UK manufacture with a UK provider and, critically, make sure that we had an exclusive contract for those critical early doses. When the other manufacturer was not willing to sign up to those conditions, we switched to AstraZeneca, and Oxford signed the deal with AstraZeneca with Government support. The rest is history.

I had my red lines on this. I provided the resources and the leadership, or tried to, to make it happen, but this is not my personal success. It is a massive, massive team effort.

Q1464 **Aaron Bell:** You said earlier—probably about three hours ago now—that you were advised that it would take five years on 25 January.

Matt Hancock: Yes—that it would normally take five years.

Q1465 **Aaron Bell:** At that point, actually, Moderna had already designed their vaccine. The genome of Covid-19 was identified on 11 January. They had their vaccine designed on the 13th. I think the first trial dose of that anywhere was on 16 March.

Could we have done things even quicker? I accept that it has been at breakneck speed, but could we have done things even quicker? What

lessons do you learn from that? What lessons should the scientific community learn from that, and should we have adopted human challenge trials given the scale of the pandemic and the economic and health devastation?

Matt Hancock: It is worth asking an expert like Jonathan van Tam or Clive Dix if you want a view on whether we could have accelerated human challenge trials. I pushed for the system to go as fast as possible and for them to use human challenge trials. I was not prepared to go faster than the science would credibly allow.

When it came to other clinical trials, I do hope that for variant vaccines we will be able to get them through quicker, because the platform will already have been approved. The agreement that we made in Oxford last week at G7 level will undoubtedly speed up future vaccine production. The reason for that is that at the moment, in each country, clinical trials are essentially separate because the design of the data standards can be different in different countries and therefore you cannot always amalgamate the data to get the extra power that you need to get a clinically validated result as soon as you could if the data standards were the same and therefore the data is interoperable.

This may sound technical, but the consequence of the clinical trials charter that we aim to rapidly implement will be that we will be able to get both vaccines and treatments faster and with a more diverse range of clinical trial treatments. It is that sort of granular hard work improvement that we need to be doing to make sure that we are better prepared in future and can do these things faster still in the future.

Q1466 **Aaron Bell:** Absolutely. I completely understand that you did not want to compromise on safety in the regulatory approaches. Do you think there was perhaps an element of group-think in the scientific community that did not recognise that the scale of what the world was facing required a change to scientific methods to try to produce these things even quicker than we did?

Matt Hancock: No. What I would say is that the MHRA under Dr June Raine did an extraordinary job of removing anything that was on the critical path while maintaining safety standards. You will have to ask her, but I think probably the most important innovation that they came up with was the idea of rolling data. Instead of doing the trial, having the data package, submitting that to the MHRA and then the MHRA analysing it, the main vaccine companies opened their data to the MHRA during the process so that the MHRA knew where they were up to. They still then needed to check the final results, but that took a matter of days and not weeks.

There is one other thing we have learnt. The NHS itself has such good data systems now that, after deployment, you can track the effectiveness of a particular treatment, whether it is a vaccine or a medicine. Therefore, effectively, deployment in the NHS is itself a very large clinical trial.

That raises a longer-term question of whether the Helsinki declaration, which is currently the guiding international principle on clinical trials, could be improved to take into account the fact that now, in later stage, you are actually watching what happens. That has to be done carefully. It has to be done rigorously. It has to be done with the scientific backing of the experts. You can't just wave a magic wand and say, "This could have gone a whole lot faster." You have to make sure you have the clinical confidence in safety and efficacy, otherwise things wouldn't work. The proof point of that is that we managed to get the vaccine at record times, but we still have uptake in 96% or 97%. We have the highest enthusiasm for vaccines in the world because we took the approach that we did and we did not remove steps that were required for safety.

Critically, we did not stop clinical trials early, as they did in some other countries. On hydroxychloroquine you might remember—

Aaron Bell: Yes.

Matt Hancock: —that some quite influential figures decided early that it was obviously right and declared victory on it, but when the recovery trial saw it through to the end, when you had a clinically validated and statistically accurate answer, it found no benefit of hydroxychloroquine. You have to follow the science on it. This is one of the areas where Britain absolutely nailed it. Political intervention to undermine that science would have been wrong.

