Thursday, 21 November 2024

(10.00 am)

LADY HALLETT: Ms Carey.

MS CAREY: My Lady, may I call, please, Matt Hancock.

MR MATT HANCOCK (affirmed)

Questions from LEAD COUNSEL TO THE INQUIRY for MODULE 3

LADY HALLETT: We meet again, Mr Hancock.

MS CAREY: Mr Hancock, your full name, please.

A. Matthew John David Hancock.

Q. I think you have in front of you a copy of your statement, ending INQ000421858, and that is the fifth statement you have made to the Covid Inquiry.

A. Yes.

Q. And I know you've been here and given evidence before. You were the Secretary of State between 9 July 2018 and 26 June 2021; is that correct?

A. That's right.

Q. Can I ask you some background questions before we descend to the detail.

Do you think now, Mr Hancock, that the Stay at Home, Protect the NHS, Save Lives messaging struck the right balance?

A. Yes.

Q. And why do you say that?

A. Because we needed to ensure that the public across the

whole of the UK understood the importance of staying at home whenever possible, in order to stop the spread of the virus. The Protect the NHS element was important for two reasons. The first is that it was a motivating factor to encourage people to follow that advice because belief in the NHS and support for the NHS is one of the strongest things that holds this country together.

And the second reason is because it was literally true that if we didn't stop the spread of the virus then the NHS would be overwhelmed, by which I mean the system as a whole would have been unable to cope with the demand on it, as we'd seen in other countries like Italy.

Q. All right, we're going to come back to --

LADY HALLETT: Can you just pause, I'm sorry.

I mean, it's really important that we all are able to focus on Mr Hancock's answers, and particularly that Mr Hancock and I can focus on the answers, and, I'm sorry, I know how important it is to you to have photographs of your loved ones, but I'm finding it really distracting because my eye is going over to the photographs all the time. So please could you just lower them. I would be really grateful. Thank you very much.

Sorry, Ms Carey.

MS CAREY: Thank you, my Lady.

Mr Hancock, we're going to come to the question of overwhelm a little later, but in terms of protecting the NHS --

A. Yes.

Q. -- do you think now healthcare workers were kept as safe as possible at work?

A. Well, it was obviously extremely difficult to keep healthcare workers as safe as possible, because effectively the wards of the NHS became the front line in this deadly battle. When I visited hospitals, GP surgeries, pharmacies, as I did regularly throughout the pandemic, I saw for myself. And I did that both publicly but also quietly, in order to understand what was happening on the front line.

So part of the point of the Inquiry is to understand how as a system, as a country, we can do that as best as we possibly can.

Q. I understand that you say it was difficult, but I want to know do you think they were in fact kept as safe as possible or not?

A. Well, in the circumstances, facing a pandemic of this scale for the first time in living memory, what I can say accurately is that I and all those around me in the team in the health system did everything we possibly

could. Does that mean, in a system that employs 1.4 million people in the NHS, with another around 2.5 million in social care, that every decision was perfect? Of course it wasn't. And part of what we're here to do is to understand how that could be done better.

Q. Do you think now that the imposition of the visiting restrictions which meant that some people could not be at the bedside of a dying relative or could not have their partner with them in childbirth were too strict?

A. I think that we were balancing incredibly difficult considerations on both sides. I think on balance we got those broadly right across the pandemic but I entirely understand and feel very -- the very strong arguments on both sides. On the one hand, protecting lives and ensuring people as many as people as possible could survive the pandemic and, on the other side, taking into account the deep emotional considerations that were important. And as you can see in the paperwork, I engaged with these issues all the way through.

Where I think we got it wrong, for instance, was the way that the funeral guidance was applied on the ground. It wasn't as had been intended. But of course funerals are places where people gather and are deeply emotional and people come together, and that was also

the thing that was driving the spread of the virus.

So these were very difficult considerations, and broadly, on balance, we -- I think they were about right. But we can go through every single decision and you could easily make an argument one way or the other.

Q. Do you consider that entering the pandemic with low ICU bed numbers and high bed occupancy meant that hospitals had to surge all the more and put them all the more under strain?

A. Yes, of course.

Q. Do you think now that the decision to suspend all non-urgent elective care was the right one?

A. Yes.

Q. I asked those questions at the outset, Mr Hancock, because we're going to look at some of them in more detail, but I thought it might be helpful just to see where you stand now, some years on from the pandemic.

A. Yes.

Q. Can I ask you this though, before we descend into that detail --

A. Yes.

Q. -- what did you understand it would look like if the NHS were overwhelmed?

A. That people wouldn't be able to get any treatment at all in hospitals; that there would be the inability to give

the basic level of care that people needed.

When I said that we needed to stop the NHS being overwhelmed and I set that as an objective, what I meant was that people in this country have a right to healthcare from the -- provided free at the point of delivery according to need, not ability to pay. That is incredibly important and has been part of the social fabric of this country for more than 75 years, and I wanted to protect that, not only because it's the best way -- one of the ways of saving lives and protecting life during a pandemic, but also because of the very strong attachment that I, and most people in this country, hold to it.

Of course, of course, every part of the NHS was under pressure, and some individual parts were -- found that pressure overwhelming but the system as a whole withstood the pressures, thanks to enormous efforts from literally millions of people. And, as I say, I spent as much time as I could on the front line doing night shifts when I could, actually participating myself because I found as the leader of the health system I needed to be on the ground listening to people and finding out what was actually happening, as well as, of course, what was being provided to me officially in my role as Secretary of State which you can see in the

paperwork.

Q. Let me ask you about that. What insight did the efforts by you to visit GPs, visits hospitals and the like, what insight did that bring to you as the minister that actually helped inform your response or inform a decision that you made?

A. Well, there were endless -- I'll give you one example that is incredibly clear in my mind. In the early stage of the second wave, in the peak of it, really, in January 2021, I went to Basildon hospital and I did a night shift.

Q. Yes.

A. And my -- because I'm not a trained doctor my role was to help the nurses to turn patients because patients on a ventilator needed to be turned regularly, and some -- and typically these patients needed two or three people to help turn them, so I was one of the team and I spent the night doing that.

But the thing I really took away from this was (a) I was in the intensive care unit and there was a patient who was lucid and talking and -- but obviously unwell and you could see his oxygen levels were low and falling, and the doctor took the decision that he needed to be intubated and went and asked for the consent of that patient to be intubated. And he within -- he gave

his consent and within about a minute he was anaesthetised and intubated and the doctor came over to me and said, "I think he's got a less -- he's got less than a 50/50 chance of waking up", and seeing this man going from lucid and talking to effectively, you know, likely never to open his eyes again was deeply moving, and, of course, people working in the ICU saw this day in, day out, many times a day, and the doctor then had to go and call the patient's wife and I remember thinking, the patient didn't even say, "Can I speak to my wife first?" He knew what the chances were if you are intubated.

And then afterwards I was visiting the wellness centre that was put -- that the hospital had put together to look after staff and the doctor came down to see me there and burst into tears and said, "We're in a second wave, Secretary of State, you cannot allow a third."

And I'd spent the whole autumn before that fighting to get the lockdown -- to stop the second wave that was obviously coming and it just -- that was -- you know, the impact of that I was -- I mean, I'd been determined to everything I could but that made it even stronger.

Q. Now, Mr Hancock, I think you have given that example

before, and it's not to diminish the impact that it had on you, but having seen that, what did you do when you went back to work the next day to think: I am going to try and do something to help those staff members or to help the patient?

A. Well, you have to remember that at that time I was in a battle with other parts of government to ensure that the measures that we were taking were enough to stop the spread of the virus. And there were pressures from others to try to release the measures what -- in my view, too soon and it stiffened my resolve to resist those measures to relax too soon, and we were also in the middle of the vaccine rollout, which was the ultimate way out of it, and it was critical that we didn't release too soon before the vaccine had the chance to work, and so that was a direct consequence of that particular example.

But I've got -- there's other examples we can talk about if you like.

Q. All right. May I just ask this. It's not always easy to focus on the scope of Module 3, and her Ladyship, though, has heard about lockdown decisions and the rightness or wrongness and the timing of them. I'd like, if you can, during the course of your evidence to really focus on things that practically help the NHS.

I appreciate that if we all go into lockdown and we all don't get infected it's inevitably going to help the NHS, but for actual practical things that we might want to adopt in the future, or things we might not want to do. So can I just ask you keep that in mind throughout your evidence?

A. Of course, although you'll also understand that the operation of the NHS is independent so you need to speak to the chief executive of the NHS in order to answer -- ask some of those questions.

Q. Well, we --

A. My role was overarching, protecting the system as a whole.

Q. I follow that. That brings me on to your role. You've told us, I think, you don't have a medical background. I think you actually have a background as an economist; is that right?

A. Yeah.

Q. And you then became MP for West Suffolk in May of this year.

A. Until July of this year.

Q. July of this year. It says May in your statement, but not to worry.

A. Oh, no, May, when the election was called, yes.

Q. And the role of Secretary of State, as you have just

said, is to set the strategic direction, secure the budget --

A. Yes.

Q. -- and support the delivery of health and social care.

A. Yes.

Q. Mr Hancock, your statement sets out how decisions were made, the make-up of your red box, your early starts and your late nights and so I'm not going to ask you about that.

Can I ask you, though, about your relationship with your devolved counterparts?

A. Yeah.

Q. We know that there are four nations calls, we know that you met them on a number of occasions, certainly at the beginning, but can you just help, not about lockdown decisions, but how was your relationship with them in relation to decisions that affected healthcare in each of the four countries?

A. Well, the running of the NHS in each of the four nations of the UK is, of course, devolved so, as you know, at the start of the pandemic I thought that it was important to bring the four health ministers together and I went and visited the other three and then from then on, we had a weekly Zoom call.

Those meetings were -- I say Zoom. It was --

I can't remember what platform it was on.

Those meetings were incredibly helpful for understanding and actually -- and discussing the decisions that we were making, as well as the sort of practical interaction of the systems. But the NHS itself is devolved, so really they were mostly concerned with things that you just said are outside the remit of this module because they were mostly concerned with things like PPE availability, testing, lockdown decisions, vaccines.

The operation of the NHS was essentially for each of the four of us on those calls, although in England independent and delegated to the chief executive of NHS England.

Q. All right. May I ask you, please, about a read-out of one of the weekly calls.

Can we have on screen INQ000279766_1.

This is a read-out of a meeting between you and the ministers in the other nations. It's 18 May 2020. And if we just scan down the page, we can see there a number of topics, not all of which are within Module 3's scope. But at the bottom bullet point:

"[Jeane Freeman] made a request to reset the relationship between the English and Scottish administrations regarding Covid-19 handling. All on the

call agreed they are keen to ensure they can have conversations and share information and confidence ..."

Can I ask you, was that resetting of the relationship anything to do with the matters that are within Module 3 scope or is that matters that are unrelated?

A. No, this was all about now Nicola Sturgeon was causing all sorts of difficulties.

Q. Right, I'm not going to ask you about that, then, Mr Hancock.

Generally speaking, though, was there good collaboration between you and your counterparts --

A. Yes, at a health level there was excellent collaboration.

Q. Right.

A. Between the CMOs, who themselves had their own call and then between the four health ministers, and you can see from the minutes and the WhatsApp group that we had a really genuinely collaborative approach.

Q. One of the matters you did say, not in relation to the devolves, was in, I think, your witness statement to an earlier module, you spoke occasionally of "inappropriate political interference from No. 10" and I'd like to ask you, please, whether that interference related to any of the matters within the Module 3 scope

as well?

A. Well, of course, some of it did, for instance -- the biggest interference that caused difficulties was within testing where some of the political appointees in No. 10 caused incredible difficulties but that's not to do with this module.

The -- within the running of the NHS we were protected in a way because of the independence of the NHS and therefore many of the operational decisions were taken by the chief executive of NHS England formally and therefore the -- you know, if there were people being difficult from No. 10, part of my job was to provide a shield from that and I know that I ruffled some feathers in doing so, but my job was to -- my job, ironically, was also to Protect the NHS from some of that.

Q. All right, so we shouldn't -- it's not the case that you wanted to bring in testing on X date and someone said, "No, you can't", or you wanted however many millions or billions and someone from No. 10 said, "No, you can't", we shouldn't read that into that?

A. Well, obviously I had to go and get the budget. But one of the things the Treasury was very good at in the pandemic was ensuring that the NHS had the budget available. Budget constraints were rarely the immediate

problem, it was resource constraints more broadly.

Q. All right. Can I ask you, please, about asymptomatic transmission. And I know that you have answered some questions on this topic before, but it's really about the effect it had on hospitals and the staff working in them and the patients going --

A. Absolutely, yes.

Q. Now, I know that you have said previously that this is an area where you considered you failed, and you said that you failed to drive home the importance of asymptomatic transmission and you said that you consider this had very significant consequences.

From your perspective, what were those consequences for the healthcare system?

A. Well, the challenge with asymptomatic transmission was that the system as a whole and the advice to the system, the clinical advice, was that asymptomatic transmission could not be considered a material factor until -- and that only changed in April 2020.

