HOUSE OF COMMONS

Health and Social Care Committee

Oral evidence: Preparations for Coronavirus, HC 36

Friday 17 April 2020

Ordered by the House of Commons to be published on 17 April 2020.

Watch the meeting

Members present: Jeremy Hunt (Chair); Paul Bristow; Amy Callaghan; Rosie Cooper; Dr Luke Evans; James Murray; Taiwo Owatemi; Sarah Owen; Dean Russell; Laura Trott.

Foreign Affairs Committee Member present: Tom Tugendhat, Chair.

Home Affairs Committee Member present: Yvette Cooper, Chair.

Housing, Communities and Local Government Committee Member present: Mr Clive Betts, Chair.

Science and Technology Committee Member present: Greg Clark, Chair.

Questions 296-386

Witnesses

I: Dame Donna Kinnair, Chief Executive and General Secretary, Royal College of Nursing (via video); Dr Alison Pittard, Dean, Faculty of Intensive Care Medicine (via video); and Professor Anthony Costello, Professor of Global Health and Sustainable Development, UCL, formerly Director, World Health Organisation Department of Maternal, Newborn, Child and Adolescent Health (via video).

II: Rt Hon Matthew Hancock MP, Secretary of State for Health and Social Care (via video); and Professor Jonathan Van-Tam, Deputy Chief Medical Officer for England (via video).

Examination of witnesses

Witnesses: Dame Donna Kinnair, Dr Alison Pittard and Professor Anthony Costello.

Q296 **Chair:** Welcome to this session of the House of Commons Health and Social Care Select Committee. Our guests this morning are, at half-past 10, Matt Hancock, the Health and Social Care Secretary of State, and before that Dr Alison Pittard, dean of the Faculty of Intensive Care Medicine, Dame Donna Kinnair, chief executive and general secretary of the Royal College of Nursing, and Professor Anthony Costello, director of the UCL Institute for Global Health.

Because coronavirus affects every aspect of our national life, we also have some MPs from other Select Committees as guests: Yvette Cooper, Chair of the Home Affairs Committee, Tom Tugendhat, Chair of the Foreign Affairs Committee, Greg Clark, Chair of the Science and Technology Committee, and Clive Betts, Chair of the Housing, Communities and Local Government Committee.

We are going to start with an update on how things are on the frontline. Dr Pittard, I would like to start by thanking you, on behalf of all MPs but also on behalf of the whole country, because your colleagues in intensive care are right on the frontline, and all of us are full of incredible admiration for the courage that they are showing in risking life and limb to keep us all safe. There are lots of issues with PPE, testing and so on, but could you just give us an update on how things are at the moment on the frontline?

Dr Pittard: Everyone has worked together to try to meet this demand. Everyone has worked incredibly hard. Obviously, critical care is at the frontline, but it is not just critical care; it is everywhere else as well. The only way we have been able to get anywhere near being able to meet the demand is by working in very different ways. We have had to look at expanding our capacity into other areas of the hospital. We obviously have the Nightingale hospitals as well. Everyone is working incredibly hard together as a team.

What staff at the frontline are concerned about is this. We have had to change the way we work and so we have non-critical care staff helping us. They have been incredible in using their skills to help us as part of the team. But we are working differently; we are working in different environments and in different ways. For instance, the normal standard of care for a critically ill patient would be one highly trained critical care nurse per patient, but in order to meet the increase in demand we have had to change those ratios.

So although we do have spare capacity, that is capacity that isn't at the normal standard; we have had to spread ourselves more thinly. We have developed guidance to try to make sure that continues to be safe, but if we had to expand even more and spread ourselves even more thinly,

there would be concern that safety could be compromised. Everyone is working really well and we are doing everything we can, but staff are genuinely concerned.

That, on top of concerns about the availability of PPE, the testing issues and everything else, means that staff are under increased stress. We need to make sure that not just doctors but nurses and all the allied health professions who work with us to provide critical care remain resilient, so that we can see this pandemic through, care for patients and continue to provide that care when we start to get back to normal.

Q297 **Chair:** Thank you very much, Dr Pittard. We will come back to you, if we may, but now we will move on. Dame Donna Kinnair, thank you for the incredible courage we are seeing from nurses. As I think you said, their work is always up close and personal, and at high risk to themselves. Perhaps you could start by telling us what the situation is like for nurses on the frontline, both in hospitals and in the community.

Dame Donna Kinnair: I will start with hospitals. This week I personally worked as one of those nurses who is not a critical care nurse but helps critical nurses on the frontline, in the Nightingale hospital in London. What you see there is nurses working incredibly hard, but so are other untold professionals. This week I worked with a clinical scientist who has taken on the role of a health professional.

There is an issue with capacity, but there is also the issue that when people are volunteering, you do not get the same staff all the time. Therefore, that is where you are sometimes compromising the safety standards, because although we are all fit to do the work, we might be only one critical nurse in a range of other people trying to deliver the care to those in the intensive care environment.

On the frontline, people are changing and adapting the way they work, but they are concerned. Even in some of our environments such as the Nightingale, people have become ill. There is an issue about how we get nurses and others tested, because actually that is not quite clear.

You would expect, if you started to become ill, that you would be able to have a defined place to go—that your employer's occupational health would instruct you where to go. What I am hearing from the frontline is that nurses are sometimes driving two hours to get to a testing station, feeling very unwell with possible symptoms of coronavirus. If you haven't got an appointment, sometimes you are turned away and told to come back another time.

We need a clear direction on how we can access tests, both in the NHS and, more so, in social care, which does not have the same infrastructure as the NHS. For me, there is something about our STPs giving clear instructions to the hospitals or social care outlets in their environment about how to get tested, so that people are not turned away, we can make appointments and people who are feeling very unwell with those symptoms can get access to this.

Q298 **Chair:** Thank you very much. We will come back to you as well, if we may, but that was very helpful. I will now turn to Professor Costello. You have been a prominent critic of the Government's approach to testing so far. On 4 April the Health Secretary announced this big target of 100,000 tests a day. To what extent has that assuaged your concerns about the overall approach that the Government are taking?

Professor Costello: If we are going to suppress the chain of transmission of this virus in the next stage, we all hope that the national lockdown and social distancing will bring about a large suppression of the epidemic so far, but we are going to face further waves, so we need to make sure that we have a system in place that cannot just do a certain number of tests in the laboratory but has a system at district and community level.

I pay huge tribute to the people on the frontline—the intensive care nurses, the doctors and the like—but there is also a massive transformation going on right now, with general practices and public health local authority outbreak management teams. It will fall on them to put in place a system that enables you to test people rapidly in the community, in care homes, that makes sure the results get back to them quickly, and that maintains social distancing of a kind after we lift the national lockdown.

If we can do that, we will be focusing on the people we really want to lockdown, which are cases and contacts. As the WHO has said all along, you need to find cases, test them if you can and trace their contacts, and then you isolate them and do social distancing, but most importantly you do it all at speed. The harsh reality is this—I hope that I have been constructively critical, because I believe that we should not have any blame at this stage. We should have a no-blame audit: where were the system errors that led us to have probably the highest death rates in Europe? We must face the reality that we were too slow with a number of things. But we can make sure that, in the second wave, we are not too slow.

In reality, I am not sure that we need 100,000 tests per day if we can get the epidemic damped down. More important is to have the systems in place. I would like to know much more from Matt Hancock about how they are restructuring the public health teams and whether they have plans in place. Will they need additional volunteers, for example? We have 750,000 people queuing up. I bet there are many retired doctors and nurses there who could maybe come in and help with some of the contact tracing, being online and giving that personal service.

Just asking people to self-isolate will not achieve the quarantine that you want. Korea did it with testing, and perhaps we need to hear about apps. China and a lot of the Asian states did it by symptomatic identification and then careful quarantining—some in hospitals, people with milder symptoms in special places where they can rest, and others in hotels. We need to think this all through, because right now all the countries in Asia are facing little flare-ups and we will face the same, so we need to damp that down.

It is the number of tests, and I think that we will get there now that we have widened the reach of who is helping with the testing, but we must also have the systems and the logistics in place so that we can suppress this and maintain it for a long time. In that way, we will get the economy going again.

Chair: Thank you very much. My colleague, Tom Tugendhat, has a question for you, Professor Costello. Then I will come to Luke Evans who has a question for Dr Pittard.

Q299 **Tom Tugendhat:** Professor Costello, thank you very much and thank you very much for the impressive work that you have done in publishing your thoughts. I have been reading them with great interest. What are the implications for the spread of covid-19 in the developing world, and what actions should the UK be taking alongside international partners? I have spoken this morning with the heads of UN agencies who are deeply concerned not just by the spread of the disease, but by the implications of the lockdown in terms of widespread famines and perhaps social or even civil unrest.

Professor Costello: You are absolutely right. Most of the poorer countries will find social distancing extremely difficult because of the many people living in shanty towns, in one-room accommodation. You are seeing this mass migration of labourers in India, for example. India has testing capacity, but it also has a massive population. Most countries in Africa will struggle to test. Some countries have no more than a couple of ventilators. They probably do not have intensive care units sufficient to deal with this. Personal protective equipment is, of course, going to be a massive issue. On all those counts, there will be a crisis. We are only just starting that because they are a couple of months behind us.

I know that a lot of the usual aid agencies—DFID, of course, has a great reputation in many countries for giving aid and for making sure that it gets to the right places. There must be a co-ordinated effort. We do face potentially incredibly high death rates if the epidemic behaves in southern countries the way that it has behaved in northern countries. It is possible that there will be some seasonal issues there and that the southern hemisphere might be relatively protected for a few months, but we do not know about that. Clearly, there is the support to the countries that we usually support and the agencies that are doing work like the WHO, UNICEF and a number of others. All of these are big issues, and I hope that the UK can play its part, obviously, not just to get it right for our country, but to make sure that we are very generous to the southern hemisphere.

You are right to mention food security and also the economic impacts. The real risk is that they are going to see big unemployment rates without social security, as well as bankruptcies and a huge new debt crisis, because they will have loans in dollars that they will not be able to repay. All these things require not just doctors and nurses; this is for economists and aid specialists.

Q300 **Tom Tugendhat:** Can I follow up briefly and get you to touch on why this is important for us? Forgive me; we are responsible for the money and the welfare of the British people, as Members of this Parliament. Could you touch on why it is so important that we do not allow ponds of disease, as it were, in other parts of the world, and the potential implications of it coming back to the UK?

Professor Costello: There is that, but we are also a trading nation. Africa has been the fastest growing region of the world in the last decade. If it collapses, that will be a burden on aid for everyone, and there will be migration—there will be flight. The economy that we deal with—particularly after Brexit, because we will be looking for new markets—will be very important.

The other thing is longer term, from a foreign policy point of view. We have seen President Trump cut budgets to the WHO, which I think diminishes the status of America. China is delivering an awful lot of personal protective equipment and testing capacity to many countries in Africa. The long-term impact of that may be that people will start to turn to the east, rather than the west, for help. I hope that we will preserve our really strong reputation for aid. We have always kept our aid budgets up, under whichever colour of Government, and I hope that that will be maintained. We must also remember that, with the open borders that you need for trade, you will have the risk of people bringing imported infections in if we do not get control all over the world.

Chair: Thank you very much. I would like to bring in Luke Evans for a question to Dr Pittard.

Q301 **Dr Evans:** Hi, Dr Pittard. Thank you so much for all that the frontline staff are doing. You are right to mention your allied professions who are stepping up—I hear from my clinical friends of vascular surgeons doing ABGs and things like that. From a Faculty of Intensive Care Medicine perspective, were you guys consulted about the set-up of the Nightingale hospitals? How much influence have you had in that process?