I was willing to drive and intervene where it was appropriate, but I absolutely would not undermine the science in this area. That is one of the reasons that it worked so well.

Q1467 **Aaron Bell:** This is lessons learnt obviously for the UK, but I think there are lessons for the global scientific community. We talked earlier about some of the things that SAGE got wrong, that we got wrong internationally and that the WHO got wrong. You were referring to the asymptomatic transmission.

Do you think they got it wrong on the origins of the coronavirus? We have now seen that this lab leak hypothesis is gaining a lot of credibility around the world with intelligence agencies and scientists. Do you think that the WHO let us down on that at the start of the pandemic?

Matt Hancock: I don't know, and nobody knows. I know the clinical advice. That is public. I think it is vital that we have a fully independent investigation in China into finding out all we can about this, and that that is allowed to happen unencumbered. Part of the reforms that we need to the way that the worldwide systems operate is to make sure that we can properly find answers to these questions. At the moment it is impossible to know.

Q1468 **Aaron Bell:** It will be hard to get into China, but do you feel let down by the way the British scientific establishment backed up the original position of the WHO without any real evidence for doing that?

Matt Hancock: No, I don't. We do need to get to the bottom of this, but, of course, for the day-to-day management of a pandemic the origin is only of secondary consequence. What matters is the problem that you have in front of you. For learning the lessons and avoiding future pandemics, these things are very important.

Chair: Thank you.

Q1469 **Carol Monaghan:** Secretary of State, thank you very much for spending so much time with the Committee today. All of us appreciate that.

We know that in March things were obviously frantic. You have said this morning that you had limited information and you were working at great pace. By September we should have had a clearer idea of what we were dealing with. So I would like to ask some questions about that.

In September, the Prime Minister rejected SAGE's advice for a short. circuit-breaker lockdown. Dominic Cummings told us two weeks ago that the Prime Minister took that decision without consulting Cabinet and without any formal advice against a lockdown.

What is your recollection of the decision process?

Matt Hancock: The challenge of having a two-week, so-called, circuit breaker is the question of what you do at the end of the two weeks. In Wales they did try a two-week lockdown, and at the end of the two weeks the cases started to go up again.

The scientific theoretical argument for a two-week circuit breaker is that, if everybody on the planet did not see a single other person on the planet for two weeks, then the disease would not be able to pass on. Unfortunately, in real life that obviously can't happen. The practical question in this period was what action to take to slow the spread of the pandemic. We turned to the tier system and then to a national lockdown in November. Of course, during this whole time we had the growing problem that we only fully knew about in early December of the new variant that made life so much more difficult.

Q1470 **Carol Monaghan:** Did the Prime Minister discuss this circuit-breaker that SAGE was advising with the Cabinet?

Matt Hancock: I certainly discussed it with him. I cannot recall whether it was specifically discussed at Cabinet, but I know that I discussed it with him.

Q1471 **Carol Monaghan:** Did anyone challenge the Prime Minister's decision?

Matt Hancock: We had an ongoing debate over that period as to what the appropriate action was, given that there were rising cases, especially in some parts of the country. It was very regional, whereas the first peak had been uniformly national. We took the action that we did towards the end of October.

Q1472 **Carol Monaghan:** Mr Cummings also claimed that in September the Prime Minister had said, "We shouldn't have done the first lockdown and

I'm not going to make the same mistake again." Is this true?

Matt Hancock: I certainly never heard the Prime Minister say anything like that.

Q1473 **Carol Monaghan:** If this isn't true, why was there not more discussion about the circuit-breaker lockdown?

Matt Hancock: I am sorry, that is a non sequitur.

Q1474 **Carol Monaghan:** When SAGE was giving clear advice for a circuit-breaker lockdown, why was the decision taken? You have said, "What do we do after the circuit-breaker?" We all understand what a circuit-breaker is, but why was there not more discussion about the requirement for a lockdown in September?