Q. Yeah.

A. And my failure was to -- my inability to override that consensus. But I've described how, you know, that was a global clinical consensus. But the consequence of that was that there was a -- the formal advice going into the system was that asymptomatic transmission

should not be considered as the most likely cause of transmission.

Now, in terms of the impact on the NHS though, in early March we took the decisions to increase PPE requirements within the NHS presuming that anybody could have Covid. And one of the reasons that there was such a sharp increase in demand, and all the logistical and practical consequences that I'm sure we'll come on to, was that -- was that we increased the -- we increased the demand for PPE by increasing the recommended use of PPE within hospitals.

So, in a way, whilst the formal advice was that asymptomatic transmission wasn't the most likely, and therefore shouldn't be considered as the basis for policy decisions, within the NHS we -- working alongside Ruth May, who had the formal responsibility for this within NHS England, we actually effectively overrode that and put in place PPE requirements that took into account the possibility of asymptomatic transmission. So I wouldn't regard that as an area where this had as big an impact as in other areas.

Q. We're going to look at PPE obviously.

A. Sure.

Q. But can I just track through for those who aren't familiar with the chronology of asymptomatic

transmission. You say in your statement that from about 26 January of 2020 you were concerned about reports from China of asymptomatic transmission?

A. Yeah.

Q. And you say this, that you asked officials for advice on that?

A. Yeah.

Q. And you say this:

"At this stage PHE [Public Health England] was adamant that a coronavirus could not be passed on asymptomatically and that tests did not work on people without symptoms."

A. Correct.

Q. Who at PHE was that adamant?

A. The then clinical leadership.

Q. Right. And how was that communicated to you, Mr Hancock?

A. In every -- every time I asked.

So from 27 January I had daily meetings on Covid and, for instance, Sharon Peacock would come to those meetings and she was one of the people who made this argument very firmly to me: tests don't work if people don't have symptoms and there are six known coronaviruses that affect humans and none of them have asymptomatic transmission. So that was the strongly

held view at that stage.

Q. Can I pause you there so we can just look at 27 January. It's set out in your statement meeting record.

Could we have on screen INQ000421858_13.

And one can see there -- you say you raised concerns with officials.

A. Yes.

Q. The Private Secretary's note of the meeting said it opened by outlining your concern upon hearing the virus is transmissible when patients are asymptomatic, and need to plan -- and set out the need for a plan.

A. Yes.

Q. The CMO said:

"There is still a lack of clarity over what the Chinese official position is."

But he said it:

"... was unlikely to transmit whilst patients were asymptomatic (but this was/is unable to be definitive)."

And at the end of that meeting the record note says you asked the department to gain clarification from China on whether asymptomatic transmission is occurring and to scenario plan accordingly?

A. Absolutely.

Q. And I think you also had some evidence from Germany as well that was pointing towards asymptomatic

transmission?

A. Yes, I was close to the German health minister, Jens Spahn, and he was worried about this too, and I remember speaking to him on the phone about that.

Q. Right. So there's varying views: there's some evidence of asymptomatic transmission from China and Germany, PHE are telling you, on the other hand --

A. "No".

Q. -- "No". On what basis was it that you trusted the advice of Public Health England despite reports to the contrary?

A. I challenged the advice from Public Health England repeatedly, from then over the next three months and eventually the formal advice was changed. I mean, for instance, I went to the lengths of setting up a phone call with the Director-General of the World Health Organisation about this evidence from China and he said that he thought -- he said that it was a mistranslation. So the whole global clinical system was trying to say there's no asymptomatic transmission, and I kept seeing straws in the wind, if you like, anecdotal evidence that there was and continued to challenge on this point.

Q. Mr Hancock, are you aware that the WHO guidance, not to say it's not important, but it's not binding --

A. Correct.

Q. -- on England?

A. So the WHO guidance of course influences public health views, and the views of Public Health England, which is an agency of the department, were -- clearly agreed on -- with it. I could not, at the stroke of a pen, overrule that advice. That is not within the power of the Secretary of State.

Q. So just pausing here now at the end of January 2020, given that there is some evidence of asymptomatic transmission, did you at that point consider there needed to be any specific measures put in place to protect healthcare workers?

A. Yes.

Q. What did you do at the end of January as far as the healthcare workers were concerned?

A. Two things. The first is we brought in -- we'd already brought in a set of PPE guidelines for what became -- it wasn't even called Covid-19 at that point, what became Covid-19 -- called the -- the guidelines around high consequence infectious diseases. Which is essentially, in lay terms, hazmat suit style PPE. And you can see in the minutes I was at that time asking to ensure that we had that PPE available, because this was before any -- there were any known cases in the UK I think. They came around this time.

The second thing that I did was, anticipating that there would be a huge rise in the amount of PPE, I instructed the opening of the PPE stockpile, which had been -- yeah, I knew was constructed for these purposes, and also, in January 2020, I ordered the mass purchase of PPE from around the world, knowing that there was going to be huge global demand. So that started -- that work started in January -- January -- 2020, buying the PPE.

Q. All right, we're going to come on to the stockpile as well, Mr Hancock --

A. Yes, but it's not just about the stockpile, it's also about getting going buying from around the world.

Q. I follow that.

Jump forward to April, please, and even on 2 April the WHO were saying there'd been no documented asymptomatic transmission?

A. Yeah, but by it's nature it's very hard to document, because it's asymptomatic. So that wasn't evidence that there wasn't asymptomatic transmission. It was deeply, deeply frustrating.

Q. It wasn't a criticism of you, it was just to set out --

A. No, I don't feel the criticism, I'm -- what I'm expressing is how I felt at the time, which was like -- don't -- you're trying -- they were trying to prove

a negative, if you like. They were saying: because there's no documented evidence, therefore we can't say that it's happening. It's like -- well, you know, you can't see asymptomatic transmission, you can't see it. That was the problem.

Q. Yes, that's the danger. I follow that. But this is where I want to get to on this point.

On 3 April the CDC in America publish a study, don't they --

A. Yeah.

Q. -- saying that there is?

A. Yeah.

Q. Right. And you say in your statement you instructed the department to review its guidance. Which guidance were you talking about there, Mr Hancock?

A. All of the guidance that had been based on the presumption of no asymptomatic transmission.

Q. And did that include, from your perspective, a review of infection prevention and control?

A. Absolutely, yes.

Q. All right.

A. You've got to remember, you know, as the evidence shows, there was high transmission in hospitals. And nosocomial infection in hospitals is always a problem even when there isn't a pandemic. It is the

responsibility of NHS England to ensure that it's minimised. But I was deeply concerned to stop this, the problem of people catching Covid in hospitals. And this was a repeated problem. I mean, we can -- the use of testing within hospitals is another issue where I was trying to drive the use of testing --

Q. Pause, pause, I'm going to come on to it --

A. Okay.

Q. -- all right? I can sense your frustration. Let me just ask you this. Clearly, the advice to you was: don't assume asymptomatic transmission until we know it's happening?

A. Correct.

Q. Some may argue that you should assume it is happening until you know that it's not happening?

A. Absolutely.

Q. You're the minister in the middle.

A. Yes.

Q. Given the uncertainty about whether or not a new virus is or isn't transmitting asymptomatically, what approach do you think should be adopted in the event of a future pandemic?

A. The precautionary principle, absolutely. Which we did on things like the guidelines around use of PPE within hospitals.

Q. So one should assume that it is happening until you can prove that it's not?

A. That would be a very -- that would be the safer assumption in future, yes.

Q. And you would say, therefore, that your IPC guidance for example, should be predicated upon that assumption that asymptomatic is happening?

A. That asymptomatic transmission is happening.

And there's another thing that I would recommend, which is challenge studies, which is where you intentionally infect consented adults, obviously, in order to find out. So by using challenge studies you can find -- you can investigate this question better than if you refuse to use challenge studies. And I think the barriers to using challenge studies was one of the problems -- not on this -- and in particular on -- you can accelerate vaccine testing using challenge studies.

Q. I stopped you as you were going on to talk about testing, but clearly an ability to test for asymptomatic transmission depends on you having the capacity of testing available.

A. Yeah, but it also depends on your presumption of whether a test works on somebody who is asymptomatic, and we were told that they didn't, and that wasn't true.

Q. No, all right. A number of the witnesses have impressed upon her Ladyship the need for testing to be up and running ASAP.
A. Absolutely.
Q. I take from that answer you wouldn't disagree with that?
A. I spent -- you just -- in one of the earlier questions you said "jump forward" from January to April, and I thought, well, that's quite a big jump, a lot happened in February and March in the health department, and one of those was driving up testing capacity, as the records show.
Q. All right. Can we turn to NHS overwhelm. And in your statement you say in terms:

"One of the most considerable achievements of the UK during the pandemic was ensuring that the NHS was never overwhelmed, or in other terms, the NHS was always available to all according to need, not ability to pay, and we did not have to ration care."

A. Yes.
Q. All right. There was, do I take it, no agreed definition of what it meant within government as to what "overwhelmed" meant or "overwhelmed" looked like?
A. There was a -- that's not quite right. There's a sense of what "overwhelmed" looks like. It's not a -- it's accurate to say there's no formal definition, but the

best approximation you could have and what I held in my mind at the time, for it to mean, was what happened in Lombardy in February 2020.
Q. So do I take it from that it was a desire to ensure that if people needed a ventilator, they got it; if they needed to get into ICU, they were able to get an intensive care bed?
A. Yes.
Q. Right.
A. What it does not mean is that these -- the availability of these things were not stretched and in some cases deeply stretched. For example -- I'll give you an example of what I mean by that.

In normal times one nurse cares for one patient in ICU.

Q. Correct.
A. In order to ensure that there was enough ICU capacity one of the things we did was stretch that so that one nurse cared for six people. Now, imagine the impact of that on that nurse, on all ICU nurses during the pandemic. It's a deeply challenging situation. It's very hard. And there will always, always be boundary cases where people feel that they or their loved one should have had that level of care and feel that it wasn't available, and I absolutely understand that and

I saw some of that.

The system as a whole, though, withstood the challenges. And if I might just add one other thing at this point. It was not only -- what I was saying was not only accurate in the big-picture sense, it was also important to say. Because at the same time as having to tackle Covid, we wanted to ensure that people who desperately needed NHS treatment for other reasons, where it was safe to do so, would come forward and get it and, you know, that balance between "Protect the NHS", ie, don't use it unless you have to, and "Please do come forward if you really need it" was something that was in my mind throughout this in terms of how we communicated.

LADY HALLETT: Can I interrupt, I'm sorry, Ms Carey.

You said that the NHS was always available to all according to need. Well, it was always available to those with Covid who needed ICU treatment, but it wasn't always available to those who needed cancer screening or who needed a major elective surgery like a hip operation. So I just -- I can understand why you say we had to do that, but I don't understand how you can maintain that it was right to stop non-urgent elective care, and then say but it was always available to all according to need. Because it wasn't, was it?

A. Well, I don't think that -- I don't want to get into the linguistic analysis of it, what I care about is the substance, and the substance is that it was not safe clinically to go for some cancer treatment during the pandemic because cancer treatment sometimes involves reducing the immune system. It was better to delay some non-urgent operations, in order to protect both the space in the NHS and the patients themselves because, as we know, hospitals are -- you're more likely to catch Covid in a hospital than in almost any other setting.

So that -- of course those decisions were taken but according to -- it depends how you define "need". And "need" -- at the same time needing to protect people from the pandemic.

So I think that -- I think the broad thrust of the NHS being available is true and being -- and whilst individual parts were under enormous pressure, like there was a time when 111 was under massive pressure, there were many hospitals individually under pressure and we triaged patients to other places. But the overall point is that we did not have a collapse in the system.

MS CAREY: I'm going to come back to that, I suspect.

You mentioned ratios. So let me deal with that at this stage. You set out in your statement that it was

you that suggested to Sir Simon Stevens, the then chief executive of NHS England, that ratios be stretched. When was it that you suggested that to Sir Simon?

A. I don't recall.

Q. Are we January, February, March? Can you help at all in the timeline?

A. It will have been during the period when we were building the Nightingales, as well. So it was probably February 2020, but we'll be able to -- it'll be there in the paperwork.

Q. It's not meant to be precise. It was 10 February. That's not what I'm asking you, it's generally to try and get an overview at what point it was you decided to ask Sir Simon to stretch the ratios in the way that you did?

A. Yes, so one of the things that we were doing -- yes, February -- the answer to the question is February.

Q. All right, and on what basis did you make that decision?

A. Oh, so, it was clear that there was likely to be very significant pressure on the NHS, and I wanted to ensure that there was as much capacity as possible in the NHS, and I was pushing for the building of extra hospitals -- we'd seen the Chinese had built a hospital in two weeks. And one of the responses that came back was, "There's no

point in building extra hospitals because we don't have enough staff", to which my response was, "Well, what we're going to have to do is stretch ratios of -- the staff/patient ratios as much as is clinically possible, even though that's difficult, and at the same time build more hospitals", which is what became the Nightingale project.

So it was essentially -- the reason I pushed that was because I was rejecting advice that we couldn't increase NHS capacity in short order.