Dr Pittard: The Faculty of Intensive Care Medicine has not had direct input into development of the Nightingale hospitals, but I know that clinicians have been involved in looking at sites and how they would run.

A number of different clinical models are being used, depending on the geography, the population density and so on. For instance, in London, they were aware that their critical care capacity would not be enough to deal with every critical care patient, so the Nightingale at the ExCeL centre would be used to manage critically ill patients. For some of the other Nightingale hospitals, if the critical care facilities within that geographical area—including the surge capacity within the normal hospital footprint—could manage with the critically ill, those Nightingale centres would probably be used for either the less sick or for patients recovering who, rather than staying within the hospital, could be moved out to the Nightingale hospital, which would free up capacity within the normal hospital footprint for those who were sicker.

That sort of model will need to be looked at as we start to get back to normal, because we know that, after being critically ill, it takes a long time to recover, irrespective of what takes you into the intensive care unit. It can take 12 to 18 months to get back to the sort of place you were at before you became critically ill. That area—life after critical illness, which is a workstream that the faculty is currently engaged in—is something we will need to look at, because if patients are staying in hospital when they do not necessarily need to, but they need increased support and rehabilitation, that will hinder the speed with which we can get back to normal healthcare practice afterwards.

Q302 **Dr Evans:** Thank you. You partly touched on where I was going with my question. I am aware of the criteria—for example, the amount of noradrenaline that patients should be on when they are transferred. On the first point, do you think that coronavirus patients are stable enough for a judgment call to be made on whether or not they can go to effectively a step-down ITU at the Nightingale? Is that something that you think is clinically possible? In terms of that rehab and those slow-to-wean patients, have you got any ability to predict that? If they are in the Nightingale hospital and, as you point out, taking a long time to recover from the intensive care unit and longer term, who should be picking that up? Does the ITU have the capacity to deal with that?

Dr Pittard: To deal with your first question about transferring patients, we transfer critically ill patients all the time based on their clinical need, for example if a patient presents to hospital X where those clinical services are not available. A classic one would be neurosurgery. If a patient has a subarachnoid haemorrhage—a brain haemorrhage—and they present to a smaller hospital, they will get transferred to a larger hospital that has a neurosurgical centre. We transfer patients all the time, and we do it in a safe way. We would not therefore transfer a patient where we thought it was unsafe to do so. My clinical colleagues in critical care and I are highly trained to be able to say which patients are suitable to transfer and which are not. It will not be undertaken if it is not safe.

To come to your second question, there are two issues about recovery from critical care. There is the issue when you are still in the acute phase—when you are not too concerned as a clinician about whether the patient is going to survive; it is about when they build up the strength to be able to get off a ventilator. That might be something that could be undertaken in a Nightingale hospital to take off the pressure from the acute main hospitals. Again, that is the sort of thing that critical care is used to doing all the time. Even when those patients are well enough to come off a ventilator, they then have a long journey in front of them, not just in terms of getting home, but in getting back to the quality of life that they had before.

Something as simple as getting back to work is a major indicator of when somebody is starting to make a good recovery. It can take 12 to 18 months to get to that point. If you can get back to working, you are then contributing to the economy, and that is a major area that we in critical care are aware is not adequately resourced at the moment.

The faculty is engaged with a group of experts to try to produce some guidance as to what would need to happen, because obviously if we can get patients out of hospital, adequately supported by the right people—we currently have follow-up clinics and we manage patients, but we do not have the resource to do that. If we can get people back to work and back to contributing to the economy in the longer term, that will be beneficial for everybody.

Chair: Thank you. I think we have probably got time for a couple of brief questions before we bring in the Health Secretary.

Q303 **Paul Bristow:** Thank you, Jeremy. I just wanted to follow up with Professor Anthony Costello on some of the points that Tom made in relation to the impacts on the UK from infection in the developing world. I am thinking particularly of India, Pakistan and Bangladesh. There are of course many British nationals and dual nationals living over there. If they are likely to see considerable outbreaks there, they will understandably want to come back home. What could be the impact on the UK of that type of migration back to the UK? Can we manage that, and how?

Professor Costello: Yes. First, in the UK this is not a single epidemic. It moves into cities, like it did in Wuhan. It then went out to four cities in China, which they supressed very quickly in about two weeks with partial lockdown. It was the same in Korea. In this country, it has been in London, Wolverhampton and maybe in bits of Liverpool and Glasgow, but the rest of the country is largely—was largely untouched until 12 March. There were 50 local health authorities that had fewer than 10 cases then. I was against the idea that you should stop contact tracing in those communities, though it was right to stop it in London, because it was too difficult.

The recent estimates, even from the chief scientific officer, are that after this wave, where we could see 40,000 deaths by the time it is over, we could have maybe only 10% to 15% of the population infected or covered, so the idea of herd immunity would mean maybe another five or six more waves to get to 60%. I do not think we should be using phrases such as "flatten the curve" because it implies continuing. We have to suppress this right down. Then, you run the risk of community transmission both within the country and if you open the borders to people coming in, not just from the developing world, but from Europe or anywhere, so you will have imported cases. In China, they have been watching incredibly carefully and have picked up mainly imported cases but are now seeing some transmission—it is the same in Singapore, Hong Kong and the like.

That is the challenge; we are all playing for time. We need to dampen it right down, we need a community-protective shield to try to keep it that way, and then we have to pray that the vaccinologists come up with something. Professor Sarah Gilbert from Oxford says that she is 80% confident she will have a vaccine by September. We have to be positive here, keep everything down, stop the deaths and keep the economy open as much as we can, without a national lockdown, and hope that we get a vaccine.

Q304 **Laura Trott:** This follows on from Paul's questions. Professor Doyle from Public Health England gave evidence to the Committee a couple of weeks ago. She told us that intensive contact tracing was not effective when there is community transmission. Do you agree with that, Professor Costello?

Professor Costello: No, I do not. I agree with it in hotspot areas and areas of intense transmission. Obviously, then it becomes much more difficult and your focus in London and other hotspot areas would shift to protecting health workers. I am in Yorkshire right now, where fewer than 10 confirmed cases had been identified, in a population of 300,000 or 400,000, around the time that we stopped all our community testing and contact tracing. I would have had a more nuanced view whereby, in quieter areas, you maintain contact tracing.

Of course, now that we have national lockdown and are suppressing the epidemic, the aim must be to get all the logistics set up, with digital apps and public health teams—maybe with volunteers and primary care, who have all been doing this—to have an absolute plan to protect the community as soon as we lift the lockdown, and then focus on the people who we really want to lock down, who are cases and contacts. We can then let the economy get going again.

That has been backed up by the Nobel prize-winning economist Paul Romer, who has shown very elegantly that if you focus on that, it is much less disruptive to the economy. Chris Whitty has talked a lot about the indirect effects on mortality—he is absolutely right—from economic damage, bankruptcies and unemployment. We have to get the economy going, and if that means locking down 10% of our population—even by giving them incentives to stay in quarantine, and with digital apps to help to monitor their symptoms and give them support—that is the way to really keep this going until we get a vaccine and safe herd immunity.

Chair: We have a brief final question for this part of the hearing, from Sarah Owen to Dame Donna.

Q305 **Sarah Owen:** We heard this week changing guidance from the Secretary of State on visitors, particularly around end-of-life care. Do you think that hospitals have the resources and the correct PPE to facilitate that and to do so safely?

Dame Donna Kinnair: We are currently very worried about the shortage of PPE in hospitals, particularly gowns, as we have heard on the BBC this morning. If we can get more PPE into the country, we will be able to do that, but at the moment I am very worried that we do not have enough PPE for staff to protect themselves, let alone to give to visitors so that they can see their loved ones during end-of-life care.

Chair: Thank you. That concludes the first part of the session. I would like to say a very big thank you to Dame Donna, Dr Pittard and Professor Costello for your very informative answers to our questions.

Examination of witnesses

Witnesses: Rt Hon Matthew Hancock MP and Professor Jonathan Van-Tam.

Q306 **Chair:** We now move to the main part of this morning's proceedings, with the Health Secretary, Matt Hancock. I would like to welcome you to this session, congratulate you on your own recovery from coronavirus and thank you for your own huge efforts during this crisis, but also ask you to pass on our thanks, first to your team at the Department of Health and Social Care, who are working extremely hard, and to NHS staff more broadly, who we all know are doing an absolutely superhuman job at the moment. Thank you for joining us this morning. You asked yesterday if you could have a few moments at the start of our session to set out what you think the state of play is and your battle plan, so please do go ahead with that.

Matt Hancock: Thanks, Jeremy, and thanks very much for having me. I think it is very important that we have these sessions, and I am delighted that Parliament is operating in this virtual format. I thought it was worth starting by setting out the way we approach the things that we need to do to protect the health of the nation. We think about this through our battle plan, which has six elements. We have put more detail on some of these in the public domain already.

The first, of course, is social distancing. Everybody knows where we are up to on that after the decision yesterday to extend the social distancing measures. That, of course, is mission critical for bending the curve down, and that is working.

The second part of the battle plan is building up NHS capacity, because making sure that the NHS always has the capacity to treat patients is also mission critical. Thus far, that has always been the case. As of this morning, we have the highest figure, again, of spare UK-wide critical care beds: 2,769. Of course, the NHS Nightingale project, which has been an unbelievable roll-out, is a critical part of making sure we always have NHS capacity. The ventilator project plays into that; there is a whole load of parts to it.

The third element is supply, which we have as a separate strand in our battle plan because it is so challenging. If you think about it, what has happened is that, suddenly, the world has needed a huge amount more of a quite small but very important list of kit. That includes PPE; the key medicines; again, the ventilators; the standard ICU medicines that are needed; and the potential treatments as they come down the track. Everybody is buying up hydroxychloroquine in case the clinical trials demonstrate that it is a very effective treatment, because that is what the early signs say.

The fourth part is testing. I am sure we will come to testing. Clearly, the ramp-up of testing is very important, but we put testing in with test, track and trace. Testing on its own is very important, especially for staff and for treating patients, but for controlling the spread of the disease you need

the testing, the tracking technology and the large-scale contact tracing. It is the combination of the three—test, track and trace—that we have. That is the fourth part of our battle plan.

The fifth part is vaccines and treatments. Clearly, having treatments that mean the morbidity and mortality from catching coronavirus are less severe changes the impact of the disease on society, and the more we can do on treatments, the less dangerous the disease is. On vaccines, obviously, the UK is playing an absolutely world-leading role, but there is still some time to go. The reason that there is still some time to go is that because the mortality and morbidity from this disease are relatively low—terrible as the death toll is, the proportion of people who, sadly, die is relatively low—you do have to test vaccines, because of the risks of putting a vaccine into the general population that itself does damage.

The sixth part of the battle plan is shielding, because the more that we can protect those who are most vulnerable, the safer society is from the disease.

They are the six parts of the battle plan, and you can see, I hope, all the different things that we have to plot into those six parts. Overall, the goal is clearly to bend the curve down and to make sure that the NHS capacity is there, and at the same time to do the work to try to improve our ability as a society to cope with this disease, with the goal of lifting some of the incredibly restrictive methods that we have had to place on the population in order to get the disease under control.

I end my opening by thanking the NHS staff and social care staff, who are doing amazing work—I am grateful to you, Chair, for opening with that—and also the public. It is only because the vast majority of the public have followed the rules that we are now seeing the flattening of the curve.

Q307 **Chair:** Thank you very much indeed for that. I want to start with the reporting of data, which I think people have been puzzled by. Can you explain why we are only reporting hospital deaths on a daily basis?

Matt Hancock: The overall goal is to be as transparent as possible. The quality of the data is the critical part of the answer to this question. We have daily reports of deaths from covid-19 and of people with covid-19, depending on whether it is deemed by clinicians as the direct cause or as somebody with covid-19 dying. We have that in daily reports that come in from the four national health services in the four nations to a central point and are then published.