Matt Hancock: There was constant discussion about how to respond to the rising case numbers. I said in public at the end of August that we could see a second wave coming. From that time onwards, we had a debate in Government about these incredibly difficult balances. We took action in the local areas where it was needed.

Q1475 **Carol Monaghan:** You have previously told our Committee that you felt a circuit-breaker lockdown was disproportionate. It has also been reported that you yourself argued for that very circuit-breaker. What is the truth of this? If you were arguing for the circuit-breaker lockdown, why did the Prime Minister reject your advice?

Matt Hancock: He didn't. Also, it misrepresents the way that Governments make decisions of this magnitude. We have discussions of the pros and cons. Of course, as the Health Secretary, I am inclined to take a cautious view. That is my job. My job was to protect lives and to get us out of this. That has been my central mission for the last 18 months since 1 January when I first heard about this virus, and certainly since it became clear that it was coming here a month or so later.

Of course, I am going to make the cautious arguments. Others make arguments for the absolutely serious, real and immediate costs of lockdown, as was discussed. We did this on a regional basis over the autumn until November. We then had the national England-wide November lockdown, and then we had a regional approach over December until the 4 January lockdown. All that was while the situation got more difficult to manage because of rising numbers of what became the Alpha variant, as colleagues from Kent, I am sure, are delighted that it is now called.

Q1476 **Carol Monaghan:** One of the points that Mr Cummings made repeatedly to our Committee a fortnight ago was that decisions were taken by the Prime Minister himself, and he would ignore other people's opinions or advice on this. Is that the case? Was that your experience?

Matt Hancock: No. I discussed all these issues with the Prime Minister throughout. I speak to the Prime Minister almost every day—usually several times a day. I have done since I first alerted him to this problem

on 7 January. It is an incredibly intense period for any Government and remains so. These judgments and the consequences of the judgments that we make affect everybody in the country. The way that decisions are made is through discussion. Of course, people have a tendency for one side of the argument or the other at times. At the moment everybody is very aligned, and the data is still not yet clear ahead of the 21 June decision. The way that decisions are made is that people make their argument, the Prime Minister makes his decision, and then you fall in line behind that decision because that is what collective agreement is all about. Ministers go out and explain it, and advisers advise.

Q1477 **Carol Monaghan:** What we are trying to establish is whether the picture that was painted by Mr Cummings is a true reflection of what was taking place; whether it was a one-person decision; whether Cabinet were involved; and what advice was taken on board. This is really what I am trying to get to.

Matt Hancock: What I would say is that I spoke directly to the Prime Minister throughout this period and he took advice from a huge range of people, as he should and as he does.

Q1478 **Carol Monaghan:** The point of learning lessons is to identify where things have gone wrong, to identify mistakes and to address these for the future— hopefully, we will not have another global pandemic—but even for future dealings with Covid. What would you do differently?

Matt Hancock: Where to start? There is so much that we have learnt.

Chair: I am afraid we are going to have to draw it to a close.

Matt Hancock: The best place to start is probably the things we do differently now from at the start. We have different policies on protecting care homes. We have different policies on the border. We have learnt a huge amount all the way through. A lessons learnt exercise is not a novelty to me.

Q1479 **Carol Monaghan:** I am sorry, but when we see three weeks for the border from India to be closed—

Matt Hancock: But you don't. No, you don't. We acted when we saw the data.

Q1480 **Carol Monaghan:** The data from Public Health England shows that positivity from India was three times greater than the positivity from Bangladesh, but that data was not acted upon for three weeks.

Matt Hancock: But we did not have that data, because there is a long lag from the date on which the case occurs to the date when the sequencing result comes back. You have to act on the data that you have. I keep repeating this whenever I am accused by somebody with the benefit of hindsight that I should have acted sooner. I have tried to stress it during this whole—

Q1481 **Carol Monaghan:** I think many people were asking you to act sooner in the early days of April, and that didn't happen.

Matt Hancock: The different Governments across the United Kingdom, including the SNP Government, acted at the same time in these things because we were acting based on the same scientific advice.