Q. Now, the stretching of the ratios into Nightingales is a slightly different matters because we have heard evidence they were being stretched within an ICU unit within a hospital itself because the ICU unit had to expand by --

A. Yeah, absolutely.

Q. -- double or triple its capacity?

A. Yes, so it's not just the Nightingales, that was another part of the overall stretching of the NHS's capacity to deal with this. And there's one other factor which made this -- which is important here. Which is that -- which is that in normal times the NHS is dealing with many, many diseases, obviously. The pressure wasn't just the pressure of numbers, it was the pressure of very large numbers, all suffering from exactly the same disease.

And so that led to acute pressure on particular aspects that were necessary for dealing with Covid-19, like ventilators, oxygen supply, et cetera, that may not have been necessary for other purposes.

So, it was not just the pressure of numbers, and at this point, remember, anticipated numbers, because there were very few in hospital in February, it was the pressure of -- it was the pressure of very large number of people presenting with the same condition.

Q. Okay. On what basis did you or were you advised to go to 1:6, as opposed to 1:3, 1:4? Who was telling you that's an acceptable stretching?

A. That was a -- I think that was an NHS decision.

Q. All right. Did you appreciate in the context of intensive care, stretching to ratios of 1:6 would mean providing a very different level of care --

A. Yes, of course.

Q. -- to patients?

A. Yes, of course. And not only did I appreciate it, I saw it for myself. I mean -- and I talked to the ICU nurses. You know, I took the advice, I think it probably came from -- through Simon Stevens, probably from Ruth May as the Chief Nursing Officer, but -- and it would have been Simon Stevens' decision, actually, the actual 1:6.

The -- but did I appreciate it? Absolutely.

Q. Did you -- let me ask you this. How did you assure yourself that stretching to those ratios wasn't putting the nurses under absolutely intolerable pressure?

A. Well, the actual decision will have been a decision, as I say, for Sir Simon Stevens, so you'd have to ask him that. My role was to say we have to expand NHS capacity and to push against the initial feedback which is that the limitation on this will be the number of people that we have.

Q. All right, but the question I wanted to know, was how you assured yourself, not the actual ratio, it doesn't matter for these purpose if it's 1:4, 1:6, but how did he ensure the stretch, per se, didn't put those nurses under intolerable pressure?

A. I had to rely on my clinical advisers and the NHS England advice and I'm sure the CMO will have had a view on this as well, that that was an appropriate level to go to. You have to remember that the formal running of the NHS was independent and so this really is a question for Sir Simon Stevens.

Q. Well, given that you were suggesting to him that the ratios be stretched, people might forgive me for asking you what --

(Unclear: Multiple speakers)

A. -- to ask me --
Q. -- you did to assure yourself that they weren't put under just the most immense strain?
A. Yes, but that's, if I may say so, a slight misunderstanding how the system operated. My job was strategic. It was to drive the system, but also to accept advice from the system. So the conversation would have gone, over a period of days or probably weeks: we need to ensure we expand NHS capacity; can we build more capacity?

And the first response was: there's no point in doing that because we won't have enough staff. Can we stretch the staff numbers? They would have come back and said, yes, we can, we think that it's okay to stretch them to 1 in 6, and I would have said, as you said, the degree of stretch, whether it's 1 in 4, 1 in 6, was not a decision for me. And that's how the system operated. I was strategic.

But, really, for all of these questions you are going to have to ask Sir Simon Stevens because he was running the NHS, remember; I was the Secretary of State. And we worked very closely and very well together but there was a clear distinction and this section is about the NHS so, you know, it's perfectly reasonable to ask him.

Q. All right. Let me ask you not about the impact on the staff that were stretched in that way but on the impact, actually, on those in ICU.

Could I have on screen, please, INQ000480139_7.

I think, Mr Hancock, you've been sent an extract from an ICNARC report who look at intensive care data and we have heard from Kathy Rowan who heads up ICNARC. She told us, if one looks at paragraph 6.1, that:

"Prior to the pandemic, ICNARC reported that how busy an intensive care unit is on any given day impacts on patient outcomes ..."

A. Of course.
Q. "... with higher strain associated with higher acute hospital mortality."
A. Absolutely.
Q. And the strain is the mismatch there between supply and demand, availability of beds and staff or other resources, and the ability to admit those that were needing critical care.

And their ultimate conclusion, if one goes over the page, please, to paragraph 6.4, that when they adjusted for potential differences in important patient factors, compared to typical ICU strain, they found significant association between exposure to higher ICU strain and higher acute hospital mortality --

A. Yes.
Q. -- both for those with Covid --
A. Yes.
Q. -- and those in ICU that were not Covid?
A. Yes.
Q. Higher strain, higher mortality.
A. Absolutely. So --
Q. You don't sound surprised by this finding.
A. I'm not surprised at all and we said it at the time -- and you have to remember that I was trying to drive up NHS capacity because -- I know it's technically outside the remit of this particular element of the Inquiry, but really my role was overarching rather than specific to the NHS because you have to remember at the same time I had the Cabinet Office and others trying to tell me that we shouldn't be taking the actions that I thought were going to be necessary in order to stop the spread of the virus. And so I knew that we were going to have a problem. And therefore I had to increase hospital capacity as well as try to reduce the spread of the virus.

So, not only do I know this, and I saw it, but we articulated it. And the Chief Medical Officer in one of the early press conferences set out that there are four reasons that you get more people dying in a pandemic.

One is the direct impact of Covid. The second is the impact of unavailability of health services that would be available at other times as per our exchanges earlier, for instance cancer care. And then, of course, the impact on the measures taken, for instance, lockdown, and the fact that if you have higher hospital admittance then the treatment of those with Covid becomes more difficult, and we saw this in the first phase and we saw it in the second phase as well, and it's one of the reasons that I feel so strongly about the need to ensure that we're ready to bring in measures to stop the spread of the virus next time round.
Q. Do you think, though, Mr Hancock, if you just stand back for a moment that the fact that the nurses are being stretched to the ratios that we've looked at and the potential adverse consequences for those who were in ICU, doesn't that not in fact demonstrate that the NHS was in fact overwhelmed?
A. No, because people could get treatment. The treatment was not as good as normal, in the same way that the waiting times for a knee operation was not as good as pre-pandemic. But that is not the measure -- I'm not saying that the NHS was perfect in the pandemic, and I'm not saying that it wasn't severely pressured in many areas and that that pressure had consequences.

The point of saying that it wasn't overwhelmed is that the system as a whole withstood the pressure, and as I say, that is not only accurate but it was also important to say during the pandemic because we had to reassure people that the NHS remained there for them. Remember, there were people who didn't turn up -- they might have found a lump and didn't go to their GP because they thought, "I don't want to put pressure on the NHS." And we have seen that in the excess mortality figures of people who didn't have Covid, as well as people who died with Covid.

So I was acutely aware of this and it weighed heavily on our decision-making at the time.

Q. Let me come to intensive care capacity, then, please, because you say in your statement that at no stage were you advised that intensive care capacity was exceeded:

"I understand that there may have been some individual hospitals where intensive care capacity was exceeded, and patients needed to be transported elsewhere, but there was capacity in the system as a whole."

And are you referring there to not just the baseline capacity but the capacity the hospitals had once they had surged up?

A. I am but, again, the detail of that and the triage of

people to a different hospital if a hospital became full was -- that was core business of NHS England and I didn't get involved at a day-to-day level.

Q. I wasn't asking you about the transfers, it was just simply when you're talking about ICU capacity, in your mind, that's baseline plus whatever surge capacity there was?

A. Yeah, of course. At only baseline capacity there was no way we could have treated as many people as we did.

Q. Were you made aware of how far over baseline hospitals were operating?

A. Yes, and remember I was visiting hospitals whenever possible and I saw it. I remember going into Bart's and seeing the ICU beds which in normal times have a stack of equipment behind them on the wall and they were -- there were just far more beds than there was space for. Of course I saw it for myself, yeah.

Q. In England we've heard that NHS England reported occupancy based on the surge capacity which sometimes suggested there was a lot of beds available but didn't really alight upon the fact that these hospitals were operating at double their intensive care --

A. Yeah, exactly, and you've got to remember also --

Q. No, no -- can I finish? Thank you.

A. Of course.

Q. What I wanted to ask you was, do you think in reporting that way that gave perhaps a more positive picture of: we've got a lot of beds available, it's okay, rather than demonstrating that some of these hospitals were running --

A. Incredibly hot.

Q. -- 20, 30 more beds?

A. Absolutely, but -- sorry, the point I was going to make was precisely to your question, which is that you also have to remember that at the start of the pandemic we didn't have -- I couldn't get an answer out of the NHS about how many beds they had. And by the end of the pandemic that data was much better but -- and in the second phase it was much better, but that sort of definitional issue, of course we should consider now as part of the Inquiry, but at the same time it was a moot point because if you say to the NHS, "How many beds have you got?" and they say, "Well, it all depends how you define it", then the extent to which that includes surge or not is second order.

And just in their defence, the reason that they couldn't define -- they couldn't say exactly and definitively how many beds, is because it depended on how many people were available, because the NHS counts beds according -- not just the physical bed but the bed

with the ability, then, to support a patient which includes people and equipment and what have you. If you have a bed -- if you have an intubation bed with no oxygen flowing to it then it's no use for these purposes.

So that's why it was difficult, so I'm not saying -- I'm not blaming the NHS for inability to measure that at the start. What I'm saying is these things were difficult to measure and so picking precise points in the methodology just was not our lived experience.

But this was another reason that I went to see -- went to hospitals and went and talked to people.

Q. It's not so much about whether it's difficult to measure, but from the public's perspective if you're saying there's still 10% of beds available across the country, it might be thought by someone that's presenting a rather rosy picture when in fact those hospitals were operating double, triple their usual baseline capacity?

A. And in some cases --

Q. But you agree it presented a rosy picture, or not?

A. I think that we got -- I think that by the end of the pandemic and in the second phase we were able to present this much more accurately. Whether it was rosy or not

in the first instance, as I say, I don't think you can define that because we just didn't have the data available at all.

Q. Can I give you an example, please, of some evidence we've heard from Queen Elizabeth Hospital, Birmingham, and I want to know if this kind of information filtered up to.

A. Yeah.

Q. They had, in March 2020, 67 ICU beds and they went to April, the following month, to 126, so it nearly doubled?

A. Yeah.

Q. That meant, for them, finding 205 additional doctors.

A. Yeah.

Q. 429 nurses.

A. Yeah.

Q. And an extra 59 actual physical beds.

A. Yeah.

Q. At a time when they had 25% absence of the workforce due to ill health.

A. Yeah.

Q. Now, were you being told that's actually -- let me finish, please.

Were you being told that's actually what it means if a hospital has to double up its surge capacity? We

have to find vast numbers of staff?

A. Yeah, not only was I being told but I was seeing it. I went to the Queen Elizabeth Hospital in Birmingham. I saw it for myself. So yes, of course, and I was deeply involved, for instance, in trying to hire more doctors and get doctors who had retired back into the workforce in order to try to solve these problems.

So, you know, the reason I interrupted is the question gives the impression that I was somehow sat in an office this whole time. I was out on the ground as much as I could be and talking to people about what the real-world problems were as well as getting the official advice through paperwork. That's how you lead in a crisis as big as this.

Q. Can I ask you to just pause for a second.

Some of these questions are not designed to trip you up, Mr Hancock --

A. No, no.

Q. -- but I want to understand whether some of the detail that we've now heard did in fact make its way to you. That's all I was asking.

A. Okay, and I'm being emphatic in my response that it's not -- not only did I get it in reports as much as the data was available, but I chose to go out there and see it for myself.

Q. Now, were you made aware that not everyone who needed an ICU bed got an ICU bed?

A. Yes. Yes. In individual cases that happened, yes.

Q. We've heard a number of examples, some of which we've provided to you, and I'd just like to take you through some of them for your comments on them, if I may.

A. Right.

Q. You are aware, I think, that on the first day of evidence we heard from Mr Sullivan, who told us about his daughter Susie, who had Down's syndrome, and was taken to hospital, and she was refused admission to ICU because what was recorded on the notes was she had cardiac comorbidities, she had a pacemaker, and had Down's syndrome. Did you get reports like that, that people were being denied ICU care?

A. I did get reports like that and I also got reports about the misuse of DNR notices as well.

Q. We'll come on to that.

A. Well, they're all part and parcel of the same thing, because it's about availability of care.

Q. Yeah.

A. And if you recall, I was also getting advice from the BMA and others that we should have a code of who you should give care to and not --

Q. I'm going to come on to that as well.

A. Yes, but what I'm saying is I was deeply involved -- of course. Not only did I know these things were happening, I was fighting on behalf of those to whom it was happening.

Q. Can I just stick with what happened to Susie.

And can I have up on screen, please, INQ000483295_8.

This, Mr Hancock, is a serious incident investigation report that was carried out into the care that she received, and one can see that she was admitted to intensive care. The essential advice was if she worsens she should be considered for escalation up to ICU.

A. Yeah.

Q. And then in due course, about three hours later, was deemed not suitable because of her cardiac comorbidities and Down's syndrome.

Can we look, please, at what was going on in the hospital at the time. And if we highlight, please, the paragraph beginning "It is recognised":

"It is recognised that intensive care units were having to clinically prioritise patients ..."