The data on deaths of people who have covid-19 and die outside of hospitals takes longer to collect, because it is recorded on death certificates, which are often written a couple of days after a death—they are not always written at the same time—and are then registered and go into the registry, and then the data can be published. The reason why the Office for National Statistics publishes, with a lag, the overall number of deaths, as opposed to deaths in hospitals, is a data collection issue. Every

death in any setting matters and is of course an important part of our analysis.

We have managed to work with the ONS to bring forward the publication of overall deaths of people with covid-19. I think the lag is now five days, whereas when it started it was two weeks. The ONS has done good work to bring that data more up to speed. However, naturally, because everybody is looking at this data not only to understand what has happened but to try to understand where we are with the transmission of the disease, I understand why people want that up to date. Rather than holding the hospitals data back until we have the whole data, we think it is better to publish the hospitals data when we have it, and to then publish the overall data when we have that.

Q308 **Chair:** Okay. We have a lot of questions to get through, so I ask you to be fairly brief on the answers. You talked about the ONS, which says there have been 217 covid deaths in care homes to date. Scotland thinks a quarter of all its covid deaths have been in care homes, and France, Italy and Spain think it is about half of theirs. Does it really seem likely to you that less than 2% of our covid deaths are in care homes?

Matt Hancock: No. The figure that you mention is from a couple of weeks back. I can say with a high degree of confidence that the number and the proportion are higher than what you say. I will wait for the official statistics to understand it.

Q309 **Chair:** I wonder why we cannot do what France does and collate and publish that information on a daily basis so that we all know exactly what the situation is.

Matt Hancock: Well, my understanding is that that is not what the French do. I know there has been a lot of attention on the way that France publish this data—they do publish it a couple of times a week. As I said, we are working with the ONS to try to reduce this lag, and because I am concerned about this, I asked the CQC to make sure that we record the data in care homes specifically of those who are residents of care homes, whether they die in hospital or the care home. They started collecting that data yesterday, and it will be published very shortly. So I have introduced a new measure that will directly address this question.

Q310 **Chair:** I want to bring in my colleague Sarah Owen, but finally I want to ask you about something sensitive: the news this week that 27 NHS staff have, sadly, lost their lives in this terrible crisis. Do you have an update on that number? Is it still 27, to your knowledge?

Matt Hancock: The official verified figure remains 27. It gets updated three times a week, and I will let you know as soon as I get an update. Sadly, we have all seen the reports about Mary, an NHS nurse in a late stage of pregnancy, who died since the publication of the previous figures. So we know that the figure is higher.

Q311 **Chair:** Will you commit to publishing that number three times a week when you have it?

Matt Hancock: Yes. I would quite like to get it to daily.

Q312 **Sarah Owen:** Thank you, Secretary of State. At the last meeting of the Health Select Committee, I asked three times about guidance for pregnant healthcare workers. As you have just said, we have now, tragically, seen the death of 28-year-old Mary Agyeiwaa Agyapong at Luton and Dunstable Hospital in my constituency. The current guidance on pregnant healthcare workers during this pandemic comes not from the NHS but from the Royal College of Midwives and the Royal College of Obstetricians and Gynaecologists, which states, "It may not be possible to completely avoid caring for all patients with covid-19. As for all healthcare workers, use of personal protective equipment…and risk assessments according to current guidance will provide pregnant workers with protection from infection. The arrival of rapid covid-19 testing will significantly assist in organising care provision, and this guidance will be updated appropriately when such tests are commonly available." Despite continual promises to ramp up the distribution of PPE and testing, healthcare workers on the frontline have been left wanting. Will you commit to ensuring that there is a review of the guidance for pregnant healthcare workers in the light of the delays in PPE distribution and of testing being a long way from commonly available? Will you commit to that revised guidance coming straight from the NHS and Government?

Matt Hancock: There are several things to answer. First, we work very closely with the royal colleges, and whether guidance comes from the royal colleges, Public Health England or the NHS, we try to ensure that it comes from the most appropriate body for that group, and we work very closely together. So whether guidance comes from the royal colleges or from the NHS is much less important than what the guidance says and what the situation is on the ground.

With respect to your constituent, Mary, her death was incredibly moving to so many people not only in the NHS but across the country. As was made public when her death was made public, she had not been in work for a month.

Sarah Owen *indicated dissent.*

Matt Hancock: But we look into every single death of somebody who works in the NHS to make sure that we fully understand it. It is incredibly important to ensure we get to the bottom of each and every one of these cases, and that also includes access to protective equipment and tests.

Finally, on testing, we have now made testing available to everybody who needs it across the NHS. All staff who are symptomatic are now able to get tests. I can tell you that over 50,000 people who work in the NHS have now had tests.

The good news is that because we are expanding the capacity to test, we are able to expand the number of tests that are done, not only on patients going into care homes, for instance, as I announced earlier this week, but

on NHS staff and members of their household, if a member of NHS staff is isolating because of household isolation.

Chair: We will come back to testing and PPE later, but Yvette Cooper has a question on that point.

Q313 **Yvette Cooper:** Just a quick factual question. Do you have an estimate for the number or proportion of NHS staff or social care staff who have been infected with covid-19?

Matt Hancock: No, I don't. What I have is an estimate of the proportion who are off work because they have suspected covid-19 or a household member does, which is a little over 8%. Obviously, with the expansion of testing, we hope to be able to get that figure down.

Chair: Thank you. Tom Tugendhat and then Taiwo Owatemi.

Q314 **Tom Tugendhat:** Matt, please do pass on our thanks to everybody in the NHS doing an amazing job, not just for British citizens here but for many others from around the world who are in the UK. On that basis, what agreement have you been able to come to on reciprocal arrangements for British citizens abroad and other citizens here, so that British citizens overseas can access care wherever they happen to be?

Matt Hancock: It is a very important question, Tom, and one that we went through in the debate around Brexit. We also have reciprocal healthcare arrangements with a small number of other countries in the world, such as Australia. I would like to expand that. We had to drop the legal changes to do that during the Brexit parliamentary process, but I would like to see us expand those formal reciprocal arrangements around the world.

First and foremost, one of the principles of the management of epidemics is that people should be treated by the health system in which they find themselves ill. You will remember that the first covid-19 patient in the UK was a Chinese citizen who had come to visit. We treated him and one of his parents in Newcastle. That is the overriding principle.

We are also highly pragmatic, however, and we have run a huge effort, of which no doubt you will be aware, that Dominic Raab has led, to ensure that people can come back to the UK because of the collapse of the international travel system as it was before the crisis hit. That repatriation has been both for people who are ill and who are not ill. It has been particularly challenging and acute for people on cruise ships, because they do not have a nation of residence, but the time taken to get a cruise ship on the high seas back would have been, in many cases, too long, given that there was an outbreak onboard. There has been a huge operational side to that, which you would do better to ask Dom about than me, but there is also the overriding principle that we treat the people who are here.

Q315 **Tom Tugendhat:** We will of course ask Dom about the practicalities, as you rightly say.

The second thing I wanted to ask briefly about, on the international aspect, is that clearly, in a pandemic, learning from others is essential. How are you finding that the transparency and openness from other countries is affecting our ability to respond and keep our people safe? What conversations have you had with countries that have been successful, such as Taiwan?

Matt Hancock: We have conversations with colleagues right around the world all the time, especially in the regular G7 discussions and a set of G20 discussions that are coming up this weekend, and with countries outside of those sorts of formal settings. Especially early in the crisis, there were issues around quality of data, but I think everybody is doing their level best to get the best data that they can.

Right from the opening question of this Select Committee, there are challenges in getting the right data and getting the data out. My task is to use the very best data and to try to understand the countries where certain things are going well, and the countries where things are not going so well, and to learn what has gone wrong as well as what has gone right. We do talk to countries right around the world, and we are constantly trying to learn.

Chair: I want to make sure that we have plenty of time to ask about testing and PPE, so the final three brief questions on this section on data are from Taiwo, then James Murray and then Rosie Cooper.

Q316 **Taiwo Owatemi:** Good morning, Secretary of State, and thank you for coming. With regard to PPE, yesterday a nurse at my local hospital spoke about her experience on the frontline. She described the low morale among staff due to the lack of support and said that she comes home every night crying after her 12-hour shift. Megan said that she is "scared and terrified" given the lack of PPE. Due to the nursing shortage, those on the frontline are scared and afraid about the virus. I want to know what support you are giving to ensure that nurses and other professionals feel safe, and to address the lack of morale among those teams.

Matt Hancock: That is an incredibly important question. Can I ask which is your local trust?

Taiwo Owatemi: University Hospitals Coventry and Warwickshire.

Matt Hancock: Okay. It is incredibly important, because the morale of those on the frontline is so important. People talk about some of the things that the public do to show their value. I know from talking to people in the NHS and in social care that they really matter. Things like the new CARE badge have gone down very well among people in social care, and I am really proud of it. But these things are only part of the story, because making sure that people have the support that they need when they are in work, exactly as you say, is so important. We will come on to PPE in detail, no doubt, but this is why PPE is absolutely critical. It is also why that is the case with the expansion of testing to NHS staff and to social care staff

when they need it. I am very pleased we have been able to do that because we have been able to ramp up the amount of testing so fast.

The final thing I would say is that we pay tribute regularly to the staff in the NHS, but the fact that we have the staff and the physical capacity—for instance, through the Nightingale hospitals, with the ventilators—to be able to treat everyone who needs it is a really big, positive thing that we have been able to achieve during this crisis, because it means that NHS staff are not having to make decisions about who gets the treatment.

Of course we have got to resolve the issues around PPE and to keep expanding testing, but making sure that we have that capacity—not only the physical capacity, but also the staff—is a very good thing. We have had staff returning to the NHS—almost 10,000 nurses; I will try to get the overall figure—and that has been something that I think people have seen, and people really value the things people have done there as well.

Q317 **Taiwo Owatemi:** I have spoken to a lot of pharmacists over the past weeks, and a lot of them have expressed their concerns about the fact that a lot of frustrated customers have been attacking them, and some pharmacies have resorted to hiring security staff. What I want to know is: what is the Government going to do to ensure that these frontline workers feel safe and are not subjected to abuse while they are actually doing their job?

Matt Hancock: Well, I am really glad you have picked out pharmacists, because I think pharmacists are a critical part of the NHS family. Because they work in the community, they are often closer to the communities they serve, and they are part of the NHS. We have put extra funding into pharmacy—an extra £300 million—because of the challenges that they face, and in particular the high demand for medicines, to help them with their cash flow. We are also working with them on PPE: not only on having the equipment, but also on making semi-permanent changes—for instance, putting glass screens up so that there is a lower amount of transmission and a lower risk within pharmacies, and supporting them to do that. Pharmacies are an absolutely critical part of the NHS team.

Chair: Thank you. Taiwo has a background as a pharmacist, which is why it is important that she asked that question. We are going to have two final brief ones on data from James Murray and Rosie Cooper.

Q318 **James Murray:** My question is just really to understand how we are using the data to make sure the strategy is right in different regions, and in particular, in my case, in London. On 2 March, Secretary of State, you wrote in the *Evening Standard* that your "actions will always be guided by expert scientific advice." On 17 March, the Government chief scientific officer told this Committee that "London is ahead of the rest of the country in where it is on the outbreak at the moment." Putting to one side the question whether the Government was too late in waiting until 23 March to introduce lockdown measures nationwide, why did you not at the very least apply them sooner in London?