Q1482 **Carol Monaghan:** No, that is not true. The SNP Government closed the borders.

Chair: We are going to conclude—

Matt Hancock: You are referring to the period of March and April last year. We all had the same scientific advice.

Q1483 **Carol Monaghan:** I am talking about April of this year.

Chair: Do you want to come back on that, or shall we move on?

Matt Hancock: The Government in Scotland took a different approach. The rules around international travel are essentially a decision for the UK Government, but I am not particularly—

Chair: I am going to have to move on to the next question. You have been very generous with your time. We just have two more people—you can see them on the screen in front of you—and then we will be through.

Q1484 **Paul Bristow:** Thank you, Chair. Secretary of State, I want to probe slightly further on those decisions made in September. Mr Cummings told us very directly that by September it was the economic arguments against lockdown that outweighed everything else. Is that correct?

Matt Hancock: It is not correct. What you have to do when you are making a decision as a Minister or as the Prime Minister is to weigh all of the factors. You have to weigh the economic factors. They are real; people's livelihoods are at risk. You also have to weigh the health factors and the growth of the virus.

The proper and appropriate way of taking a decision is to listen to all of the voices. Some voices were arguing one way and some were arguing the other. Then you have to take a decision based on those judgments.

Q1485 **Paul Bristow:** Where did the balance in decision making lie between scientific, medical, economic and social factors? How did they change over time?

Matt Hancock: Ultimately, that balance is a balance that only the Prime Minister can bring together. Of course, I will make the arguments that I believe in. Being the head of the Health Department and the health family, if you like, I am going to make that argument, but, ultimately, these judgments come together through the Prime Minister.

Q1486 **Paul Bristow:** On a slightly different question, on 27 May you said that the new variant—we are talking about the Delta variant—may represent as many as three quarters of new cases. What is the most recent assessment of this?

Matt Hancock: The assessment that I saw from last night is that the Delta variant now comprises 91% of new cases in the UK.

Q1487 **Paul Bristow:** Ninety-one, okay; all right.

Just to return to some of the questions that Barbara asked two or three hours ago, I want to return to the DNR notices—the resuscitation notices. You said that no one was denied treatment. NHS England’s guidance on DNRs was very clear. What *The Daily Telegraph* is saying today is that at least one person died because she was issued with a notice that very clearly said that learning disability was listed as the reason that CPR was likely to be unsuccessful.

I know that there are many factors, suggestions or levers to try to ensure that guidance is issued across the country and people act appropriately, but could you at least commit to investigating this one particular case?

Matt Hancock: Absolutely. If you, *The Daily Telegraph* or anybody else has other cases of people disobeying the guidance, then I want to know about it. The CQC is there to investigate formally as the health regulator and to make sure that this sort of guidance is followed.

When I said what I said, what I meant of course is that that is what the guidance states. People should not do it. In a system as big as the NHS, making sure that that happens everywhere is a challenge, in the same way that on patient safety issues, for instance, making sure that everybody follows the guidance is a challenge. That is always a problem with a very large system.

As Secretary of State, along with the entire clinical and non-clinical leadership of the NHS, I am absolutely crystal clear that having learning disabilities is never a reason for a DNR notice. Consent, properly attained, must always be taken on an individual basis before a DNR process should ever be put in place.

Chair: Last but not least Taiwo Owatemi.

Q1488 **Taiwo Owatemi:** My first couple of questions will just be about lessons learnt in the past 18 months and what could have been done differently.

First, do you accept that the large staffing shortages that the NHS already faced made it more difficult for hospitals to cope during each wave of the Covid-19 pandemic?

Matt Hancock: I think the best way of putting it that I can think of is that I am just delighted that we were recruiting at pace when we went into the pandemic, and then we recruited very significantly in the early days of the pandemic by having a call to arms to people, including people who had retired, people who were in the latter stages of their studies, and others to come forward, whether as volunteers or to become fully fledged clinicians or into all sorts of other roles.

Q1489 **Taiwo Owatemi:** I am sorry to interrupt you, but what I am trying to get at is, how are we going to avoid such dangerous and widespread staffing pressures in the future? That is what I am trying to find out.