A. Yes.

Q. Occupancy on this particular hospital on 27 March, the day Susie was taken in, was 27.

A. Why is the hospital redacted?
Q. Because it's not necessary to name the hospital. This is just an example of issues that the Inquiry has been made aware of.
But put that to one side for a moment, Mr Hancock. Just concentrate on what was going on in the hospital.
There was 27 level 3 patients, which was already an increase from the 21, and the baseline there was 23 beds, normally staff for 9 level 3, which is the highest level of care, ICU beds, and 14 level 2. So they were already running at over capacity.
Did you ever get examples of particular problems like this brought to you? I know you're looking at it from a national picture, but did you ever get --
A. Yes, of course.
Q. All right. It might suggest that, in her case, the decision was wrongly taken to deny her ICU or it might be that the notes are very badly and incorrectly drawn, but either way do you not think this is an example of tragic overwhelm in the NHS?
A. This is an example of a tragic case and serious case reviews happen -- are intended to get -- to find out what happened. And individual clinicians make judgments like this in normal times but made judgments like this because of the pandemic more so, and of course there was

enormous pressure and of course it had consequences, absolutely.
Q. The Inquiry has sent you its research conducted by IFF, and can we just have a look at that because it's not an isolated experience.
Can I have up on screen INQ000499523_3.
And we have there a summary of the research. I'm not going to suggest to you, Mr Hancock, this is representative of entire healthcare professionals but clearly a large number were surveyed, over half of whom, 58% of healthcare professionals, reported that some patient could not be escalated to the next level of care due to lack of resources --
A. Yes.
Q. -- during either wave of the pandemic, so wave 1 and 2.
"A&E doctors ... and paramedics ... were more likely to have ever been unable to escalate care ..."
If we just go on to page 17.
And if one looks at the bottom two responses, from critical care nurses and critical care doctors, during the first wave those doctors were significantly more likely to have ever been unable to escalate care. 20%, and 19% of nurses and doctors, respectfully, said that that happened to them on a daily basis?
A. Daily basis, yeah.

Q. You don't sound surprised by the findings of this research either, and, in fairness, neither was Professor Whitty when we asked him --
A. I'm not surprised in the least. And of course we knew that these pressures were intense. You know, Professor Whitty himself worked on the wards.
Q. Yeah.
A. I visited them and I worked, in an appropriate capacity, as a non-clinician. Of course we knew. Absolutely. And this is what we were trying to prevent. This is what we were trying to prevent by fighting for lockdowns, by buying as much PPE as we could get our hands on, by developing the testing.
I know that -- you say these things are outside the remit -- you can't present this as if it's a -- sort of dessicated statistics. These were -- this is what was going on in the ICUs of the nation. This is why it's so important that we're prepared to stop pandemics before they start. And so absolutely, yeah.
LADY HALLETT: Did you tell your cabinet colleagues and the Prime Minister, then Mr Johnson, of all of this material that you were well aware of?
A. Yes, as much as was -- of course we talked about it, yeah. Yeah.
LADY HALLETT: So you --

A. I don't know the detail of how much -- you know, whether I presented a particular slide or what have you, but, yeah, absolutely. Stopping the NHS from being overwhelmed was something I talked about frequently.
And I can see that you have picked up on that language as if I was trying to say everything was perfect, and that is emphatically not what I meant and it is not how I mean that. And I understand if that is how it could be interpreted that that was not the reason. It was used as a term of reassurance. And that is true. But it was absolutely part of our discussions to say -- in fact, the then Prime Minister would say, "It mustn't be topped out", I remember because I thought that was an unusual phraseology. But, yes, this was part of our discussion, the enormous pressure on the NHS, yes.
LADY HALLETT: So you made it plain to your cabinet colleagues and the Prime Minister at the time that numbers of doctors and nurses were unable to provide the level of care that their patients needed? You made that plain to all your colleagues? You didn't present a rosy picture that some have suggested?
A. I have in previous modules been accused of painting a rosy picture. There are -- for each of those -- as I said in those modules, for each of those specific

accusations there are -- there are inaccuracies in the other accounts that we didn't go through in detail. But all you need to know, Chair, is I was not one for buck passing. And maybe we've seen a little bit of that in previous modules.

MS CAREY: I ask you this because, in your Module 2 statement, you said had the NHS been overwhelmed treatment would have had to be rationed. And it was being rationed, wasn't it, Mr Hancock?

A. What I was trying to avoid and what we successfully avoided was an overall rations to say people, according to these characteristics, aren't going to be cared for. That's what would have happened if we had let the virus get more out of control. And we managed to avoid that both in the first and the second phase.

Did people get as good care as they would have done in normal times? Of course not. There was a pandemic.

Q. No --

A. So I totally -- I mean, I think we're agreeing with each other --

Q. I think we are. It's just this. If people can't get into ICU, for example, because the doctors don't consider that they can be escalated, we've sent you an ICNARC report which suggests that older people --

A. You sent me endless evidence showing that the NHS was under incredible pressure as if I didn't -- as if I wasn't there.

Q. No, I know --

A. But I was on -- I visited as often as I could. I talked to the doctors. Of course I relied on the official advice that I was getting, but the -- but I went to see it. And I spoke to people regularly, as did my senior advisers. We were emotionally engaged in trying to stop this from being -- from getting worse, frankly.

Q. I want to deal with one final aspect on this, please. Can I ask, please, that we look at a clip of footage from a witness that gave evidence by the name of Kevin Fong. I think you've seen his transcript but I'd just like to watch a short clip of what he told us.

(Video clip played of a portion of witness Professor Kevin Fong)

Q. Watching that now, and looking at the number of different examples, statistic, real life stories, do you think perhaps the use of the phrase "overwhelm" is not the right word to use when we're talking about how the NHS coped or otherwise in the event of a pandemic?

A. I agree with everything that that was said in that clip and I saw it for myself.

Q. Yeah.

A. The system as a whole had to cope with more than it has had to cope with at any other time in modern history. And, thanks to the work of those in ITU, did so.

Now of course -- of course -- there were deeply challenging problems, as we've just seen, and that's -- there were countless examples of that.

At the same time, we had people who were at risk of dying from not coming forward, and it was therefore important and my responsibility and my duty to ensure that the public felt that, should they really need it, the NHS was there for them. And balancing these considerations was difficult and hard, but they did need to be balanced. And so that's why I use, and used, and I was right -- I still believe I was right to use, that language, because of course there are individual -- it's similar to PPE provision, right?

I have said that there was no national shortage of PPE. That is true. It is verified by all of the paperwork. But that doesn't mean that there weren't shortages in individual places where the logistics couldn't get it to. And this is a similar concept. My responsibility was for the system as a whole and then to try to relieve the individual pressures as much as possible.

But it comes back to the point that this modular

approach is -- sort of narrows the point. The best way to solve that problem was to have measures in place at a national level to stop the spread of the disease, and that is -- that was core to my responsibility as well.

So that's my explanation, and I think you can have an endless debate about the linguistics; what matters is the substance.

Q. Well, yes and no, Mr Hancock, because actually if you make a statement like "the NHS was not overwhelmed" and you can't get an ICU bed because you're old or you have Down's syndrome or because there aren't enough nurses, plenty of people would say that is "overwhelm", wouldn't they? And that's why it's not just semantics.

A. I'm saying that the substance is what matters here and, for instance, when an ICU didn't have any more capacity, the NHS's response was to then ensure that there were transfers available to other places, because the picture was never even across the country. That is the system-wide response but it doesn't take away from the individual pressures. And as I say, there were other reasons to explain why -- and to use the word, the language that I did, and you have to take them into account as well. You just can't take one element of this response into account on its own, you can't do it, because then you miss some other consideration that had

to be balanced.
Q. Let me ask you this, finally, on this topic perhaps before we break. In your final paragraph of your statement to Module 3, you say this:
"Finally, I would strongly recommend that an early objective of any future pandemic is to make sure the NHS is never overwhelmed."
A. Yes.
Q. How, practically, do you suggest that that can be achieved in the event of a future pandemic?
A. As soon as you see that a pandemic is -- it comes back to the pandemic doctrine that we've discussed in the previous two modules. As soon as you see that a pandemic is going to require action that -- what are called non-pharmaceutical interventions, you get on with it straight away, you don't wait in the hope that it'll disappear or stick your head in the sand.
Q. Right, so you buy more PPE, you start your surge capacity plans; is that what you're talking about?
A. No, what I was talking about very specifically was bringing in lockdown measures as soon as they might be needed, because you're going to have to bring them in anyway.
Q. Right. Outside of lockdown measures, thinking about it from the NHS perspective --

A. Well, you can't think about the NHS response out of lockdown measures. The system as a whole -- this is an overall policy response. You know, there were seven elements of the battle plan and you can't just say, well, how did that one work? You have to ask how the system worked. Because it's impossible to answer the question without talking about overall measures because we were in a pandemic.
Obviously -- but what I can say is, as well as lockdown measures, you, of course, also need to have an adequate and accessible PPE supply. You need to have a testing system that's ready to grow and ready to expand rapidly. You need to make sure you can get a vaccine as soon as you possibly can. You need to undertake the challenge trials to understand spread not just by observing evidence in the wild, so to speak, but by having a scientific approach to doing that and getting over the improper ethical caution around using challenge studies.
You have to have an overall system response and that is why -- I'm getting to the point of repeating myself so I'll stop.
MS CAREY: Would that be a convenient moment?
LADY HALLETT: Certainly.
I think some members of the public gallery here

are suffering some distress at this evidence. Please can I encourage them to seek any support if they need it, but also if people are at home feeling distressed, could they check out where they could get support.
MS CAREY: Yes, thank you very much, my Lady.
LADY HALLETT: Thank you. 11.30.
(11.15 am)
(A short break)
(11.31 am)
LADY HALLETT: Ms Carey.
MS CAREY: Thank you.
Mr Hancock, can I pick up on one of the things you referred to before the morning break. Which was potentially some of the difficult decisions that may have to be made in the event that effectively there was no extra bed or there was two people vying for one ICU bed.
A. Yeah.
Q. We've called it an escalation tool or "in the event of saturation" has been another way it's been described.
A. Yeah.
Q. Generally speaking, do you think that ministers should be involved in such guidance, by which I mean not the actual detail of who might get the bed, but the need for an escalation tool per se?

A. Of course ministers should be involved in the principled decision about whether such a tool is necessary, and also the level at which such decisions should be made.
Q. What do you mean by the level at which a decision --
A. I was very strongly of the view that these decisions are best made locally, according to the local judgment of the clinicians with the most information, rather than through a national tool.
Q. Ah, well, that's what I wanted to ask you about. Because I think you are aware that on 21 March 2020 the four CMOs commissioned guidance in the event that critical care was saturated and I'd like, please, just to look on screen -- this was intended to be a UK-wide tool.
A. Yes.
Q. Can we have a look at -- thank you -- please -- I'll just read it out for the record, INQ000478863.
This is an email to you on 27 March and, just to help you, it was commissioned on the 21st and then not in fact published around 27 March. It happens in a very short space of time.
A. Yeah.
Q. All right? And we've heard, just so that you know, from one of the doctors involved in drafting the guidance.
A. Yeah.

Q. All right. Let me just turn up my document.
Were you made aware, as this email sets out, that some local regions were requesting guidance, and in fact there with a was a desire by a number of different people working within the ICU sector that they wanted a tool in the event they had to start making those decisions?
A. I was aware there were some voices calling for that, including within the BMA as well.
Q. Because we've heard from, for example, the Royal College of Anaesthetists and the Faculty of Intensive Care Medicine, saying that they felt extremely exposed without such guidance, and indeed some of our spotlights started developing their own tool in the absence of guidance. All right? So there was clearly a degree of a desire for the tool.
A. But it would be inaccurate to say that that was a consensus or indeed, in my view, a majority view, but there were some people calling for it.
Q. All right. I think you said you didn't see it in your statement but you were aware that it was going to be published?
A. That's not quite right.
Q. Help us with that then, please.
A. If I can give a slightly longer answer.

Q. Of course.
A. It comes back to the exercise that we did in the middle of February. When we did that exercise, it was proposed in the meeting that such a piece of guidance should be put together, and I objected, and in the Inquiry Simon Stevens said that I'd called for it and wanted to make the decision myself, and that was inaccurate and not --
Q. Pause, I want to take it slowly to help you.
A. Okay.
Q. Just pause, Mr Hancock.
A. So the first time I came across this concept was in that exercise.
Q. Which is Nimbus?
A. Nimbus, yes.
Q. All right.
A. And in the Nimbus exercise it was put forward as a proposed solution to there being -- you called it saturation, I call it if ICUs were overwhelmed, right?
Q. Yes.
A. That is -- it comes back to our previous discussion. And I -- we had a discussion about it and I concluded then that we shouldn't have such a tool and that my main conclusion from Nimbus was we must ensure this never happens.