Matt Hancock: It is an important question. I think that we took the right measures at the right time. We did consider having a London-specific lockdown, but decided that it was better to do it across the country as a whole, for two reasons. The first is that if you put a lockdown in one part of the country, there is still travel from there to the rest of the country, so it isn't as easy as that. The second reason is that, actually, one of the really strong things that has come through this crisis is that the country is acting in lockstep. If you look at the responses to the social distancing measures, they have been very similar across the whole UK. The country has really come together, and to separate off one part of the country from the rest has downsides in terms of the national unity in the support for the overall response. These are incredibly difficult measures, and the national unity that has been shown in response to them has been extraordinary. These are difficult judgments—as you say, based on the science. We did consider a separate London policy, and we decided it was better that the whole nation moves together.

Chair: Thank you. Final question on this bit from Rosie Cooper.

Q319 **Rosie Cooper:** I acknowledge that everybody is working tremendously hard in the health service top to bottom, and I accept that all the statements that have been made were made in good faith, but I would like to address the elephant in the room, and that is the question of trust and confidence both of the public and of clinicians and people working in the health service.

Take ignoring the World Health Organisation's "test, test, test" without giving any real public health reasoning. So far, a lot of people feel they have had statement after statement after statement, and within days or weeks those statements fall apart—on PPE, on testing, and on testing not being needed in care homes, and things like this. The testing centres that have been set up in out-of-town areas could only have come from the centre—from somebody who has no idea, locally, how people are supposed to travel miles and miles and miles to get tested. They might as well be on the moon, frankly.

We have a whole list of statements which are aspirational, and that we can regard as aspirational rather than factual. Hope is not a strategy, so what is your message to the people out there who go out to the frontline every day expecting their PPE, expecting the rules to be applied to everybody and for them to make sense, and expecting to be supported? What assurance—not reassurance—can you give to people that the basis for the decisions you are taking is real? For example, we could ramp up testing in hospital labs. We don't do that, yet we are still talking about 100,000 tests. Overall, how can you tell people to go and risk their lives without giving them the evidence to do that?

Matt Hancock: There is quite a lot to unpack there. I am not sure that I agree with your assessment at all. We have had a principle throughout this whole crisis of transparency being at the heart of what we do, and we have published enormous amounts of data and information. It is true that, if you want to make something happen, you have to say what you plan to

happen and then follow through on it. The 100,000 tests per day by the end of the month is a clear goal and commitment. I set it out in public to galvanise the life sciences industry, and that is exactly what has happened in response.

I can go through a couple of the other things that you mentioned. The morale on the frontline is absolutely vital. Current covid-related absence is 7.1%, which is lower than the previous publicly reported figure of 8%. That shows that it is coming down, partly because we have expanded testing to NHS staff. You talked about the drive-through testing centres, which are a big policy success so far. We now have 22; we will have 50 right across the country, precisely to get the testing capabilities out into the community. Once we have those established, we will have mobile units, and when the technology is good enough we will have home testing kits as well. I say that not to set out our hope, but to set out our plan for what we will deliver.

On public confidence overall, I am really pleased that the public in very high proportion have followed the evidence that we have given. That has had the consequence of, overall, doing the most important thing in this crisis, which is flattening the curve. We can see that, over the last 10 days or so, the number of new cases and the number of new cases arriving in hospital are both flat, which is very good.

Q320 **Rosie Cooper:** I just ask you to think about the actual implementation locally. Doing all this centrally, through out-of-town testing centres is really difficult. You are not getting the throughput that you should have.

Matt Hancock: We will come on to that in testing, but there is spare capacity that we need to use.

Q321 **Chair:** Thank you. That was a good bridge into our next topic: testing. On 2 April, you announced a very ambitious target of 100,000 tests a day. That has been widely welcomed. Could we start with an update, not on capacity, but on how many tests were actually conducted under each of the pillars of that programme yesterday, so that we can have some sense of how we are doing?

Matt Hancock: Yes, I can give you those data. The overall number was just over 18,000 yesterday—a rise of 4,000. The vast majority of that was in pillar 1; the number in pillar 2 was around 4,000. We do not have any tests that are good enough to work clinically in pillar 3 yet, and the number in pillar 4 was a couple of hundred. I will get the exact numbers for you.

Q322 **Chair:** Thank you. Would it be possible—as this is so central to what the Government is doing—to publish the numbers on a daily basis, so that we can see exactly how the progress is happening?

Matt Hancock: We do publish the number. Do you mean broken down by pillar?

Chair: By each pillar, yes.

Matt Hancock: By all means. We can do that.

Q323 **Chair:** Thank you. Given how critical testing is and the fact that countries that have done the most testing seem to have the lowest death rates, one thing that puzzles people is why we stopped community testing on 12 March. You could, for example, have announced the 100,000 daily test target on 12 March. Had we done that, we would have been ahead in the global race for the reagent chemicals and could perhaps be testing everyone who leaves hospital now and testing more people in care homes. Why the three-week gap between stopping community testing and the announcement of the 100,000 target?

Matt Hancock: I do not think that if we had announced the 100,000 target a couple of weeks earlier, as you suggest, we would be in a different position now, because we were continuing the drive to increase testing all along. The challenge has been the radical increase in the amount of testing over the last two months, from 2,000 tests a day at the start of March to 10,000 tests a day at the end of March, with the ambitious goal that I have now set of 100,000 tests a day by the end of this month. That ramp-up has been ongoing throughout. I set a public target partly because people were asking how fast we were going to get there, and also because it managed to galvanise the non-diagnostics pharmaceutical industry here—the diagnostics part of the pharmaceutical industry, which is brilliant but relatively small here, had been heavily engaged throughout.

The overall project to ramp up testing has been going since day one. The challenge is that as the epidemic increased exponentially at that point in the middle of March, it meant that the incidence of the outbreak was broad and that we were not able to test everybody with symptoms. Now that we have got the curve under control, I want to be able to get back to the position in which we can test everybody with symptoms, and I anticipate being able to do that relatively soon because we are increasing capacity, as I say.

I can now give you the full figures for yesterday: at midday yesterday, we had done 18,665 tests in the previous 24 hours. Of those, 16,166 were from pillar 1; 2,323 were from pillar 2; and 176 were from pillar 4.

I know that the history of testing is going to be a long-debated subject. What really matters is what we are going to do from here on in. What I can tell you is that today we are able to expand the eligibility for testing, which is currently for patients, for surveys and NHS and for social care staff, and some that go to LRFs for local urgent need. I can today expand the eligibility for testing to the police, the fire service, prison staff, critical local authority staff, the judiciary and DWP staff who need it. We are able to do that because of the scale-up of testing.

Q324 **Chair:** If we look at a country like Germany, they have a population 25% bigger than us but only a third of the number of deaths. They never stopped testing in the community; they have carried it on right the way through. Under your strategy—your five pillars—mass community testing

does not appear as one of the main focuses of any of the five pillars. It might be that it is there, but the thing that has worried people—perhaps you can clear this up—is that Dr Jenny Harries, your deputy chief medical officer, said that community testing was not an appropriate intervention, and Yvonne Doyle said that the ship had sailed on community testing. Is the Government view that mass community testing is part of the strategy, or do you think the ship has sailed?

Matt Hancock: It is part of the strategy and we will be introducing it when we can. It was not possible when we had small numbers of tests, but as we have expanding numbers of tests, so it will be possible. The way that it will be delivered is under both pillar 2, as we expand the commercial swab-testing capabilities, and under pillar 3, when we get a mass antibody test that has a high enough specificity for us to be comfortable putting it into the community.

Q325 **Chair:** Okay. As you said earlier, it is not just about the testing—it is the tracking and the tracing and the quarantining, too. Dr Lee of the Korean Centre for Disease Control told the Science and Technology Committee last week that there were up to 1,000 people doing contact tracing in Korea, alongside all the digital apps. PHE had 290 people doing this at their peak, but they now say that that has been wound down. Are we going to be building up those teams again?

Matt Hancock: Yes.

Q326 **Chair:** Is that going to be something that will involve local government or central Government? How are you going to do that?

Matt Hancock: We plan to do that through a central team. It will be run as part of the test, track and trace strategy, which is one of the pillars of the overall battle plan. That brings together teams from NHSX, who are leading on the design of the app, with a huge array of partners that are working within that. Public Health England are the experts in what we refer to as external contact tracing. That is where somebody else comes in and helps you to work out the contacts that you need to get in contact with and then helps you contact them. The app is itself a contact-tracing app. That is the point of it—to assist individuals to do contact tracing themselves by notifying people who they have been in close contact with, when they have downloaded the app. Then, of course, there is the link to testing, so people can get the test. Test, track and trace is one piece of work, with those three critical strands, and then you have to have a quarantine policy to back it up.

Q327 **Chair:** Kathy Hall is your official in charge of testing. Has she got someone working directly for her who is full time on the contact tracing side of this?

Matt Hancock: The way this is organised inside the Department is that David Williams, who is the second permanent secretary at the Department of Health, is responsible for test, track and trace overall; Matthew Gould, who is the chief executive of NHSX, runs the app part; Kathy Hall runs the

testing part; and Duncan Selbie at Public Health England is responsible for the contact tracing element.

Q328 **Chair:** Thank you.

A final question from me on this one. Yesterday, Dominic Raab announced the five tests that would need to be passed before we exit the lockdown. The WHO guidance for ending lockdown actually has six criteria that countries are advised to follow. The second of those six criteria is that there must be capacities in place to detect, test, isolate and treat every case and trace every contact.

If we are going to be able to end the lockdown in three weeks—if that is going to be a theoretical possibility for the Cabinet to consider—do you accept that we would need to get comprehensive contact tracing in place by then, if we are going to be following WHO guidelines?

Matt Hancock: We do need to have comprehensive "test, track and trace" in place as soon as possible. We need to get the technology right. We need to have the people. We are building that resource. Obviously, we need to have the testing and we are ramping that up as well. We do need to have all three of those in place and we are working incredibly hard to make sure that they are.

Q329 **Chair:** But you accept that we couldn't lift the lockdown, if we are going to comply with what the WHO advise, until we have got that mass contact tracing in the community in place.

Matt Hancock: The answer is that it depends on scale. The scale of contact tracing that you need depends on the incidence of transmission, not on the R. The R, which we have heard a lot about, is the rate of transmission; it determines how fast the incidence of transmission goes up or down.

What matters for the scale of contact tracing that you need is essentially the number of people who are catching the disease—the incidence of transmission. If you start with a high incidence of transmission, like we have now, then you need a massive contact tracing capability, whether that is e-contact tracing or external contact tracing. As you bring the incidence down, which we plan to do—we have seen the flattening of the curve; we now need to drive that curve down—then, of course, the amount of contact tracing that you need reduces over time.

Chair: Thank you. I'd like to bring in Greg Clark, followed by Clive Betts.

Q330 **Greg Clark:** Thank you, Jeremy. Secretary of State, my Committee, the Science and Technology Select Committee, has heard international evidence that a very high proportion of people with covid-19—it said over 50%—are asymptomatic themselves, but can infect others. Have you received expert representations that asymptomatic NHS and care workers should be routinely and regularly tested?

Matt Hancock: This is something that we are looking at. The asymptomatic transmission of covid-19 is one of the novel features of it. It

is not typical among coronaviruses, and is one of the single most difficult things that has caused this pandemic to be so severe across the world. The answer to your question, very precisely, is, yes, that is something that we are looking at and I am talking to hospital chief executives about.

Q331 **Greg Clark:** When do you think you might be able to make a response with actions on that?

Matt Hancock: In the coming weeks. This is all determined by capacity within testing and by the gap between the testing that we are doing at the moment—I have read out the figure: 18,665—and the current capacity as of today, which is 30,000 across pillars 1 and 2. That means that we have capacity for 10,000 more tests a day than we did yesterday, which I find, given the pressures on testing, is frustrating.

We want NHS staff to come forward. I have also expanded testing to social care staff and to more residents in social care and now, today, to other public services like police, fire, prison staff and others. One of the further things that we are considering, but have not yet been able to take forward, is mass testing of asymptomatic staff within the NHS.