Matt Hancock: The starting point is that we are going to deliver on our manifesto commitment to have 50,000 more nurses in the NHS. I am

very glad to say that we are on track to delivering that manifesto commitment. I am looking forward to working with the Committee to think about how we can make sure that there is always an assessment of what is needed, not least with the passage of the health and care Bill in the forthcoming session.

Q1490 **Taiwo Owatemi:** I hope the 50,000 nurses are 50,000 who are registered in universities to actually practise nursing rather than something else.

Matt Hancock: Yes.

Q1491 **Taiwo Owatemi:** Secondly, do you think that the comparatively small numbers of ICU beds across the NHS, compared to our European neighbours, put us at a disadvantage when coping with mass hospitalisation caused by Covid?

Matt Hancock: Thankfully, because of the actions that we took and because of an expansion of ICU capacity done in emergency circumstances, we were always able to give treatment. There is no doubt that one of the lessons is that we needed more ICU capacity, and we have expanded it over the last 18 months.

Q1492 **Taiwo Owatemi:** Will that expansion stay in place?

Matt Hancock: Yes. Earlier I mentioned the Nightingales project. There is no doubt that the Nightingales project is something that the NHS should always be proud of. Do you remember that we saw those images of China building a hospital in two weeks? We thought, "Well, we will never be able to do that here." Then we built one in nine days. The NHS should be very proud of what it did on the Nightingales project. However, that, of course, was temporary.

We also expanded permanent capacity, both in ICUs and in emergency departments. Infection control rules mean that you cannot have as many people in waiting rooms in emergency departments, and so they needed expansion as well. Almost every emergency department and almost every A&E in the country has been expanded in the last 12 months. Yes, some of the expansion is permanent and some of it was temporary.

Q1493 **Taiwo Owatemi:** Roughly how many ICU beds are you planning to keep permanently?

Matt Hancock: That is a great question. I do not know the answer to that. Can I write to you?

Q1494 **Taiwo Owatemi:** Yes, that is fantastic.

Thirdly, throughout the pandemic do you think that critical NHS infrastructure such as oxygen supplies in hospitals was ever under sufficient pressure that patients' lives and staff safety were put at risk?

Matt Hancock: Yes; there were moments when we had a significant shortage in an individual setting. There were hospitals that got to the limit of the number of patients they could have on oxygen. That was not

the actual oxygen itself; it was the piping—the supply mechanism. However, because of the NHS, we were able then to divert patients to other hospitals, and in some cases move them to other hospitals. It is one of the many advantages of having the NHS during a pandemic.

As I said at the start, some of the things that went well were because we had such strong institutions. In this case we had the NHS, which had record funding and record levels of staff going into this. Thank goodness that we did, because it meant that we were able, with the expansions, to always have that care available for Covid patients.

Q1495 Taiwo Owatemi: Following up on that, will your Department look very closely into the several near misses in hospitals across the country where critical infrastructure did very nearly collapse under the pressure of the pandemic? How can we ensure that the critical infrastructure is not at risk of being overwhelmed in the future?

Matt Hancock: It is a really important question about the resilience of the NHS in the future. First, as to system working in the NHS, if a hospital is coming near to being overwhelmed, it can move patients to a nearby hospital or sometimes to quite a distant hospital. That is very important.

Here again, I come back to the data. It is understanding which hospitals have spare capacity. We are so much better at that than we were 18 months ago. There is a big operational role for making sure that the NHS can deliver that care as well as possible.

Q1496 Taiwo Owatemi: My last question is a question that I am sure members of the public have all been asking. It is a question that my constituents in Coventry North West want to know.

Previously you said that there is nothing in the data to suggest that we are definitely off track to remove restrictions on 21 June. Is this still your view? Essentially, is 21 June the end of restrictions?

Matt Hancock: You tempt me, but unfortunately I am not going to be able to give any more information about this ahead of the Prime Minister setting out the decision on Monday. As you can imagine, we are looking at this data every single day, but I do not want to give an answer that would give a hint one way or the other. We still have a couple more days' data to look at, and we will make the decision very soon.