Q. Yes.
A. Right. Then we go forward six weeks or so and there were calls, public calls -- you know, the BMA were in the press, there were private calls for it from, as you say, some of the local areas, and this is an example of the sort of thing I would then talk to people on the ground about and -- so I took a wide array of views.
Q. Who did you speak to? Give us some examples.
A. Well, I remember talking to Chris Whitty about it, but I can't recall exactly who those conversations would have been with.
Q. Can I ask you though, Mr Whitty is not working in an ICU ...
A. No, but he's very -- he has a lot of experience of working in ICUs and we all knew the pressure that ICUs were under.
Q. All right.
A. I may have spoken to some people at the royal colleges who I spoke to regularly throughout the pandemic.
My view was that these decisions must not be taken by ministers. They are best taken as close to the patient as possible, with as much information about that individual patient, and that doctors make these sorts of decisions all the time. Of course they were having to make far more of these decisions in the pandemic because

of the enormous pressures. And I then -- so I knew that there were these public calls. I then received this note that's in front of us, and my recollection is that this was the first time such a tool was brought to my attention.
Q. Okay.
A. And I immediately went to see Chris Whitty, who I knew was sceptical of such a tool, and even though -- so I was surprised to see that it had been commissioned by the CMOs.
Q. Yes.
A. And he agreed that he -- he agreed with me that it wasn't necessary. And then I phoned up Simon Stevens and I said I'm really uneasy about this sort of tool, and he said he thought that it was not a good idea either.
Q. Right.
A. And having spoken to those two people, that's all I needed.
Q. Right.
A. To make -- having followed the debate for the previous six weeks, and it been in my mind throughout that time, I therefore -- you know, the system -- you can see what happens in government, right? The system effectively got ahead of itself without -- before asking whether

this was something that we should consider. And started putting in place -- you know, arrange a meeting -- that "HMIG" is a meeting of the healthcare ministerial group on Sunday so --

Q. We're going to come on to that.

A. -- they got going.

Q. We're going to come on to that.

A. So I just said -- I got this, I took advice from those two people and made the decision that it shouldn't happen.

Q. Right.

A. The other thing that is happening at this point is -- of course, this is the worse point in the first phase of the pandemic because this is when case numbers were really shooting up and we didn't know if the system, as a whole as opposed to individual incidents, was going to cope and, frankly, I was petrified that the actions that we were taking in terms of lockdown might not be strong enough to stop the NHS being completely overwhelmed and us getting to the situation as we had seen in Lombardy of a generalised across-the-board inability to access care, and all the consequences of that.

Q. Right, so just pausing there, just to try and get a sense of why it was you were opposed to it. Is it your evidence that you were opposed to it because you

felt there wasn't a need for a national tool, and that actually there should be individual tools taken within trusts or regions?

A. I felt strongly that if we tried to write a national tool, its local interpretation might end up being too legalistic or box ticking. What I wanted is the doctors to have the discretion to make the decisions as they see fit, with the best way to save lives in the circumstances.

Q. Can I ask you, please, then about that weekend that you've just alluded to.

A. Yes.

Q. And can we have a look on screen, please, at INQ000048276-3.

And as is the way, Mr Hancock, with emails, we have to start towards the back and work our way forwards.

A. Yeah.

Q. But essentially what is going on here, so that you know, is the tool has been drafted and, incidentally, in your statement you said, "I didn't see any of the proposed guidance." Is that right or wrong? Did you actually see the guidance that was being proposed?

A. I don't recall.

Q. All right, okay. It's getting ready for publication and

then there's supposed to be a meeting between ministers to discuss the tool which didn't happen?

A. You say "supposed to be".

Q. Yes.

A. A meeting had been organised. That doesn't mean -- there's no value judgment on whether there was a meeting, because if you say "supposed to be" and then I cancel that it implies it was a mistake. It wasn't a mistake.

Q. Let me rephrase it for you then.

A. Thank you.

Q. There was a plan for a meeting --

A. Yes.

Q. -- which then was cancelled?

A. I cancelled.

Q. All right. I'm just trying to give you a bit of context for where we are to help you when you answer the questions.

A. Sure, yeah.

Q. All right. So there is the plan for a meeting to discuss with the ministers this tool and these are some of the discussions about what led to the background, what the strategy is, and what the risks and mitigations are, and it said that "Lead authors have advised" -- if we look at the bottom of the page -- that:

"... most clinicians in acute settings will be receptive to this guidance as it provides a standardised approach on which to base difficult decisions in unprecedented times. However, it is likely it could be sensationalised by media and cause unnecessary panic and concern among the ... public."

So there's competing arguments there about how this may in fact be viewed once it's published?

A. Yeah.

Q. And then if we go, please, to page 2 of the document, 30 March, which I think was a Monday -- sorry 28 March, my fault, second email down:

"I've just heard from the CMO's office this isn't going to ministers tomorrow and has been paused for now. I'll make sure duty team have the current version ..."

And it was because:

"[Secretary of State] and Simon Stevens have spoken and have a cancelled the Ministers implementation group", that was there to discuss the tool.

"This is because both are unhappy issuing the tool as it stands (noting how potentially controversial it is/difficult landing)."

It does not say there they're unhappy about it because they think there should be localised decisions, not a national tool. Is it the case that you were more

worried about how this might look and whether the professions themselves wanted the tool to provide them with the guidance for the difficult decisions they may have to make?

A. Oh, I see. No, that wasn't my consideration at all. Obviously I had to take into account the impact of such a tool on people's confidence in the NHS. My assessment in reading this, and the previous page, is that it says most people -- most clinicians will be comfortable with it, or something like that. I thought that I'm not sure that's right. There were, as I say, some voices calling for one of these but that was not a generalised approach, and my assessment is that it is very hard to write something that would improve on an individual clinician making a decision according to the Hippocratic oath and their best medical assessment of how to save lives.

That is -- and so I don't -- I, actually, until I've re-read this now, I hadn't really considered the wider controversy that might happen as critical. The question is, what's the best way to save lives? That was the question I was asking throughout this entire period on every single subject, including this one.

Q. If you didn't read the guidance itself, how do you know whether it's going to improve or not on the --

A. Because I had deep experience in government and the consequences of writing guidance which is to reduce the discretion of those on the front line and to increase a rules-based approach and I couldn't think -- and so I thought that the idea of taking these decisions nationally through guidance was wrong. I believe in the principle of subsidiarity for improving the quality of decision-making. The closer a decision can be made to those who are affected, generally the better that decision is.

Q. There's nothing in this email that mentions "We need to be actually doing this at a local level", is there? If one follows to the bottom --

A. There isn't, but I didn't write this email, so -- this is an email from Max Blain at No. 10 -- he was head of comms. So, of course, the comms people would consider the controversy element of it, this is a communications email, this isn't about the substance of the decision.

Q. The final bullet on that email says, "Everyone is clear that this needs to be right and not rushed out."

A. Right.

Q. The CMO's view is that it's not urgent -- there's not an urgent need for it right now.

And he's told us it didn't come in because as at 27 March or 28 March there was still capacity in the

system. That's why, from his perspective, it didn't come in.

A. Right.

Q. Given there wasn't an urgent need for it right now, did you consider revisiting the need for this guidance at any stage during your tenure?

A. No, I think it would have been a mistake to bring this in and I think in a future pandemic it would be important not to constrain decision-makers in this way. We train doctors to an incredibly high standard, including to be able to make decisions like this, and substituting an, effectively, ministerial decision for a decision of the doctor who is looking after that patient would be, in my view, a mistake.

Q. At any stage did you say to NHS England for example, "I'm not bringing in a national tool but I would encourage local regions or particular trusts to adopt their own"?

A. No, I think decisions like this need to be made according to the professional judgment of the clinicians closest to the patient.

Q. Yeah, I understand that. What I'm saying is if your opposition to it was in part that there needs to be local decision-making, did you do anything to encourage or support those that wanted a local decision-making

tool?

A. No, I didn't want a local decision-making tool as in mid-level, as in at a hospital level, I wanted doctors making these decisions, not administrators, not ministers.

Now, the -- as I've said many times, the operational running of the NHS is for NHS England and the individual hospital trusts, but -- and so I am aware now that some trusts brought in some guidance. I don't think it would be -- I don't think it's right to constrain doctors' ability to act in the best interests of their patients in this way.

Q. All right. Can we look at some of the decisions that were taken to increase capacity within the system?

A. Yeah.

Q. Obviously, firstly, there was the discharge decision. And I'm not asking you about the impact it had on the care sector itself, but did you agree with expedited discharges as a way of increasing hospital bed capacity?

A. Where that was clinically appropriate, yes. But on that, as with other areas, that really is a question for NHS England.

Q. I was just asking you for a broad overview of whether you were in agreement with the principled decision, not the detail, all right?

A. Yeah, remember hospitals are dangerous places in pandemics. You know, there were more people -- the estimate is that more people caught Covid in hospitals than in almost any other setting, and that's often forgotten in the debate around this.
Q. We're going to look at nosocomial infection rates a little later, all right.
A. Yeah.
Q. Okay. There was clearly the decision to suspend non-urgent elective care, and you said, I think at the outset, that that was a decision that you agreed with and you thought it was a right decision?
A. Well, obviously reluctantly, but, faced with a series of awful options, that was the least bad. I mean -- but that -- that applies to almost every decision that we took in the pandemic.
Q. When that decision to -- was taken, I think you were urged to explore with NHS England whether there was any elective work that would be protected at the height of the pandemic.
A. Yeah.
Q. And what was the answer and why was it you wanted to just explore that with them at all?
A. Because I recognised the impact, the negative impact of taking that decision and I wanted to make sure that it

was mitigated as much as possible. But on that I would very much -- it's a classic case where the minister asked questions to ensure that people have considered these things properly, but the operational decisions are for NHS England and the clinical decisions are obviously for the clinical staff.
Q. All right. So, as a strategy, you approved of it?
A. I broadly approved of it, reluctantly, yeah.
Q. All right. For what it's worth, Mr Hancock, the experts that we've heard about not non-Covid care have agreed with the decision in principle, they think it was the right one, but what they're concerned about is the resumption of non-urgent elective care and how quickly or otherwise that was rolled out, particularly after the first wave.
A. Oh, yeah, absolutely.
Q. All right. Well, you say "Oh, yeah, absolutely", help us then, please, what was your position on how quickly or otherwise non-urgent elective care was resumed?
A. It was a difficult balancing act, and I relied on the judgment of the chief executive of NHS England.
Q. You didn't say -- did you say to him, "You need to bring in targets", to Simon, did you say anything like that to him? Or just "I want you to restart it as soon as you can"?

A. As soon as we safely can. But that's the sort of decision he'd go and take anyway. He was, after all, the independent head of NHS England.
Q. Clearly you accept, don't you, that the decision to pause elective care had a significant impact on the waiting times for either diagnosis or for treatment?
A. Yeah, of course, yeah.
Q. All right. I'd like to ask you about an email that you, I think, were sent.

Can we have up on screen INQ000421416_3.

We are in March 2020, Mr Hancock, I think around the 28th or thereabouts, and this is an email that was forwarded on to you, all right?
A. Right.
Q. It says it's a sad case -- this is:

"... one of my constituents was due to have a cancer operation at [a] hospital this week but it has been cancelled due to the issues with Coronavirus ...

"He completely understand the pressures on the Health Service but he understands if he does not have this operation he will lose his battle with cancer in the next 12 months."

It makes the point that he's 68, he obviously wants to be around for his children, his grandchildren.
A. Yes.

Q. He's going backwards and forwards to prepare for the operation.

"The family are saying online 'Boris Johnson said that no emergency operations will be cancelled due to Coronavirus but that is not true'."

He says:

"I am ... conscious that you are up to your eyes [in it] but is there anything you, the [Secretary of State] or one of the Ministers can do? I very much want to help this family."

They were writing to the chief executives too.

And if we go, please, then to page 2 of this document.

In the middle of the page sets out that they were clear -- I think "Simon" is probably a reference to Sir Simon Stevens:

"We are clear that no urgent cancer operations should be cancelled. Individual clinicians and patients will discuss what's most appropriate given the risk of increased infection."

Forward on another page where there's reference to you at the bottom of the page. You had three concerns:

"Do we need to clarify the position on urgent cancer treatment and other ... therapies. There have been a further two cases people having cancer surgery

stopped -- while they're not urgent in the sense of a matter of days, it probably could not be deferred several weeks. Do we need to issue any further guidance on this?"

A. Yeah.

Q. And then here you are as at 30 March saying:

"[I'd] like to begin thinking about the plan for restarting non-Covid care ..."

A. Yeah.

Q. "... perhaps Simon ..."

Stevens, is that?

A. Yeah.

Q. "... and [you] could have an initial discussion at [the] Quad [meeting] next week?"

And then there's risks of people coming into A&E and what that might entail.

So this shows that you were clearly concerned from early on in the pandemic, Mr Hancock, about how best to restart.

A. Yeah, but also what it shows is I'm asking -- I'm asking questions of Simon Stevens and respecting his independence running the NHS.

Q. Yes. Now, no one is going to criticise you for asking the questions but it really brings us on to what did you do to make sure that those questions were being answered

and that elective care was being resumed.