Q332 **Greg Clark:** Thank you. It is obvious that if we are going to test asymptomatic people within our care settings as well as expanding—to care workers and others—testing, we are going to need much more testing.

Matt Hancock: Yes.

Q333 **Greg Clark:** Now, you have talked about ramping up testing capability, but it is important that we should learn the lessons as we go. That is the basis on which science proceeds.

The approach taken from the beginning by Public Health England was a centralised and a sequential approach. First of all, we started with the central lab and then the 12, I think, Public Health England labs, then expanded it to the NHS—so it was done sequentially.

Other countries, we know, including South Korea, did everything at once. They had a decentralised approach and they did everything from the outset. That meant that, rather than having to ramp up capacity, more was available.

A decision was made to reject that model; Sharon Peacock, in evidence to my Committee, said that it had been considered and rejected. So the first thing is: will the evidence that informed the choice to reject that model be published? It was nearly four weeks ago when Sharon Peacock committed that she would do that. It is important that we should be able to see it.

Learning the lessons going forward—and it is important to do this—when it comes to the wider deployment of antigen tests and subsequently of antibody tests and indeed, we hope, vaccines, will this approach of being centralised and sequential be revised in the light of the evidence?

Matt Hancock: Well, we are ramping up on all of the pillars, and, as you know, some of the pillars are the delivery of the in-house capability, like, especially, pillar 1—Public Health England and NHS labs, and other labs that can contribute; and then pillar 2 and 3 are very much commercial-based, in parallel, bringing the commercial capabilities that we can get our hands on to bear. So that is happening, absolutely, in parallel. I didn't know about the commitment to publish any evidence behind PHE's original decision, but I will certainly look into that.

Chair: I now call Clive Betts, and then we will have Laura and Yvette.

Q334 **Mr Betts:** Secretary of State, we have rightly given our thanks to all those in the NHS doing such a wonderful job for us, but I am sure that you would want to join me in also thanking everyone in local government—whether those in social care, those organising volunteers, or those in public health and environmental health—who are really contributing enormously to the battle against this virus.

It is the issue of environmental health and public health capacity that I want to ask about. You have rightly highlighted the need for testing and then contact tracing and tracking. Local government, public health and environmental health are going to play a very important part in that, but we know that in the last 10 years, austerity has meant massive cuts to those services, in terms of the resources they have.

Are you confident, from talking to your colleague, the Secretary of State for Housing, Communities and Local Government, that there is now the capacity there and the ability to really ramp up and deal with that programme in the way that we need?

Matt Hancock: I think it is incredibly important that we do, Clive, and I agree with you about the thanks that we should give to everybody working in local government, especially in the public health departments and across the board—and, of course, in social care. One of the things that I am really proud of in this crisis is that the country recognises the commitment and thanks those working in social care, just as much as the NHS.

I have said before that it is "Clap for our carers", not just "Clap for the NHS". Both are wonderful and are making an amazing contribution in very difficult circumstances. That is true also for wider local government staff and I am glad today that we have been able to extend testing to local government staff who need it.

On the financial point, I also agree with you that we need to make sure that, obviously, the public health capabilities as well as the social care responsibilities of local government are properly funded. We have put in a total of £2.9 billion extra since the Budget in order to provide support, and the Chancellor has said that he will do whatever it takes.

Q335 **Mr Betts:** Right. Does that mean therefore that if we are going to move significantly to the contact tracing and tracking, which you mentioned, local authorities are going to have a major role to play in that— it is not

just going to be about apps; there is going to be a lot of physical hands-on work—and local councils are going to be fully compensated for that?

Matt Hancock: To the extent to which local authorities are needed to do that, then of course they will be compensated for it, yes.

Q336 **Mr Betts:** Sorry, you said the extent to which they are, but surely public health and environmental health officers are going to be absolutely key to getting that done—it is going to be done at a local level, isn't it, if we are going to get it right?

Matt Hancock: No, we haven't made that decision, not least because the interaction with the e-contact tracing—with the app—is critical. Whether it is done locally or through phone banks at a national level, that decision is not yet made, but if it is done through local authorities, then, of course, they will be paid to do the job.

Q337 **Mr Betts:** Secretary of State, do you accept, though, that apps are clearly an important part of this and a way forward but many people, such as perhaps those who are the most vulnerable—the elderly, for example—are not always comfortable using new technology?

Matt Hancock: Absolutely.

Q338 **Mr Betts:** For them, physical contact tracking and tracing done at a local level may be, in the end, the only way you are going to get a comprehensive approach to it.

Matt Hancock: Absolutely. The role of people in contact tracing is very, very important. These things are complementary, but what I cannot prejudge, and I am sure you will understand this, is a decision about exactly how to organise that.

Q339 **Mr Betts:** When are we going to know that? Is there a date for that?

Matt Hancock: We haven't got a date, but we will publish more details on this soon. The point I would make is that so much of this is done over the phone. Going round to somebody's house is not always necessary. It may be necessary and I can see the point about having a local angle to it, but given the scale of contact tracing that is likely to be needed, doing this nationally over the phone has a lot of advantages.

Chair: I would like to bring in Laura Trott and then Yvette Cooper.

Q340 **Laura Trott:** Thank you, Chair, and thank you, Secretary of State, for coming along today. I want to ask a question about managing the supply and demand of testing. You mentioned that we have capacity for 30,000 tests and are carrying out 18,000. My local CCG has said to me that it has capacity for a huge amount more tests than are actually being carried out.

I know that from today—from the welcome expansion to local government, firefighters and so on—we will take up some of that excess capacity, but what is being done centrally to make sure that we are using resources where they are needed and that we are managing the system

in that way?

Matt Hancock: This is an incredibly important question—it is a real challenge, because you want to match demand to supply. I do not want massive queues and inability to get appointments at the drive-through centres, but I do want the drive-through centres to be fully used—of course I do; everybody wants that.

This problem has come up over the past week, as capacity has increased. At first, it looked like it was a problem due to the Easter weekend, because the number of people wanting to come forward for testing over the weekend was lower than expected, but we have also found that within the NHS the number of staff coming forward for testing is lower than was anticipated. You will understand why we had a priority order for the use of the test, which was: patients first, then NHS staff. Frankly, the number of NHS staff coming forward was not as high as expected and therefore we extended it very quickly to social care—both to residents and staff in social care. But because capacity is going up sharply, I am therefore able to expand it further, and I will expand it again as soon as the capacity is there, to make sure that that capacity is used up.

We have a priority order and we are running through it. It includes the suggestion that was made—by you Jeremy, I believe—that we should also test asymptomatic people in hospitals and in care homes as part of the survey strand, which goes alongside all of this, so that we can find people who are asymptomatic but who are carriers of the disease and may transmit it, and also so that we can understand the prevalence of the disease, especially in hospitals and care homes.

Q341 **Laura Trott:** Thank you. I have two quick follow-ups to that. If there is excess demand in one area and excess capacity in another, is there someone who is matching that up within Public Health England or the NHS?

Matt Hancock: Yes.

Q342 **Laura Trott:** Brilliant. Secondly, on NHS staff and carers accessing tests, is there a way in which we can increase communication as to how they do that? We had some evidence earlier that in many places it is slightly unclear, although, obviously, it is very welcome that numbers are going up overall.

Matt Hancock: Yes, from a policy level it is very clear, although I understand that this is policy that changes relatively rapidly and so cascading that to the frontline is a challenge.

In policy terms, if you are in the NHS, go to your line manager. Again, if you are in social care, you go to your line manager and the social care organisation should go through the Care Quality Commission—the CQC is playing a very important role in this. So it is really clear how to get hold of the test—that is all written on the website. There is an operational question of cascading that information, to those who are symptomatic, right through the system.

Chair: Thank you. We will now hear from Yvette.

Q343 **Yvette Cooper:** Germany, Italy, South Korea, New Zealand, Australia, Canada, Austria, Greece, Ireland, Singapore and many more countries all ask people who are arriving in the country to self-isolate or quarantine for 14 days. In the UK, we do not have any of that.

On 13 March, around the same time that we stopped the community testing and tracing, we also got rid of the guidance that said that people arriving from high-prevalence countries—places such as Wuhan, Italy and so on—at that time should self-isolate for 14 days. Why don't we have any guidance like that on self-isolation for people coming into the country? Why aren't we taking a precautionary approach?

Matt Hancock: We have the same guidance for people to self-isolate when they arrive as if you have symptoms here, and we have facilities to ensure that people who arrive and are symptomatic can self-isolate, even if they do not have anywhere to go to. The NHS has a contract with hotels to put people in those hotels if they arrive and display symptoms, so we do have that capability.

When the current incidence of the disease in the UK is high, and given that there has been a collapse in the number of people travelling internationally, I am advised by the epidemiologists that it is not an epidemiologically significant route of transmission in the UK, because the current incidence is high. Of course, if we succeed in getting the incidence of transmission lower—and much lower—which I hope we will, you have to ask the question of how to protect the UK from people who have been in a place where that incidence of transmission is much higher.

Q344 **Yvette Cooper:** It is very difficult to understand the nature of this decision, because a reported 130 countries have some kind of requirement or restrictions at the border, like isolation or testing or other forms of restrictions, and we do not. It is hard to see why the advice to us, the science that you are talking about, is somehow different from the science that every other Government across the world is looking at, especially given that you have not published any of this analysis and science.

I understand that, obviously, if the staff on the aeroplane spot somebody who is coughing heavily and so on, there may be extra provisions at the border. However, given the asymptomatic issues and so on, it is hard to understand why you do not have some kind of precautionary approach for self-isolation or quarantine, because you did have one during the time before, when you had community testing and tracing in place.

Even if these are a small proportion of the overall number of transmissions taking place in the country at the moment, a small proportion of a very large number is still an awful lot of people, so will you at least publish the analysis behind this decision, and will you look at it again in the light of what other countries are doing?

Matt Hancock: Yes. I disagree that we are not doing anything; I set out what we are doing, and it is similar to many other countries that are

following the science. However, of course, I can absolutely commit to keeping this under review, because you have understood precisely the reasoning behind the current policy, but that policy is dependent on the current situation and many things change fast in this epidemic.

Q345 **Yvette Cooper:** But if you were actually trying to minimise the number of transmissions completely, you would still be trying to minimise the number of transmissions coming from abroad, even if there is a higher number of transmissions happening elsewhere. It looks as though you are not actually trying to stop any transmissions that you can, and you are just looking at broad-brush policies.

Why would you not try to prevent every possible transmission, including for people arriving from abroad who may be able very easily to self-isolate? You are not actually asking them to do anything very hard.

Matt Hancock: That is not what we are doing; it is not the way you characterise it. We follow the science on this, as we do on the decisions that we take.

Q346 **Yvette Cooper:** Do you publish the science? Will you publish the science on this?

Matt Hancock: I am very happy to ask the Chief Medical Officer to publish the explanation behind the decisions that were taken—absolutely, yes.

Q347 **Yvette Cooper:** And the analysis behind it, as well, not just the summary?

Matt Hancock: And the analysis.

Q348 **Chair:** Thank you very much. I now want to move on to the issue of protective equipment for health and care staff. I just want to ask you about an issue that has been in the media this morning. Are you confident, Health Secretary, that all our hospitals will have enough gowns to see them through the weekend?

Matt Hancock: The challenge of getting protective equipment out to everybody who needs it is an incredibly difficult one. First, it is a challenge of logistics, because suddenly—over a short period of time—we have gone from needing a small amount of protective equipment to needing a very large amount of protective equipment.