If I could just also add something to my previous answer, having the NHS made the UK better placed in terms of the healthcare provided than many other countries. One of the really important things for any lessons learnt exercise is that we must learn about where we need to strengthen and improve. Even in the good areas we can still strengthen and improve, but we must also recognise and acknowledge those areas, like the NHS and like British science, where our strengths meant that we had an exemplary response.

Q1497 Taiwo Owatemi: Are you able to give us your own personal views on the data so far?

Matt Hancock: I am afraid I am not, no. I am going to talk to the Prime Minister and others, and listen to what the chief medical officer has to say about it, and then the Government will come to a conclusion.

Q1498 **Chair:** Thank you, Taiwo.

Secretary of State, you have been very generous with your time. We have elided the sessions in order to try to get you through this as quickly as possible, but there is one final issue I know that NHS will want me to cover briefly before you go, and that is about nosocomial infections.

The Guardian recently established through FOIs that 8,700 people had died after picking up Covid in hospitals. Now, some of those may have died with Covid rather than because of Covid, but do you accept that many people are likely to have died because they picked up the infection inside hospitals?

Matt Hancock: There is no doubt that there was nosocomial infection. The degree is hard to estimate because some people go into hospital and have caught Covid in the community. They only become symptomatic or only have enough Covid to be tested positive for it once they reach hospital. I hope that does not sound like I don't take it seriously. I take it very seriously, but the precise numbers are hard to ascertain.

Q1499 **Chair:** One of the things that might have helped prevent that would have been earlier, regular testing of NHS staff. You explained earlier in a lot of detail the efforts to ramp up the testing.

Matt Hancock: Yes.

Q1500 **Chair:** But you had to follow the order that you were given in terms of the clinical guidelines as to who to prioritise for that testing. That meant that regular testing of NHS staff was not introduced across the system until November.

Looking back, and knowing what we know now, do you think that we should have found a way of doing that earlier?

Matt Hancock: We only could have done that if we had had the extra testing capacity. That is the challenge. It was really the validation of lateral flow tests in the autumn that made a big difference there. The twice weekly testing with a lateral flow device is incredibly important and undoubtedly has helped in reducing nosocomial infection.

What I would say is that the lesson for the future for me is to make sure you have that testing capacity as a standing capacity ready to go.

Q1501 **Chair:** Could another reason be that with an airborne virus some hospital ventilation systems just were not good enough?

Matt Hancock: Yes, that would definitely be another lesson as well.

Q1502 **Chair:** Finally, do you think that some of the instructions that went out to hospitals about social distancing and other precautions in the non-Covid areas of hospitals took too long? For example, the 2-metre rule was not introduced until May. Do you think that is one of the things we need to

look at?

Matt Hancock: I think it is worth looking at the entire infection prevention and control approach throughout. I have no doubt, knowing what we know now, that we can make an assessment of that. Of course, these judgments were the best judgments that people had who were working their hardest and based on the best information they had.

In a way I will return to what I have said so often. These were big calls made on imperfect information, and often made at incredible speed against a novel pathogen. I do not want to imply any criticism of those who developed that IPC guidance. What I would say is that the lesson for the future is to be able to understand any pathogen as fast as possible so that you can produce the best possible guidance as quickly as possible.

Chair: The final question to Greg Clark.

Q1503 **Greg Clark:** Thank you very much, Jeremy, and I join Jeremy in thanking you for your commitment to the Committee in terms of the time that you have given this morning.

Looking back, given that we want to learn lessons that can be applied during the remainder of this pandemic as well as in the future, if we were to have, God forbid, a vaccine escape—that is to say a new variant that was resistant to the vaccines that we have—do you have a plan for that?

Matt Hancock: Yes. It is the life of a Health Secretary to worry about these things. The plan is predicated on having a variant vaccine as fast as possible. The Prime Minister has set a target of having a variant vaccine, treatment and diagnostics within 100 days, but we are not there yet at that speed of turnaround.