A. Yeah.

Q. What did you actually do? What did you actually say to him?

A. Well, we had -- so the "Quad", as it's put in here, was the weekly meeting that we had to discuss all NHS matters. I mean, we'd speak on the phone much more regularly than that but we'd have an overall meeting once a week with Chris Wormald and myself, Simon and Amanda Pritchard. And that was the core decision-making meeting, if you like, when issues were on the boundary between whether they were my responsibility or Simon Stevens' responsibility. And we would have had a series of discussions about the appropriate speed for restarting, given the wider pandemic.

And my concern throughout this was that the NHS needed to ensure it took full accountability for nosocomial infection, and as you'll know I had a series of meetings about nosocomial infection specifically as well, and also that there was the danger to people of catching Covid whilst in hospital for non-elective care. But at the same time obviously we did need to restart as soon as that was safe to do so.

But for the individual decisions, they're a matter for Simon Stevens so you'll have to ask him about them.

Q. All right. I'm not asking about the individual decisions, it's just a global question. There is no doubt though, if one looks at some of the data, in fact the UK was very slow to restart its elective care, in a way that affected the figures that we've seen.

I want to just ask you about hips in particular.

Can we have on screen INQ000474262.

Because this is an excerpt from the -- INQ000474262_61, please.

This is an extract from the hip experts that the Inquiry has heard from.

A. Yeah.

Q. And essentially what I'm going to show you is a graph that shows that UK fared much worse than Europe when there was a drop in hip replacements, understandably everywhere but 14% in Europe and yet 46% in the UK.

And can we have a look at the graph, please, on page 62, and can we highlight the top graph if you're able.

Again, we see there -- so there's obviously a pausing of elective care across Europe but a wide variation in how the UK has performed, and essentially we've done badly because there's a 46% drop in the number of cases of people having a hip replacement whereas the average across the EU was 14%.

Now, were you sort of ever made aware of perhaps not hips in particular but the kind of delays and, on the face of it, slowness at the resumption of non-urgent elective care?

A. I was.

Q. And what did you do about it?

A. Well, I spoke to Simon Stevens about it, and you'll have to ask him about the individual decision -- I don't mean the individual decisions as in each hip at a time, about the policy towards restarting, because that was very clearly in his bailiwick.

Q. I understand that, but, Mr Hancock, you're the one early on in the pandemic saying: we've got to have a plan for resuming elective care --

A. Yeah.

Q. -- you're on to this early, if I remember --

A. Yes.

Q. Let me finish. You're on to this early, but if we look at the data, perhaps your desire to resume it did not, in fact, pan out with what happened on the ground. And why is there -- if the minister is saying, "Get started, get restarted", why are we seeing such poor figures like the one I've just shown you?

A. I'm afraid all I can answer is that these decisions on the restart were decisions for NHS England, and this is

a module about the performance of the NHS. So you have to ask the person who was in charge of the NHS at the time.

Q. All right, but you're not powerless. If you say to him, "Do something", he doesn't ignore you?

A. Exactly, you can see in the paperwork that I am pushing on this subject, but, I mean, the NHS was legally independent. I in fact ended that legal independence. You know, Simon and I worked very closely together but some decisions were his and others were mine. So this isn't something that I've seen before and it isn't a decision that I would have myself taken.

Q. All right. Do you think -- let me broaden the question then.

Do you think in the event of a future pandemic there need to be contingency plans at either ministerial or certainly department level --

A. Yeah.

Q. -- for a strategy for how to, if not continue it, at least resume quickly?

A. Well, I think -- yes, and actually that needs to be part of a broader change in the NHS, to try as much as possible to separate out urgent care and elective care into different settings. And I know that's something that Simon Stevens believes very strongly and was

working on even before we went into the pandemic.

But that so-called split between hot and cold sites is very effective and a much more normal arrangement in other European countries. So that may be part of the explanation here, but I can't really give you any more than that because this wasn't my area of responsibility.

Q. All right, fine. Were you aware, as minister, of the use of elective hubs to ensure that there was some diagnosis or treatment for non-pandemic conditions?

A. Yes, of course.

Q. Do you think there was sufficient use made of them --

A. Definitely not.

Q. And how do you think we could improve use of elective hubs?

A. Have more of them.

Q. Have more of them?

A. Definitely. It should be happening now, yeah.

Q. And is that a decision for the NHS, for NHS England or is that something ministers can assist with?

A. Well, now, because we changed the law so that the NHS is not statutorily independent, it is something that ministers can do. But it wasn't at the time, directly.

Q. And different measure of increasing capacity is Nightingales. And I think you say in your statement

that you are supportive of them. You thought it was important to have them if we needed them?

A. Yes.

Q. All right. Given that we -- as looked at this morning, there are already stretched ratios within ICUs in hospitals, what was the plan for further stretching the staffing in the event that we had I think seven Nightingales in England?

A. The plan was to build the Nightingales within the umbrella of an existing trust, so that the Nightingale hospitals did not have to set up HR and recruitment systems from scratch but rather could be supported by an existing trust. For instance, the Nightingale hospital in the ExCeL centre in London was effectively run by Bart's Hospital.

Q. Yeah, so was it your understanding that there would be additional staff or that -- the 1:6 ratio would include staff that you'd lost from the hospital, who'd gone to staff the Nightingale?

A. Well, the answer is -- isn't binary. We were at the same time trying to recruit staff, more staff, back into the NHS, but the starting point was that that hospital trust was responsible for the staffing of the Nightingale, and we were doing everything we could to ensure that that and all hospital trusts could get more

staff as well as stretch the ratios.

Q. Do I take it that you consider, Mr Hancock, that there was a need to have the Nightingales just in case we needed them?

A. No. We needed the Nightingales in order to provide the care for those who went into them. Hundreds of people received care in Nightingales hospital and survived because of it. Of course the Nightingales were also entirely justified on an insurance policy --

Q. Yes.

A. -- because we didn't know when the pressures were going to stop accelerating. And in the event several of the Nightingales weren't used, but even those I think we can justify with what we knew at the time.

Q. Pause there, because I had like to just look, please, at INQ000474444.

Which might help you, Mr Hancock, because it's a quick and easy guide to when the Nightingales were set up, what activity they saw in each wave --

A. Yeah.

Q. -- and the costs of them, for what it is worth.

A. Yeah.

Q. And we can see there, yes, there were hundreds but it's not thousands of people that was going into the hospitals to being treated for Covid?

A. Yeah.
Q. Obviously some of them were repurposed, but if you look at Birmingham, for example, it had no patients admitted in wave 1 or wave 2 and wasn't used as a vaccination centre or to resume elective care.
A. Yeah.
Q. The question really is, once we thankfully didn't need them in wave 1, what, if any, involvement did you have in how they were being repurposed for wave 2?
A. Well, I was -- I have two feelings in response to this. The one is that I have absolutely no doubt that they were justified even as an insurance policy. And even if no lives had been saved by them, we didn't know, when I commissioned them -- well, I commissioned the expansion, it was actually Amanda Pritchard who came up with the idea of using existing buildings to put hospitals in and led the project and did a brilliant job at it.

So I think they are entirely justifiable because they were an insurance policy in case we hadn't managed to turn the curve of the growth of the virus when we had.

At the other end I also felt frustration at the time that they weren't being used for other purposes, but that happens all the time when you're health

secretary because you're responsible for a large body which is statutorily independent from you and is huge and so all sorts of stuff goes on in the health service that you would rather were done better, and your job is to try to make that happen either through specific intervention, persuasion, or through changing policy at a national level. But I didn't want to change policy because I wanted the Nightingales to be there if they were --
Q. Yeah, if they were needed.
A. Yeah.
Q. I understand that, but actually what I wanted to know is, what did you do to ensure that in wave 2 they were utilised to their best effect, particularly when we've got, for example, Birmingham admitting no one and seemingly doing nothing?
A. Yeah, well I will have raised this -- it's probably in quad minutes I will have raised this with the NHS, but obviously operational matters are for them.
Q. I follow that, but didn't you say to them, "Well, hold on, you've got a big facility there in Birmingham that's not doing anything, can we repurpose it, can we use it?"
A. Yes, that's exactly the sort of thing I would have said, yes.
Q. You would have said or did say?

A. You're asking me for recollection of something four years ago. I'm pretty sure that I said it. The place to look would be the minutes of the quad meetings.
Q. Do you think, and I'm asked to ask you this, given the expenditure which in England alone was 358-plus million, that this was a good use of resources diverting money that could have been used to improve the NHS estate, for example more portable ventilation, and the like?
A. That is not an accurate description of the tradeoff. The tradeoff was: should we spend taxpayers' money that was effectively borrowed from future generations for this insurance policy? At this point the constraint on the NHS was not cash resources, it was real-world resources. And so yes, I thought it was a good use of money to have this insurance policy.
Q. I think you are aware that between wave 1 and wave 2, NHS England, supported by the Department of Health, asked for funding for a further 10,000 beds.
A. Yes, I'm not only aware. I was deeply involved in this bit, yes.
Q. Hold your horses, all right? Let me just ask the question and then you can answer. All right?
A. Yeah.
Q. You were aware that there was the request by NHS England and the department. You've just told us you were deeply

involved in it, all right? Unfortunately, though, that request was refused by the Treasury and there was a direction or a steer coming from the Prime Minister that you should focus on using the Nightingales, using the private sector, hopefully discharging more people, maybe there not being as -- sorry, using the flu vaccination to prevent flu patients going into the hospital.

Help us with the deep involvement that you say you had in this, and what did you try and do to either get the beds or get the funding?
A. Well, there were a significant number of meetings in No. 10 over that summer to work out how we were going to handle the winter of 2020 to 2021.
Q. Yes.
A. One of the things that I did get over the line, get the funding for, was an expansion of all of the A&Es in the country, in England. And -- because I was only responsible for the NHS in England.

And in addition to that expansion of A&Es, I wanted an expansion of bed capacity.
Q. Yeah.
A. For two reasons. The first is in case there was a second wave in the winter, which started to become evident from late July onwards. And the second is

because I think that the resilience of the NHS to future pandemics requires more beds. And that, you know, you never put the entire army in the field in one go. You have resilience. And in the same way, having resilience rather than running at 100% all the time in our health system is an appropriate use of national resources. It's what we ought to do.

So I raised it with the Prime Minister, I raised it with the Treasury, I will have done that in formal and informal settings. I raised it with the Cabinet Secretary, and you can see that I did that verbally and in messages. I internally campaigned for this extra funding and, as I say, I won on some counts and I didn't win on this one.

Q. Right. What do you think were the consequences of the refusal for the 10,000 beds, from your perspective?

A. The pressures on the NHS were greater in the second wave than they would have been otherwise.

Q. By the time you left office had you taken any steps or made any request to ask HMT for the funding for the 10,000 beds?

A. It had been a very -- I lost that battle, it was a clear "no", in the summer of 2020. The -- when I left office we were starting to gear up for a spending review but I wasn't engaged in -- we were starting to think about

it but it was not in advance stage of discussion.

Q. Okay.

A. You start basically -- the NHS and at a policy level we start preparing for winter in July.

LADY HALLETT: On the basis that you had the Nightingale hospitals and some like Birmingham weren't used at all, how did you justify the application for 10,000 more beds from the Treasury?

A. Because I was very worried about a second wave and I was worried about political opposition to a second wave being harder than first time round, and the history of pandemics is that the second wave tends to be bigger than the first. That is not just an -- that is not just what happened in the UK in the Covid pandemic, and that's because of a -- it being -- essentially sociologically -- across society harder to win the argument for the action that's needed second time around, and that's exactly what happened.

LADY HALLETT: As a minister you're used to dealing with the Treasury and you have to justify your case for increased funding with good arguments. How were you going to meet the argument, "but we've already funded Nightingale hospitals and they're not being used", how did you plan to meet that argument?

A. Because we needed overall long-term resilience in the

NHS.

LADY HALLETT: This was 10,000 beds generally?

A. Permanently.

LADY HALLETT: Oh, I see, I'm sorry --

A. To get them in place for that winter and keep them there in case there --

LADY HALLETT: I understand, thank you.

MS CAREY: Can I move on to a different way of increasing capacity which was use of the private sector.

A. Yeah.

Q. And in your statement -- perhaps if we could have up on screen INQ000421858_20, which sets out the use that was made of the private sector, or independent sector, as you call it in your statement, between March and May 2020.

A. Yeah.

Q. And we can see there at paragraph 78, over 7,000 -- approximately, I should say, 7,300 non-elective admissions; over 111,000 outpatient attendances; over 4,300 ordinary elective admissions; 12,900 day cases; and over 19,000 diagnostic imaging tests and chemotherapy treatments.

The money spent on the private sector, you say you considered to be value for money.

A. Yeah.

Q. Just help us understand your role in either approving the funding or monitoring what funds the -- what use was made of the funds?

A. So I didn't have a very significant direct role in this at all. I supported the use and the commissioning of the private hospitals. I asked the department for an assessment that we were getting decent value for money and I got that assurance, I think from David Williams, and my junior minister Ed Argar signed off ministerially on these but they were negotiated by Simon Stevens.

Q. All right, okay. And one other measure to try and help the predicted influx of patients into hospitals was use of NHS 111, wasn't it?

A. Mm-hmm.

Q. Is it correct that by January 2020, you wanted NHS 111 to be the single point of contact?

A. I wanted it to be available as a first point of contact.

Q. Yeah. Well, in fact, we know that from, I think, mid-March the public were urged to use 111 as the first port of call, if I can put it like that?