Just to give you a bit of context before I answer the question directly, as of this weekend we will have shipped one billion items of personal protective equipment across the UK. I have called this a herculean effort before; it is a massive undertaking. And it is understandable, in a massive undertaking like that, that there are complications and challenges, and I take responsibility for getting PPE out to everyone. Of course there are many players in this, and a hospital chief executive has to make sure that the PPE gets from where it arrives in the hospital to the right part of the hospital, but we take responsibility for the delivery of the whole system.

We are tight on gowns; that is the pressure point at the moment. We have another 55,000 gowns arriving today and we are working on the acquisition internationally of more gowns, but it is a challenge. And this follows changing the guidance 10 days ago, which increased the advice on the use of gowns but also said that they should be used for sessional use rather than for individual patient use.

It is a big challenge delivering against that new guidance and we are doing everything we possibly can. My team are up all night. We have a 24-hour operation, because the team in Beijing and some of the other embassies around the world are working through the night on that acquisition.

Q349 **Chair:** Just so the public understand, based on the information you have in front of you now, are we going to be able to get gowns to everywhere that needs them over the course of this weekend?

Matt Hancock: That is exactly what we are aiming to do, and then there is the question of exactly what type of gown, which is a technical question, where of course that has to be signed off by the Health and Safety Executive—that is how we define what type of gown is the right type. So we work closely with the Health and Safety Executive to make sure that we use all of the different types of gowns that are safe to be used.

Q350 **Chair:** Thank you. Can I just ask you about PPE in social care? At the moment, the guidance doesn't require PPE to be worn in care homes for non-covid patients. This puzzles a lot of people, because if those same patients—about 400,000 people across the UK—were living at home, they would be in the shielding category, and all the home care workers who came to look after them—to wash them, get them up in the mornings and so on—would be required to wear masks. So why does the guidance not require that in care homes? Why are we taking that risk with residents in care homes?

Matt Hancock: I do not think we are taking a risk in that way with residents in care homes. I am very happy to look at that particular point in the guidance. I can see why people might read that as an inconsistency, and I am very happy to take it away.

Q351 **Chair:** Could you write to us?

Matt Hancock: I am very happy to.

Q352 **Chair:** Thank you. One social care provider, which actually has a home in my patch, Leonard Cheshire, looks after about 3,000 residents across the country. They say that it has been a battle but they have got basic PPE now for all their staff. However, what they can't get is any of the higher-level PPE. They have nurses, for example, who are doing what are called aerosol-generating procedures, which means their staff could be infected if they get sprayed by a patient, and they could indeed pass that on to other residents. Many in the social care system feel that they have not had as equal access to PPE as the NHS has had. What would you say to them?

Matt Hancock: I would say that it is vital that everybody gets the PPE that they need, according to the guidance that has been agreed by the clinicians and set out. That is what we are working incredibly hard to do. I would also say that the challenge is that many social care settings have normally bought PPE through their normal commercial suppliers and, because of the scale of the increase in PPE needs, those commercial suppliers have found it difficult to restock. Ultimately, we have a global shortage of PPE. There is more PPE being demanded and used across the world than there are supplies. That is why ramping up the domestic supply is also incredibly important. Just to finish off on social care, because it is an important point, we have thought carefully about the differing use of PPE in different settings. For me, it is just as important to get the right PPE to the right people, no matter what their setting.

Q353 **Chair:** Would you allow social care providers to access the NHS supply chain for the higher-level PPE if they cannot secure it on the open market?

Matt Hancock: Yes, absolutely. That is one of the big changes we have made. We are rolling out what is called the Clipper service to social care, because the NHS supply chain has brought in an online delivery and request system. If you think about it, the NHS supply chain has traditionally been an organisation that gets kit to about 230 hospitals. We now have a responsibility to deliver PPE to 58,000 settings, so the NHS supply chain has gone from what is essentially a wholesale distribution to a retail distribution in a very short amount of time, under intense pressure. I think they have done an amazing job. We have then brought in Clipper and the Army to bolster their logistical capabilities.

It has been incredibly difficult, of course—I do not deny that. The team have been working incredibly hard on it, and I pay tribute to them. They deserve our thanks. On getting PPE out to everyone, I understand the pressures in the system and I understand why people feel so strongly about it, but the one thing I can be absolutely sure of, hand on heart, is that everyone in the system is doing all they possibly can to get the right PPE to the right places.

Q354 **Chair:** A final question from me. I wanted to ask about a group of people who are not talked about as much as they should be: the home care workers who go around to people's homes. There are about half a million of them across the country, and they see between five and 15 people every day. A back-of-the-envelope calculation suggests that that group alone will need about 150 million pieces of PPE between now and the end of May. Are you going to make absolutely sure that they get it?

Matt Hancock: Yes. They are part of the team across health and social care that I worry about. There are around 10,000 different locations from which the people you talked about, who work in domiciliary social care and go out to people's homes, work. They are part of the 58,000, which includes them, care homes, pharmacists, primary care and all the different touchpoints of the NHS and the social care system, who all need and deserve to get PPE.

Chair: Thank you. I have lots of questions from Committee members, so I will start with Dean and then go to Amy, James, Paul and Clive.

Q355 **Dean Russell:** First of all, Secretary of State, thank you and your team for being so reactive over the past few weeks; whenever I have had a question, I have got a response very quickly. I have two questions, and I will try to be as brief as I can. First, on PPE, from chatting to frontline workers, I hear that some of the anxiety is because of the changes in the rules around PPE. Public Health England put their guidelines out, which were different from the WHO guidelines, and then more recently, as I understand it, that has shifted to WHO guidelines. That has caused some concern about why we did not do that from the start, so I wonder whether you could answer that. My second question is not PPE-related, but it is critical for my constituents and those elsewhere in other hospitals. As you will be aware, we had a critical incident in Watford a few weeks ago around oxygen. I would be interested to know what has been done to ensure that there are no more of those issues happening either in Watford or in other hospitals across the UK.

Matt Hancock: They are both very important questions. On the first—on exactly what PPE is required in what settings—you will understand that I have to take clinical advice. However, I wasn't comfortable with clinical advice that, even though it is what our clinicians had concluded was the best advice, was not at the level set by the World Health Organisation. If you think about it, in part this is about the PPE stocks that had been built up, and fitting the proposals of what people should wear when to what the stocks are. I said that, instead, we have got to be at WHO standards or higher. The clinicians came forward with that upgrade, and I very glad that they did. Of course, PPE must also be used according to those standards and not higher, and that is why we set them out in such a clear way. We have to ensure that people know what to do in the circumstances where PPE supplies are tight, but this is something that we are constantly working on. The core answer to your question is that I am guided by the clinicians on what PPE is right in what circumstances.

On the second point, of course the supply part of the battle plan has PPE as one of the most high-profile elements, but the plan has a huge amount in it. Making sure that the oxygen supplies work is very important. I think it was almost two weeks ago now that we had a problem because one of the oxygen machines—one of the pumps—broke at Watford, which meant that we had to divert patients coming in by ambulance to other local hospitals. I am glad to say that no patients had a problem and that there was not a risk to patient safety. The situation was managed extremely effectively, and we have brought in technical experts to sort the engineering problem that there was. Throughout the NHS, we are looking at strengthening—where they are old or out of date—the physical equipment for oxygen supplies. It is an important technical problem.

Q356 **Dean Russell:** May I just follow up with a very quick PPE question about access? Can you just confirm that no nurse or doctor who perhaps wants to use some additional PPE because they are concerned about what they have been asked to wear is going to be policed and told that they cannot

do that?

Matt Hancock: Exactly. But what I would say is that the clinical guidelines have been thought about very carefully, and we have to ensure that the PPE gets to where it needs to be. It is, as I have said before, a precious resource, and the reason that it is precious is that there is very, very high demand globally. Getting hold of it is a huge challenge, and that is one of the reasons that we are ramping up the domestic manufacture—to ensure that we have more that is made here and that can go straight into the frontline, whether that is in the NHS or in social care. PPE is a precious resource and we need to make sure that it is used carefully.

Chair: Thank you. Amy Callaghan?

Q357 **Amy Callaghan:** Secretary of State, I understand that there are widespread concerns regarding the availability of PPE. I represent a constituency in Scotland, where concern around PPE procurement is high. Given conflicting media reports and statements over the past couple of days, can you please specify the alternative arrangements that you have stated are in place for Scotland and Wales around PPE procurement?

Matt Hancock: We have a UK-wide approach to PPE. Although the NHS and social care are of course devolved, I have an overarching responsibility for the response to a public health crisis right across the UK, and I work very closely with my counterparts in all four nations. For instance, we sent a shipment of PPE to Northern Ireland and they sent gowns to England because they had more gowns than they needed and we were short of gowns. So this team effort right across the UK is incredibly important. I speak to my opposite number in the Scottish Government and we make sure we work it as best as we can. We have shipped a total of 11 million items of PPE from England to Scotland, which demonstrates just what a team effort this is.

Chair: Thank you very much. James Murray?

Q358 **James Murray:** I would like to ask the Secretary of State for his comments on the report earlier this week about the reuse of protective equipment that was reportedly under consideration by PHE as a "last resort" measure. Can he tell us today by what date the supply and distribution issues of PPE will finally be resolved so this "last resort" measure can be ruled out?

Matt Hancock: Where there is a shortage in an individual setting, of course it is reasonable to follow WHO guidelines on what to do in those circumstances, and in some cases the reuse of PPE is advised by clinicians. So again, I come back to the point that this has to be a clinical decision.

I would love to be able to wave a magic wand and have PPE fall from the sky in large quantities and be able to answer your question about when shortages will be resolved, but given that we have a global situation in which there is less PPE in the world than the world needs, obviously it is going to be a huge pressure point. There is nothing that I can say at this Select Committee hearing that will take away the fact that we have a

global challenge, and we are doing everything we can to resolve it to get that PPE to the frontline.

Q359 **James Murray:** You say that there is a global challenge here and everyone is facing the same issues, but Ealing, the borough where my constituency is located, has gone in with neighbouring boroughs to procure their own PPE for care homes, because they do not rely on the national system to be able to deliver it for them. Also today ITV are reporting their survey that shows that 54% of carers say they do not have enough PPE to do their job safely. How can we trust the figures that you are giving out about what is going on in care homes when what is being reported from the frontline is so different from what you are saying? That survey also said that 42% of carers said they were looking after residents with suspected covid-19, but you said only 15% of care homes had recorded cases. I appreciate that the lack of testing means you might not know the true numbers, but won't you admit that your 15% looks like a substantial under-reporting of the true case on the ground?

Matt Hancock: There are so many things I need to correct in that question. The first is that I think it is terrific when a local organisation is able to get hold of its own PPE. After all, other than in these extraordinary and unusual circumstances, the whole social care sector gets the PPE that it uses as standard from normal commercial sources. Likewise, many hospitals get their PPE from all sorts of different routes, not just the NHS supply chain, which is the national system: they get it from abroad or from local manufacturers. That is terrific; that is part of the system working. So I pay tribute to the way Ealing is working, and I hope you would too.

On the point about numbers of cases in care homes, the latest public figure is that 15% of care homes have an outbreak—and an outbreak means two or more cases. I would expect that figure to rise. The figure is in fact robust in terms of its measurement, because we do test residents in care homes when they are symptomatic, and we have so far tested over 10,000 residents of care homes when they are symptomatic, so it is not true that hitherto we have not tested residents of care homes. This is a really important area to get right, but it is important to base it on the facts.

Q360 **Paul Bristow:** Secretary of State, there have been reports that state manufacturers in the UK, who are making fantastic efforts to produce PPE, are finding that it takes weeks to get their kit certified. Is that the case? If so, can the process be speeded up? Where there are particular shortages, can it perhaps be waived?