However, the mRNA technologies, as the Chair set out, can develop a vaccine for an individual new DNA or RNA sequence very quickly, within a matter of days. Now that the platform has been not only approved with full clinical trials but applied hundreds of millions of times across the world with the tracking of the data in many of the countries, we can have confidence and so move through the clinical trial process much more quickly and much more safely. So we will be able to bring a vaccine to bear more quickly. I am highly confident of that.

In the meantime, the tools that we have at our disposal are the tools that are available. We would need to enact them. We watch this very carefully. One of the reasons that I moved so fast on Portugal, despite the fact that lots of people were having a well-earned break, is that we have a precautionary principle when it comes to potentially vaccine-escaping variants.

Q1504 **Greg Clark:** To be clear, it is not something that we expect, but we need to prepare on a contingency basis. You have said that there is a plan to develop vaccines so that they are effective. The other measures that you are talking about are lockdowns, social distancing requirements and all the rest of the things.

Matt Hancock: I come back to the point I made about the pandemic preparedness plan. What really matters when you are in it is the capability. The plan is always going to be written to a different pathogen because it is the nature of virology that your problem is going to be with a new disease.

Q1505 **Greg Clark:** Everyone has learnt a lot through this. Is there a plan for it? Is it written down, or is it in your head and in the heads of—

Matt Hancock: We do not have a published plan. The best way to describe it is that we have the playbook in front of us.

Q1506 **Greg Clark:** Given what we have learnt and what you have said about the importance of transparency and being honest that we did not know all the answers at the beginning, and we gleaned lessons from other countries from our own practice, would it not be a good idea to publish the plan and to be explicit about it? We could allow people to consider it, interrogate it and perhaps make constructive suggestions around it. Would that not give confidence?

Matt Hancock: I will consider that. Set against that is the following. Vaccine escape is a relative and not an absolute concept. We know that variants do respond differently to the vaccine, given that the current vaccines were all aimed at the original Wuhan strain. We know, for instance, that a single dose of either Oxford-AstraZeneca or Pfizer is less effective in terms of reducing transmission on the Delta variant, but we know that a double jab is statistically significantly different.

Therefore, there is a degree—if you could describe it like this—of vaccine escape of the Delta variant from one jab but, thankfully, not from two. Vaccine escape is a relative concept, not an absolute one. Writing a plan for absolute vaccine escape is essentially writing a plan for a new pandemic. If there was a variant of the virus against which our current vaccines did not work at all, then that would be essentially a new pandemic. I think we are better prepared by a long shot for a new pandemic, both in terms of the physical capabilities that we have as a country in all the things we have been talking about and, frankly, the intellectual framework for dealing with it that many policymakers in the far east have experience of and could bring to bear. Both our policy playbook and the capabilities that we have are better placed.

I will consider it, but you can see that my initial reaction is to think that in the first instance it depends on the degree of escape.

Q1507 **Greg Clark:** A plan need not be a binary thing that just deals with one factor. Indeed, it would be a poor plan that did not consider a range of scenarios. To have it in advance might have some advantages.

Matt Hancock: Yes.

Q1508 **Greg Clark:** In your response to Taiwo you would not be drawn, for reasons we understand, on the Delta variant and the implications for unlocking. There is a decision to be taken over the weekend. For Parliament and Members watching these proceedings, they might be

interested to know that the Science and Technology Committee will be taking evidence from scientists on this next Wednesday at 9.30. We will have an exhaustive, and I hope not exhausting, consideration of that.

Thank you for your evidence today. You have made some commitments to follow up in writing with some written evidence. I hope that you at least will be able to do that promptly.

Matt Hancock: Of course. I thank both Committees for giving me the opportunity to set out the facts and the truth. If you have any further questions, please do write and I will get back to you as soon as possible. I know that you want to publish soon. For me, it was important, and I am very grateful for the chance to be able to set out what actually happened. I hope I have been as clear as I can be.

Chair: Secretary of State, it has not been seven hours, but it has been nearly four and a half hours. We are very grateful to you for your time today. That concludes today's session.