A. Yeah.

Q. Given that that was a clear way of helping to triage patients and not sending patients to hospital that didn't need to be there, what steps did you take to

monitor the efficacy of NHS 111?
A. So I had regular briefings on 111. There was a stage when it was under deep pressure and the reason for that pressure is that at the meeting to decide on bringing in lockdown, the -- Simon Stevens pointed out that if we bring in a lockdown measure and say, "If in doubt called 111" that would lead to enormous pressures on 111, and asked in the meeting for a short delay in the bringing in of the lockdown measures by, I can't remember, 24 or 48 hours, in order to spend that time urgently expanding the capacity of 111 and getting them prepared with scripts and what have you, essentially operational requirements.

The Prime Minister, based on the urging of the Mayor of London who was -- and most of the cases -- the biggest intensity of the virus was in London at that point, decided to bring in the measures immediately as in as of midnight that night.
Q. Right.
A. That was a -- I think that was an entirely -- either decision would have been entirely reasonable. It was, with hindsight, probably better to take the decision that the Prime Minister did take because we needed to stop the spread of the virus and -- but it had this operational consequence that 111 was under deep pressure

for several weeks, a few days of exceptional pressure, and then -- and whilst they got more people in and the demand sub...(*unclear words: multiple speakers*).
Q. All right, well, let's look at that exceptional pressure.

Can I have up on screen, please, INQ000474285_17.

This is an extract from the expert report of Professor Snooks who looked at the pressures on 999, 111 services, and a number of pre-hospital --
A. Yes.
Q. But in short, once it comes up on screen -- INQ000474285_17, and if it doesn't work I'll do it another way, Mr Hancock, all right?

This shows us sort of a broader view of number of calls to NHS 111, either answered within 60 seconds, abandoned after at least 30 seconds, and the calls answered over 60 seconds.

But can I just help you to this extent. In January 2020, 111 calls were at 1.5 million. In March that rose to just over 2.5 million, all right? But in March 2020, 1.1 million of those calls were abandoned and went unanswered. Now, it may well be that some of those people rang back, but there was a significant number of people abandoning calls to 111 and clearly the level of demand was substantially higher

than was predicted and was not matched by the capacity of the 111 system.

Now, were you aware of the significant number of abandoned calls in March 2020?
A. I was aware that 111 was under pressure. If I may say, if I'd received this at the time, I would have said that I don't think calls abandoned after 30 seconds is a good metric.
Q. No.
A. Because if people call 111 to find out something that is not clinically urgent, if you like, and abandon their call after 31 seconds, then they either might have found that information on the website or found it somewhere else or didn't really care deeply about that call. Calls abandoned after a longer period would be a more appropriate metric.

So, yes, there's pressures, but I'm not sure this is the best way of describing them.
Q. All right. Put aside -- on any view, there are a large number of calls that are abandoned --
A. Yes.
Q. -- within that month and a large number of calls --
A. (unclear) delay in how long people took to get that response, yeah.
Q. But take it at a wider perspective --

A. Yeah.
Q. -- the point I was asking you was, if you ask the public to ring 111 as their first port of call, isn't it incumbent that you can staff and properly resource that call centre?
A. In a pandemic sometimes you have to make difficult decisions between unpalatable options and the Prime Minister made the decision to bring in the lockdown immediately which led to these pressures being as urgent -- as acute as they were, rather than leaving 24, 48 hours to get 111 up and running. In a perfect world you wouldn't have pandemics and we were in a pandemic, so that was another example of two unpalatable choices and, I think, with hindsight, having reflected on this question, I think the Prime Minister made the least bad choice.
Q. There were clearly, though, concerns in your mind about strengthening 111 because in May of 2020 you ask that question at a quad meeting: what can we do to really strengthen 111 so it becomes the first port of call instead of A&E?
A. Yeah.
Q. What were you being told in May that provoked you asking such a question?
A. Well, this was -- by May the acute problems in 111 had

been mitigated, and the NHS had expanded capacity and the system was running well. This isn't about what I was being told. This is about the action I was trying to take. At my instigation I wanted us to bring in a system of 111 First, and the idea there is that before going to A&E you call 111 and if you can be dealt with on the phone, you are. And personally, I think it should be our national system and normal, if you like, and every citizen know that if you're going to go to A&E, before going to A&E you call 111, and that be a sort of process both so that A&E knows better what's about to come through its doors, so for operational reasons within A&E, and also because a whole lot of cases might be able to be solved on the phone or triaged to a non-acute setting.

Q. Yes.

A. So I think we should bring that in anyway. I tried to bring it in over that summer. It was a major operational change --

Q. Pause there. I'm going to ask you about it, all right?

A. Okay. But that's what that was all about.

Q. Right, okay, so let's go to May 2020.

To help you, Mr Hancock, can I have on screen INQ000409864 because there was a meeting about non-Covid A&E and NHS 111 on 22 May, all right?

And you were updated on the figures for A&E, attendance had dropped by more than 30% but had begun to rise, right, and then NHS 111 during the crisis:

"This shows calls through to 111 service rose steeply in early March."

As we just looked at:

"Capacity couldn't increase at the same rate so at peak 40% of calls were not answered. Later in March there was reduction in capacity ... while the increased activity was maintained."

There was a particular spike when you offered testing to symptomatic people through 111. By May activity levels are now much more in line with historic levels and we're now answering the vast majority of calls.

Bottom bullet point, please.

"[Secretary of State] noted he was surprised that with the sharp fall-off in A&E, NHS 111 is not picking up more of the burden (at least via the telephone service). He asked where that demand has gone. It was noted that lockdown means fewer patients of other types coming in [people with injuries and the like]. This means there's missing demand somewhere in the system ..."

And -- obviously you were concerned that if people

aren't going to A&E and they're not ringing 111, but they're still getting injured or still needing treatment, where are they going? Is that the missing demand you were worried about?

A. Yes.

Q. And what did you do about the missing demand?

A. Well, the note itself explained -- gives some explanations for why there might be less demand. There are less sports matches in a pandemic. And therefore there would be fewer injuries. And there's -- the number of non-Covid infectious diseases, actually, we didn't know this at the time but fell very, very sharply during the pandemic because of social distancing, and so that is a reasonable answer, and I had a meeting on non-Covid A&E regularly. So I would have -- if you say what did I do in the future? I've asked about it here and I would imagine I would have followed up in future meetings but I can't remember exactly.

Q. The Healthcare Safety Investigation Branch prepared a report in relation to 111, and they concluded this. There was strong messaging around patients staying at home if they reached a self-care at home disposition. For some callers, though, this was discouraged -- this had discouraged them, that messaging, from recontacting NHS 111 or seeking medical advice from elsewhere even if

their condition deteriorated.

Were you aware that there was some people that were actively not contacting NHS 111 and/or not going on to seek medical advice from elsewhere?

A. Yes, and I was talking about this publicly at the time. It comes back to the point I was making in the first session on reassuring people that the NHS was available and open and not overwhelmed. It's all part of the same -- it's all part of the same piece.

Q. Let me ask you about that now then. In hindsight, do you think the government and/or your department took sufficient action to encourage those who needed healthcare to come forward?

A. We encouraged people from pretty early on to make clear that the NHS was still available if it was needed. It was a very difficult balancing act, those communications.

Q. I follow that and you're not the only witness to have given that answer, Mr Hancock, but --

A. It's my experience of it.

Q. I know, but where I want to go is, what do we do differently next time to help encourage people to come forward where they may have to stay home because there has to be a lockdown?

A. We need to make sure that that is a clear part of

communications throughout, I think, and that's what we did. The challenge is in communications. Communicating more than one message at once is always very difficult and this was a two-part message, which is Stay at Home, (unless you really need the NHS in which case please do go).

Q. You mentioned NHS 111 First and could we just have back up on screen, please, INQ000409864_2.

There's a bullet point missing at the top which says 111 First, don't worry about that, but you mention there:

"There is a real risk that the level of demand on A&E from self-presenting, causing crowding ..."

And you need to prevent -- there is a need to prevent social distancing in a core health setting:

"[We] need to triage through 111 before self-presenting."

So you don't want A&E bursting at the seams, effectively; is that what you're saying?

A. Correct.

Q. And your overriding steer, a number of bullet points down, is to bring in NHS 111 First, which was essentially -- it's a booking system as I understand it?

A. Well, to the extent that you could use it as a booking system, I think that that's what we should have. But

of course sometimes you've still got to turn up at A&E.

Q. Yes, no, sure, but wasn't the plan for there to be a booking system so that not everyone turned up at 9 am but you separate them out through the day to help the hospital, help maintain social distancing, help prevent the spread of infection?

A. So you wouldn't want a booking system to be universal, you'd want it to be a contributor. Ie if somebody has a problem that requires treatment but the assessment by 111 is "This could wait an hour and A&E is very, very busy", you might say, "Please come in an hour's time and book in a slot", but you'd also obviously want the ability for 111 to say "This sounds urgent, get yourself to the nearest A&E without having to go through the rigmarole of a booking procedure". So, so long as it isn't required to book but is an available facility to book, I think 111 First should be, both in a pandemic and in normal times, the way that we access the NHS.

Q. So here is you talking about the rollout of NHS 111 in May. In fact you announced it in September and the plan was to roll it out from December?

A. Yeah.

Q. Can you help us with why it took from a sensible plan in May to not being rolled out for many, many months?

A. The operational reasons you'll have to ask the NHS. My

recollection is it is essentially about upgrading the NHS computer systems to allow this to happen. And anybody who knows anything about NHS computer systems knows that they are in dire need of improvement and things like this take time.

Q. All right.

Ambulances, please. We have heard, inevitably, about increases in both the number of calls and the waits people had to endure before an ambulance was available to get them. Can I ask you, please, about some of the things that people told the Inquiry's Every Story Matters record.

Could we have on screen, please, INQ000474233_110. Thank you very much.

And can you see in the middle of the page, Mr Hancock:

"Patients shared many experiences of them or a loved one being very unwell and calling their GP, NHS 111 or 999 ... but facing delays or not receiving care. Some contributors either gave up or had to wait until their symptoms became very severe before trying again. There were similar experiences among those who had suspected or confirmed Covid-19 and those who had other urgent medical problems."

And we can see a quote there from one of the

contributors:

"One night I was sick over and over again. At 1am I called 999 and they said they would send an ambulance. By 6am it still had not arrived and I got back into bed, pregnant and exhausted. At 11am someone phoned to ask if I still needed the ambulance and that other cases were more 'urgent'. They advised me to contact my GP. I did and the GP refused to see me saying I should contact 999 again. At this point I gave up. There was no help."

That's just one quote of a number of people -- about 30,000 people contributed to the Every Story Matters record. I'm not saying they all made reference to ambulance problems, but were you made aware of the intense pressures there were on the 999 system and the length of delays that some people were experiencing?

A. Yes. And again, I visited ambulance stations throughout the pandemic. In fact, one of my very first visits was to an ambulance station and I remember meeting the man who was responsible for co-ordinating sending out of ambulances and he burst into tears on me. It was incredibly difficult for him because the pressures and the number of calls and they hadn't seen anything like it before.

Q. I think you were aware there was a shortage of drivers

amongst -- in the ambulance --
A. Yes, there were.
Q. -- sector. Can you think of any practical way of resolving a shortage in a short term, in the event that we need to up-scale the sheer number of people who can drive an ambulance?
A. Well, one example may be that we should have people who are trained as ambulance drivers on a standby, a bit like we have the Territorial Army.
Q. Yes. Was there any plans in place by the time you left office to have such a reserve?
A. Well, we -- knowing the pressures first time round, I think my recollection is that in the second peak, whilst there were still enormous pressures on ambulances, they were not as acute. And again, I visited ambulance stations and talked to the ambulance service about this and I talked to individual ambulance drivers and paramedics in order to get a sense of it from the ground up, as well. So my recollection is that second time round we -- the ambulance service was able to withstand those pressures better. And I'm sure that the -- I'm sure there's lessons that can and should be learned, and the two waves compared and contrasted against each other, but obviously the running of the ambulance service itself is -- was for the NHS at

an operational level.
Q. Finally on ambulances, please. Delays are, sadly, nothing new in handover times from -- we're all familiar with ambulances being stacked up outside A&E departments and the like.
A. Yes.
Q. Do I take it you would agree that the pandemic made an existing problem worse?
A. Yes, absolutely, yeah.
Q. We have heard evidence that it was not uncommon for patients to be held in an ambulance for six to twelve hours. Were you getting reports of that kind of length of delay before the patient could actually be taken into the emergency department?
A. Not only did I get those reports but also I knew of hospitals where the delays were much, much shorter, and it was deeply frustrating that, at some settings, they'd organisationally managed to get this sorted and at others the ambulances were unavailable because they were parked on the ramp for six hours or twelve hours, as you say. And that was obviously deeply frustrating.
Q. All right. Can I ask you about that frustration, because then you've got an inconsistent picture: some places not doing so badly, some places doing really badly. When you, as minister, hear of reports like

that, what do you actually do to say, "Well, come on, guys, how come one part of the country is doing well and another part is not?"
A. Well, this is a perennial problem across different parts of the operation of the NHS. This is primarily a matter for the NHS themselves. In this instance I had a series of meetings with Pauline Philip, a very impressive NHS senior manager who had run hospitals incredibly effectively, was then brought to the national level to try to tackle these inequalities of service.