Matt Hancock: That is really important. It is true that PPE should be certified by the Health and Safety Executive, according to the existing rules. We have worked hard with the Health and Safety Executive to speed up that certification programme. In some cases, especially of relatively large consignments coming from abroad, the Health and Safety Executive has worked rapidly to certify, but if there are individual cases where that

has gone slowly, I would be happy to look into that and to work with the Health and Safety Executive to make sure that it works properly and rapidly.

You raised another important point, Paul: the domestic manufacture of PPE is a critical part of building up our capacity. I pay tribute to the companies that have already moved over some of their domestic manufacture to PPE—not just Burberry and Barbour, who we hear about, from their clothing manufacture, but Diageo, which has turned some of its alcohol production into hand gel. Although it is less of problem now, we did have a big shortage of hand gel a couple of weeks ago, and Diageo came to our rescue, because hand gel is largely alcohol-based.

The national effort to make PPE is really important when you have a global shortage; even though we started with a massive stockpile, we have run through that stockpile—not entirely but a large part of it. We need to be buying from abroad and making it at home. We need lots more companies to come forward and help us to make the PPE that people need.

Q361 **Mr Betts:** Secretary of State, you got a fairly strongly worded letter last week from directors of adult social care. They described the Department's approach to social care as an afterthought. In particular, they described the national PPE supply chain as shambolic. That is not just about the amount of PPE around but how it has been distributed—shambolic. Do you accept that criticism? What have you done to put it right?

Matt Hancock: I do not. I thought the letter was a bit unfair on the people who work in my team, who are doing everything in their power to get PPE to the frontline—as I said, with the support of the Army Logistics Corps, who are amazing. Changing a distribution model from distributing to just over 230 hospitals to delivering to 58,000 different locations is a huge and mammoth task. The truth is that a very high proportion of local authorities have played a big role in that. Since that was published, we have published the social care action plan, which we were working with ADASS on. That addresses many of the points that were made in the letter. I hope that we have made some progress.

Q362 **Mr Betts:** So do you think the supply chain is working well now?

Matt Hancock: I would say that the supply chain is working very hard to get all the PPE to the frontline where it is needed.

Q363 **Mr Betts:** When will all care workers, including those going into people's homes, which was rightly mentioned—it is not just care workers in residential homes—have the PPE that they need?

Matt Hancock: The answer to that is as soon as possible. I wish I could wave a magic wand, but I cannot.

Q364 **Mr Betts:** Finally, you mentioned stockpiles a few minutes ago, yet the figures from your Department show that the amount of PPE available in the stockpile was reduced by 40% in the last six years. Has that not contributed to the problems that we have now?

Matt Hancock: No, I think that was unfair. It is a tricky question for me to answer. This is the first time this has happened on the Select Committee, because that was before I was Secretary of State. I may have to defer to the Chair, but I asked officials to look into this, and they found that accusation not to be fair and not to be a reasonable accusation to level either at me or at my predecessor.

Q365 **Mr Betts:** Okay, so you are saying that those figures are wrong.

Matt Hancock: I am saying that on that particular accusation, which I am aware of, we have looked into it and it is not right.

Q366 **Chair:** Thank you very much. There are two final areas we want to ask you about. One of them is treatments for coronavirus, and the other is the impact of coronavirus on other treatments like those for cancer that might be interrupted.

If we could go on to treatments first, Secretary of State, you talked earlier about hydroxychloroquine, which has been used in France. Some people think there is great potential in plasma treatment. The World Health Organisation seems to think that the ebola drug remdesivir is very promising. If we were to conclude that a drug was safe, would we shortcut the normal processes involving randomised control trials and so on, put the orders in and get the drug out quickly?

Matt Hancock: I am going to bring in Professor Van-Tam, who is electronically sitting beside me to answer that question. Before I do, it might be worth setting out the principles. Of course, we want to get the very best treatment to the people who need it, and we will follow the science, which is best supported by having rigorous analysis of which drugs work. Thus far, there have not been any clinical trials around the world of which I am aware that have proved conclusively the value of those different drugs. However, we have begun to use them on patients in the UK, because the early evidence, which is not verified evidence, shows that they have some value.

All drugs also have downsides, so the approach that we have taken is, yes, to give people access to those drugs, but to do it within the structure of trials, to make sure that we also get the evidence of what works. For instance, you mentioned remdesivir. I saw evidence only this week about the value of that particular drug, but when it was interrogated, you found that there was not a base against which it was compared—the full science has not yet been concluded on drugs like that. Yes, get the drugs to the people who need them, but also make sure that that is done in a way that is structured and we can get the proper scientific verification. That is the approach that we have taken, but JVT will be able to add far more detail than I can. He is our top expert, and is one of the world's top experts in how to do this.

Professor Van-Tam: I will come in at this point, Secretary of State, and say to the Committee that we absolutely do not know what works at the moment. We have limited reports from China and other parts of the world that certain things might work, but what we do not have is proper

comparisons between treatment and not. One of the problems you get into if you just use a drug and give it a go, so to speak, is that the population of patients in whom you give it a go is very often sicker and quite often different from the ones for whom you do not need to reach for the treatment. We know with covid-19 the range of disease severity is very broad, from very mild to very severe. If we do not hold our discipline and do the randomised trials where we can compare treatments against one another and against supportive care we will never know definitively what really works and what does not work.

Q367 **Chair:** Can I be very specific, because I did ask a very specific question? I asked: once we knew a drug was safe, would we short-circuit the normal requirement for randomised controlled trials? And you are saying, "No, it's very important that we do them." Is that correct?

Professor Van-Tam: I am saying we need to know that a drug is both safe and effective, and we need to know from the clinical trials who are the best patients to use that drug in. It may not be the whole population; there may be unexpected or intolerable side effects in certain age groups or types of patient. Also, we need to understand at what stage in the illness the drug will work. That is why we have a clinical trial—a very, very large one, very fast recruiting, with 200 to 300 patients a day going into this trial—that begins at the doors of the hospital when somebody is admitted with covid-19, but we have another trial in the intensive care unit.

Q368 **Chair:** Thank you. Just so that I understand, what we are saying is that we are going to carry on following the normal processes. Some people say, "Well, obviously you wouldn't want to give a drug to someone if there were side effects," but once you know there aren't side effects, once you know it's safe, some people are saying that we should carry on and try these drugs before you know whether they are effective, just because time is of the essence. If I may, I will go back to the Health Secretary now, because I have one follow-up—

Professor Van-Tam: May I come back on that one point? You talk about safety in terms of side effects, but it is also possible that some of these drugs may worsen the outcomes of covid-19 itself. If we don't do the trials, we won't get on top of the side effects, which, for the common drugs such as hydroxychloroquine, frankly at this point we already know, and we won't get on top of whether the effects are zero, positive or negative. Whilst it's highly unlikely that we are going to get negative findings, one can't actually rule it out with a totally new illness until we do the science and understand what works, what harms and what doesn't.

Q369 **Chair:** Thank you. I've got the message: it's a belt-and-braces approach. Could I go back—

Matt Hancock: Just a minute, Jeremy. It is not a belt-and-braces approach, because we are allowing people to have access to these drugs. We are doing it within a rigorous scientific structure. That is the correct approach. It is not belt and braces, because we are accelerating the clinical trials, as JVT says, much faster than usual and allowing people

access, but doing it within a structured approach is undoubtedly the best way forward.

Q370 **Chair:** Okay. I have a brief question about a letter that Sir Robert Francis has written to me and which he has copied you in on. This is about the concerns of doctors who are essentially worried about having to play God if they had to make a choice between two patients and there was only one intensive care bed or one ventilator available. Luckily, at the moment, the capacity seems to be holding up, and long may that last, but his concern was that there isn't a national framework that allows doctors to make those choices, so they could be subject to criminal action at a later date for not giving someone the care that they clinically needed. Professor Powis told the Select Committee a few weeks back that national guidance would be issued. As I understand it, it has not yet been issued. Could you just give us an update on that?

Matt Hancock: Well, the good news, Jeremy, is that we don't need to issue the guidance. In a way, the horrific nature of the choices that are outlined in that letter from Sir Robert and the deeply unpleasant situation that they put doctors and clinicians in is yet another reason why it has been so important to ensure NHS capacity is always greater than demand. It's one of the things that in this crisis—of course I'm very happy to answer questions on PPE and testing, but the really big thing, the overwhelming of our NHS, which was expected by many people at the start of this crisis, we have avoided through a huge amount of effort from a huge number of people. And that means that we don't have to put out guidance like that which was called for in Sir Robert's letter.

Chair: Thank you. Taiwo and Yvette want to come in on this issue of treatments.

Q371 **Taiwo Owatemi:** Secretary of State, there has been a shortage of vital medicines across the country. This is particularly affecting patients with rare or complicated diseases, such as children with severe epilepsy. In order to prevent such patients from being hospitalised or needing intensive care, will you use your emergency powers to help these wonderful people and provide the funds needed to meet the prescription costs of drugs such as medicinal cannabis in this crisis?

Matt Hancock: Thank you for that question. As the question demonstrates, there are always challenges with access to some medicines. For instance, over the summer, we had a problem of access to HRT medicines, which was very significant for the women affected, because of a problem of supply in a factory in Germany, and we worked very hard to address that. There are shortages, from time to time, among the 12,500 medicines that are used in the UK. The position on medicinal cannabis has not changed since we last improved it and allowed for its importation and changed the border rules around importing medicinal cannabis products. It is an important question, but it is separate from the covid response, and we have made progress over the past year on that. Again, it comes down to having the right evidence for both the effectiveness and safety of the drugs.

There is a covid-specific challenge, which is that, clearly, the drugs needed around the ventilation of a patient have been much in demand across the world over the past couple of months. In the UK, we did put out one alert to recommend the switching from one particular intensive care drug to another that had exactly the same clinical effects, as though it did not have any impact on patient safety at all. That is exactly the sort of thing you do when there is a biosimilar drug available, but under a different branding, when there is a shortage protocol. So far, we have been able to keep the supply chain going. There have been a couple of moments when it was difficult, but I have been involved in talking to my opposite numbers around the world to make sure that the supply chain for drugs has always made sure—coming back to the point that I made in the previous answer—that the capacity of the NHS to treat people with covid-19 has always been there, and that is my absolute top priority.

Chair: Finally, on covid treatment, let us hear from Yvette Cooper.

Q372 **Yvette Cooper:** While you have some additional critical care capacity, have you looked at using it to intervene earlier and to treat more patients with oxygen at an early stage, given that there have been concerns about people being sent home again after being looked at at an early stage and then deteriorating, or, alternatively, not coming to hospital until it is too late?

Matt Hancock: This always has to be a clinical decision for each individual. I will ask JVT to answer on the details, because this is exactly the sort of thing on which he provides the advice to me, so he can provide the advice direct to you.

Professor Van-Tam: Thank you for the question. We understand that this is an illness that generally lasts five to seven days and that is generally self-limiting, but, in the proportion of patients who unfortunately end up being hospitalised, the deterioration is often later on at the five to seven day point in the illness. From that perspective, one can understand the reports of people being seen initially and potentially having to re-present on some occasions.

On your specific question about ventilatory capacity and space, and the use of earlier oxygenation, these two are clinically completely disconnected in the sense that the primary reason for admitting a patient with covid-19 to the hospital wards at all is for the provision of oxygen therapy, which does not require a ventilator or the intensive care to give. There is, in fact, a stage beyond oxygen on the ward that we call non-invasive ventilation, and beyond that again there is the intensive care where we would formally intubate a patient, pop them off to sleep and breathe for them for a period of time using a ventilator machine. So they are three very separate stages, but they are disconnected from each other in terms of when oxygen is administered.

Q373 **Chair:** Thank you. That brings us on to our final section, and we are going to discuss now the impact of coronavirus on cancer and other health conditions. I wanted to start, if I may, Secretary of State, with something

that Simon Stevens told this Committee on 17 March. He said there would be no impact on cancer treatment, but Professor Karol Sikora, who is a cancer expert, is worried about access to proton beam therapy, and there have been other stories, so I just want to check that you are absolutely certain that no urgent cancer treatment is being delayed.

Matt Hancock: That is absolutely our policy. There was a question around proton beam therapy a couple of weeks ago, which we addressed, and as far as I understand it that is now back up and running. That was to do with staffing rather than to do with patients being told that they shouldn't have access, and that has successfully been resolved. That is just on proton beam therapy at the Christie in Manchester—but there is a much broader point here. There is some oncology that it is important not to do whilst there is a widespread virus, because it requires a reduction in your immune system. No matter how well shielded somebody is, to take somebody's immune system down to close to zero, which is what some cancer treatments require—in the current circumstances when a deadly virus is prevalent among the population, that would be a mistake and the wrong thing to do. Even if we had all the capacity in the world—it is not a capacity question. It is disconnected from capacity. It is a clinical judgment.

Then there is some cancer treatment which is non-urgent, because some cancers grow extremely slowly over a period of years, and where surgery would be better done at a later date. So those are both, I think, correct policy decisions—obviously, where the individual clinical decision is taken by the clinicians of the patient; but the policy in those two cases is to avoid, at this moment, taking forward the treatment.

But there is one area where I am really concerned, because we have also seen a drop-off of first presentations, and this is a really big worry of mine. Even though cancer treatment is ongoing now—if you need chemotherapy then that is ongoing, and if you need radiotherapy that is ongoing—far, far fewer people are coming forward. This worries me, because we spent an awful lot of time over several years—time when you were Health Secretary, and the time that I have been—driving up those coming forward for cancer treatment. That has been brought to a juddering halt by this virus. We should all send a message to everybody who thinks they may have found a lump: phone your GP, and you will get treatment—you will get safe treatment, even during this virus. That is something that we plan to do much more work on over the coming weeks.

Q374 **Chair:** You used the phrase "come to a juddering halt". In some parts of the country, the referrals for the two-week cancer target are down 75%, which will potentially mean we are missing three quarters of the cancers that we would normally be picking up. Professor Richard Sullivan at King's College said there may be more deaths from the disruption of cancer services than from coronavirus. Is that possible?

Matt Hancock: I think that is unlikely, because the ongoing treatment is there, but we all know that early diagnosis is important in cancer. We have been very clear—the CMO set this out a couple of weeks ago—that we look

at the mortality impact of coronavirus: not just at the direct impact of coronavirus where we read out those sad statistics every day; but also at the impact of deaths because the NHS has been overwhelmed, which, thankfully, has not happened; and at the impact of deaths, in this case, due to other treatments not happening. I just want to stress that other treatments are available where they are clinically appropriate to do while there is a killer virus about; the biggest problem is the drop-off in people presenting. The fourth set of deaths are those that come through the socioeconomic impacts of the measures that we are having to take. We look at all of those rather than just at direct deaths, even though they are the most visible. That is something that I worry about.

Q375 **Amy Callaghan:** Secretary of State, I have concerns about how charities such as CLIC Sargent will be able to stay afloat and maintain their invaluable support to young cancer patients amid and after the crisis. Without those charities, there would inevitably be more pressure on the NHS, and it is likely that young cancer patients would suffer. Do you have a plan to support those health-centred charities to continue supporting patients?

Matt Hancock: Yes, we have; I think that is incredibly important. We have a plan for direct Government support of charities, which the Chancellor outlined. Also, we have seen charitable efforts right across the country, the latest being Captain Tom, the wonderful 99-year-old gentleman from Bedfordshire who I think has now raised £15 million—*[Interruption.]* Or £18 million, as someone has shouted from the other side of the office. That is absolutely fantastic. Obviously, we will put in taxpayers' support as well.

I would also highlight that hospices often raise a large proportion of their funds through shops on the high street, and shops have not been able to open, so we are supporting the hospice sector as well. Charities across the health and care sector have always played a very important part in the provision of healthcare, and we have to ensure that we support them through these times.

Q376 **Dr Evans:** Secretary of State, thank you for all the hard work that you and your team are doing. One of the things that was potentially missing from your battle plan is that when we talk about battle and medicine, death is an inevitability and something that you have to deal with. You have put in a Herculean effort to get ITU spaces and ventilators, but a lot of people who will suffer from coronavirus and other conditions will never make it to the intensive care unit. What sort of provision do you have for the number of people who may be dying at home? I have a few questions about that. Do you know, or have an estimate of, the number of people who are dying at home?

Matt Hancock: We do know the number of people who die outside of hospital, who, very largely, die at home. That comes back to the very first exchange I had with the Chair on the number of deaths reported. They are reported through the ONS, because we have to collect the data from the death certificates.

Q377 **Dr Evans:** A good death needs three things: equipment, medication and the staff to administer it. On equipment, do you have enough syringe drivers in the NHS to deliver medications to keep people comfortable when they are passing away?

Matt Hancock: Yes, we have. A challenge was raised on that about eight days ago—it was not as big a challenge as was made public, and we have resolved it. Yes; right now we have enough.

Q378 **Dr Evans:** The syringe drivers are used to deliver medications such as midazolam and morphine. Do you have any precautions in place to ensure that we have enough of those medications?

Matt Hancock: Yes. We have a big project to make sure that the global supply chains for those sorts of medications, as well as the ITU medications that I spoke about earlier, are clear. In fact, those medicines are made in a relatively small number of factories around the world, so it is a delicate supply chain and we are in contact with the whole supply chain.

Q379 **Dr Evans:** In line with that, morphine is currently prescribed per patient. The reason for that is to stop it being abused. I would have to prescribe it for Mr Hancock, for example. In this situation, however, if you are going into a healthcare home, you may not want to waste precious things such as morphine. Have you considered relaxing the laws on doctors and healthcare professionals prescribing morphine, so that there is no waste?

Matt Hancock: That is something we keep under review. I have looked at that particular point, to reduce wastage of key medicines. It is something that the supply and clinical teams in the Department talk about all the time. I do not know if that is JVT's part of the clinical team. He may want to say more.

Professor Van-Tam: Thank you. I have nothing really to add on that.

Q380 **Rosie Cooper:** Secretary of State, I echo your comments about people who think they have cancer symptoms going to a GP and getting it dealt with. Early detection is everything. However, notwithstanding your comments about certain types of chemotherapy, which can reduce the immune system to almost nil, there will be cancer patients right round the country who will be aghast at the disconnect between your words and what they hear when they see their consultant or oncologist.

Operations are being delayed. I virtually attended an all-party group on radiotherapy meeting last week. Radiologists are being used in other departments, and their machines are not being used to capacity, so people are not getting cancer treatments as quickly as they could. We are not using the capacity that we have. There is a huge disconnect between what you are being told and what is actually happening on the frontline. We should be using all our capacity as best we can. Will you please investigate that and make a statement? I know personally of several people whose treatment is being delayed.

Finally, as an aside, could you say whether the deaths of clinical staff who

have died working in the NHS are being referred to the Health and Safety Executive for investigation?

Matt Hancock: On the first of these, I set out the policy, and there are different reasons why surgery or, as I was saying, chemotherapy might be delayed. In the individual cases that you have, if you write to me and bring them to my attention, I will have them looked into, absolutely. On the broader point that you are making—that it might not just be those ones that have been brought to your attention—of course I will take that and talk to the NHS.

Q381 **Rosie Cooper:** Secretary of State, we are getting them from all over—on Twitter, from my constituents, from personal friends of mine, and from former MPs. It is clear that there has been a slowdown in cancer treatment.

Matt Hancock: As I was saying, in some cases that is for good clinical reasons, and we will make sure that we look into the other cases. I will take that up with the NHS leadership. Your second point was about the Health and Safety Executive. The investigations have been done by the NHS, by the employers, because they are the ones on the ground and can understand the circumstances.

Q382 **Rosie Cooper:** Should they not be sent to the Health and Safety Executive to have an independent look at it?

Matt Hancock: I am not sure that the HSE is the right body to do that. We have bodies inside the NHS to investigate patient safety issues. We are doing it through hospitals and in consultation with the employer, but we need to make sure that they are done properly.

Chair: May I come in on that point, Secretary of State? I think the concern is that if, for example, someone died because of a lack of protective equipment—

Rosie Cooper: I think—

Q383 **Chair:** Rosie, sorry. I didn't realise you wanted to come in. *[Interruption.]* We seem to have lost you. Secretary of State, can you hear me?

Matt Hancock: Yes, I can. I think you were both making the same point at the same time.

Q384 **Chair:** Yes. If someone dies because of, for example, a lack of PPE, people want to know that it will be investigated by someone independent of the organisation responsible for providing them with that PPE, because they will have a big conflict of interest otherwise.

Matt Hancock: Thanks to your work, we have that system in place. I think the health service safety investigations body is involved in these investigations, but let me go and check that.

Chair: Thank you. Two final questions from Paul Bristow and Dean Russell.

Q385 **Paul Bristow:** Secretary of State, I want to ask you a question about motor neurone disease. Clinicians have noted that motor neurone disease can cause severe respiratory difficulties, and they believe that patients ought to be shielded as a result. However, at present, it is not on the Government's list of conditions for being extremely vulnerable. Patients can self-register—I understand that—but many patients may not know that and therefore may miss out on the benefits. Is that something that you are looking to review?

Matt Hancock: Yes. It is something that I have already reviewed. My team have worked with the motor neurone disease charities on this to ensure that we get it exactly right. It is very important to get right. My initial instinct was to say that of course motor neurone disease should be on the list, but the clinical advice is that there are many stages of motor neurone disease. While those in the later stages are almost always going to need to be shielded because of the impact of the disease on them, that is not the case at all stages.

The thing about shielding is that it is a very significant burden on those who we are advising to shield—not to leave your home for three months is very significant. As you say, people can self-refer, and then it goes to the GP. The GP can make the decision, based on the advice and based on the clinical needs of each individual patient. We talked to the motor neurone disease charities and some of the campaigners about that, and as far as I am aware, the advice that I got back was that they understood and could see the point in making the decision that way. I am completely open to putting all people living with motor neurone disease on the list, but actually once you dig into why not, you can also see the case the other way for some of those who live with motor neurone disease.

Q386 **Dean Russell:** I am going to ask this question with my hat on as a member of the Joint Committee on Human Rights. If I may, I will read out the question I have been asked to share. It relates to people with autism and learning disabilities in mental health hospitals. Last November, the Committee identified that human rights were being abused for people with learning disabilities and/or autism in mental health hospitals. As part of that, one of the concerns is that with coronavirus, family visits are currently being restricted and routine inspections have been suspended, which in turn potentially increases the young people's isolation and also makes them more vulnerable to abuse of their rights. I wanted to ask on behalf of that Committee what is being done in response to that situation.

Matt Hancock: This is obviously a very difficult situation. Many people who are in-patients in these circumstances—not in all cases, but in many cases—also have a higher risk of morbidity from covid-19. The decision on an individual institution basis to restrict visitors is an understandable one in some circumstances, but it has to be done right, and it is something that I worry about, in the same way that I worry about not enough people coming forward for cancer treatment. There are many consequences of the decisions that we have had to make, which are difficult. There is an overall programme that remains working and in place to try to reduce the number

of people in in-patient settings. That is a very important piece of work that is ongoing.

Dean Russell: Thank you. I appreciate the answer.

Chair: Secretary of State, you have been very generous with your time this morning. We appreciate that you are making incredibly difficult judgments on behalf of the whole country. You have given us a couple of hours to share your thinking. Thank you very much on behalf of the Committee for giving us your time this morning. Very best of luck to you and all your team in the difficult days that lie ahead.