I mean, this is a problem in normal times, then exacerbated in the pandemic both by a combination of the pressures but also the fact that the pressures themselves were differentiated across the country.
Q. Were you made aware of concerns amongst ambulance staff about the fact that they were in the back of an ambulance cab, often in very close proximity to a potentially Covid positive patient, with inappropriate PPE?
A. I was absolutely aware of the problems of getting PPE to ambulance staff, and I remember one person, who was responsible for getting PPE to a particular ambulance hub, talking to him on one of my visits and him saying, "I've got to protect my team". And so getting the PPE out to all the individual locations was a massive

logistical problem.
Q. Yes, all right, we're going to come on to the PPE.

Just finally, please, before we finish this topic. Clearly, delays waiting to get into emergency departments, and then were you aware of the delays once in the emergency department, with patients waiting up to 12 hours or more before a decision to admit them was taken?
A. Yes, I mean, that was a problem before the pandemic, let alone during it.
Q. The Royal College of Emergency Medicine have carried out a report into the impact much delays in emergency departments. It did some modelling and it showed that, in 2021, of those who waited eight to twelve hours in an emergency department, there were 4,519 excess deaths in England associated with long waiting times in emergency departments.

What, if any, steps did you take to try to resolve the logjam of people coming off the ambulance into emergency departments and then into hospital if they needed that care?
A. Well, again, this was a frequent subject discussed between me and Simon Stevens, who was responsible for this. The challenge -- responsible as in it was his -- he was responsible for this policy area, it wasn't his

fault.

You know, the challenge of how to unblock emergency departments is a significant one. Many improvements have been made. One of the examples of things I did was got the money from the Treasury to expand all of the emergency departments during this period to make sure there was physical space. But actually one of the biggest barriers to flow in to emergency departments is flow out of emergency departments into the hospital proper. And that, of course, was also -- that in turn was -- is a question of getting the appropriate discharge at the other end.

So you can't see the hospital in isolation from the call handling system, whether it's 999, 111, through to A&E, through to the admitted element part of the hospital, through to discharge and social care, it's one system. And if you've got a blockage in one part of the system it bungs up every other part of the system.

So you can't look at this in isolation from the challenges of discharge into social care, which is why Simon was so keen to ensure that we had discharge from hospital into social care and pushed so hard for that policy, because he was responsible for ensuring that when the ambulances turned up at A&E people could get off the ambulance into A&E, and the only way to make

enough space there was to make sure people could get from the A&E department into the hospital proper.

Q. Mr Hancock, I want to change topic completely and just deal with a couple of discrete topics before we take our lunch break, and then we're going come to some bigger topics.

A. Okay.

Q. Can I ask you about DNACPRs, and you did in fact refer to DNR orders earlier this morning.

A. Yeah.

Q. I think -- were you made aware of concerns blanket or inappropriate DNACPRs were being imposed. And if so, what did you do about those concerns?

A. Yes, I was made aware of concerns about inappropriate use of do not recover notices. There were reports in the press as well, and I thought that this was appalling. The principle of healthcare has to be based on consent, and any DNR notice without appropriate consent is wrong and potentially illegal.

So, yes, I heard these concerns directly from families, and I heard them through a number of different routes.

I mean, put yourself in the shoes of the family whose loved one has not been resuscitated because somebody has said that they shouldn't be without either

that person or the family being asked. It's appalling and totally unacceptable. So the steps I took was to make clear publicly as soon as I heard about it that this was completely unacceptable. And we reiterated and made clearer, as far as I can remember, the guidance around it. But it was something that I had to get involved in, even though it's technically a matter for the NHS. Because one of the tools I had during the pandemic was to communicate directly to NHS teams on the ground through the press conferences, and this is one example where I used the press conferences not so much to communicate to the public, important as that was, but to communicate to NHS staff that this mustn't happen.

Q. All right. You said "do not recover"; did you mean "do not resuscitate"?

A. I do.

Q. All right. It's fine, I just want to be clear about the language in this area.

You said there that you heard directly from some of the families involved. In what fora did you hear them?

A. My recollection is hearing through an MP, and of this happening in the Brighton area. So that's my -- that's my recollection, but we'd have to look at the paperwork.

Q. You say in your statement at paragraph 107 that on

10 April 2020 you attended a meeting in fact with officials discuss the adult social care plan but DNACPRs came up in the course of that meeting. And your private secretary has noted the meeting, says that you commented that the DNR discussion needs to note that for many people not going to hospital is the best decision but this must be a sensitive clinical decision based on individual needs and circumstances.

Not going to hospital is not the same thing as not being resuscitated. Were you clear in your mind that a DNACPR was only there to prevent cardiopulmonary resuscitation and was not to be treated as a do not treat order?

A. Absolutely.

MS CAREY: All right.

My Lady, it's a little early but would that be a convenient moment?

LADY HALLETT: Certainly. I shall return, provided it's slightly warmer where I am sitting, at 1.40.

MS CAREY: Thank you very much.

(12.41 pm)

(The short adjournment)

(1.40 pm)

LADY HALLETT: Ms Carey.

MS CAREY: Thank you, my Lady.

Mr Hancock, can we turn to PPE, please. Do you accept that at times healthcare workers treated Covid-19 patients with inadequate PPE, thereby putting themselves at potential risk?

A. Yes.

Q. Did you understand that FFP3 masks were more protective than FRSM blue masks?

A. Yes.

Q. Can you help, please, with who led you to that understanding that the FFP3 was more protective?

A. Well, it's obvious. So I don't -- I'm not sure I was ever told it technically but if I were taken through the performance of different parts -- elements of PPE, it would have been via Ruth May.

Q. Did Public Health England ever say to you: in fact there's no clinical evidence on the ground that FFP3 are more protective than the blue masks?

A. Not that I can recall, no.

Q. All right. Would it surprise you to learn we've heard evidence to that effect?

A. I saw that and in these things I take the evidence as given by the experts.

Q. You are aware presumably, though, that there were lots of bodies acting on behalf of healthcare workers arguing for increased usage of FFP3 throughout the pandemic?

A. Yes.

Q. And I think in fact you received a number of letters from BMA, RCN, TUC, CATA, as it's now called, or CAPA as it then was, urging you to allow FFP3 usage more widely than the IPC guidance enabled?

A. Yes, and not only receive letters. That, again, gives the impression that this was somehow a dry exercise, which obviously you get from the paperwork, by its nature, but I spoke to all these people as well, and the royal colleges and -- and more than anybody, Donna Kinnair, who was the head of the RCN at the time.

Q. Did you understand that that desire for increased usage of FFP3 was linked to an argument that Covid transmitted via aerosol transmission?

A. Yes.

Q. Can I ask you about that, please. To what extent, if any, were you involved in arguments or aware of arguments about the extent to which Covid transmitted via aerosols?

A. Of course, I -- I was -- again, it was -- I was acutely aware of these things, this -- and that debate.

Q. You said this morning that you would advocate for a precautionary principle being adopted in relation to asymptomatic transmission?

A. Yeah.

Q. Can I just ask you, please, what do you understand the precautionary principle to mean?

A. Well, you have to take into account the reasonable worst-case scenario and act on that basis where you can. So the central balancing that had to be done with respect to PPE was supply, set against precautionary healthcare considerations. So -- and that's what the -- those drawing up the IPC recommendations did: they had to balance what was available, and realistically available, to buy, with what was needed to -- all with the goal of saving the most lives. I left that balance to them to make and I didn't -- I regarded it as an essentially clinical decision, taking into account available stock, the IPC decision. That isn't something that I would have interfered with or indeed did interfere with.

Q. Pausing there. You were not responsible, as we know, for drafting the IPC guidance or indeed approving it, as I understand it; is that correct?

A. That's correct, yeah.

Q. But are you saying to us you were of the view that IPC guidance was drawn up on the basis of what was available not what was actually necessary to be recommended to healthcare workers?

A. In a pandemic, availability of stock has to be taken

into account, because if you promise -- imagine if the IPC guidance had retained the initial hazmat style --

Q. The HCID --

A. HCID, the definition -- that would not have been possible. And so there is an element of the art of what is possible. In the same way that whilst I wasn't individually involved in signing contracts for PPE, I was deeply involved in trying to push the system to buy more. But on the IPC guidance itself, of course you have to consider what is feasible, because this isn't some academic exercise it's about saving lives. But in terms of when that IPC guidance was then drawn up, I didn't sign off on it and I accepted the guidance as essentially a piece of clinical guidance with which I wouldn't quibble. It was a -- if I had a question around it I'd go to Ruth May and I'd talk to Donna about these things all the way through.

Q. Are you aware of the basis upon which Covid was downgraded or declassified as an HCID and why that decision was taken?

A. Yes, it's -- I think the decision was obvious in a sense, because spread had got wider than this being a very rare and single occurrence. But again I wasn't -- that wasn't my decision, it was a clinical decision. I think, in that case, by the CMO.

Q. And may be ACDP or NERVTAG -- put aside who it was that made that decision, it was in fact declassified because it was less fatal than other coronaviruses that we've heard of.

You're not suggesting, are you, that it was downgraded because we wouldn't have had enough PPE to maintain the HCID classification, are you?

A. No, my example was that if you tried to maintain it, it would not have been feasible.

Q. All right. We have heard evidence from IPC guidance -- those drafting the IPC guidance, that issues of supply did not in fact affect the guidance that they issued. Are you suggesting to the contrary, Mr Hancock?

A. No, I'm suggesting that I wasn't involved in the drafting of it. But my point about supply is you do have to live in the real world once you're fighting a pandemic. Of course people who were drafting the guidance would also have been aware of it. The balancing point here is that you -- the practical reality is that there is a certain amount of PPE and you have to use it as effectively as you can whilst buying as much of it as possible. That is the real world reality here.

Q. You said this morning, in relation to the precautionary principle, you adopted it absolutely, "Which we did on

things like guidelines around the use of PPE within hospitals".

A. Yes.

Q. In what way do you say the guidelines around PPE in hospitals adopted that precautionary principle?

A. Well, for instance, the use of masks, which was required as part of the IPC, which was not recommended to the general public. The failure to recommend it to the general public until later was directly a consequence of asymptomatic transmission being ruled out in the official advice, yet it was adopted within our hospitals demonstrating that there was an element of the precautionary principle there.

Q. There will be those, many in this room, no doubt, that say if you were truly adopting the precautionary principle, FFP3 would have been used not the blue masks. Do you have any views or comments to make on that suggestion?

A. I can absolutely see that argument, and had FFP3 masks been recommended I would have accepted that. That was a -- but as I say, that was a clinical decision for the team who put together the IPC recommendation not for me.

Q. Can we take a stage back to the stockpile, please.

A. Yeah.

Q. And you say in your witness statement that as at

30 January 2020 you received Public Health England's audit of the PPE stockpile and there was no clear record of what was in the stockpile and some kit was passed its sell-by date?

A. Yes.

Q. The Inquiry has also heard that as at 18 February the stockpile did not contain a single gown. Were you aware that there were no gowns in the PPE stockpile?

A. Well, I was once I found that out but I wasn't in advance, no.

Q. Did you find out about it around the end of January beginning of February, something like that?

A. Yes, I asked for that audit at around that time.

Q. Were you made aware that NERVTAG in June 2019 recommended getting surgical gowns in for the event of even a flu outbreak?

A. I don't recall being aware of it but obviously I've seen it in the evidence to the Inquiry.

Q. Had you been made aware that there was a need for gowns, would you have been able to apply any pressure to speed up the procurement process?

A. Rather like our discussions about the lines of accountability with NHS England, similarly with PHE, I certainly could have raised that with the PHE leadership but it would have been their responsibility

to do it. I say this because the clarity around the roles within the health system was really clear. The fact that that would have been effectively an independent decision by them doesn't mean that we had any lack of clarity over whose decision it was, in the same way I know what was Simon Stevens' decisions on the NHSE side, what was my decisions, and if there was an ambiguity, we would put it on the quad agenda and discuss it.

LADY HALLETT: But who would provide the funding for getting more PPE?

A. That would come from PHE's budgets but obviously one of my roles with respect to PHE was to fight for their budget.

MS CAREY: Sir Christopher Wormald told us it was entirely normal government procurement that meant that even thought it was recommended to buy gowns in June, by February 2020, 8 months on, we still hadn't got a single gown in the stockpile.

A. Yes.

Q. Do you accept, though, that entering the Coronavirus pandemic, as we did without a single gown, severely hampered the ability to provide safe and appropriate PPE for healthcare workers?

A. The stockpile that we had was not as goods as it needs

to be in the future, absolutely. But I saw Sir Chris's evidence and he was absolutely right, if I may say so. There have been some criticisms of the department, indeed me personally, because of the accelerated procurement that we put in place. This is an example of normal procurement processes. So you can see why we needed to accelerate them. This is how slowly government buys stuff, it's just really, really slow, and it's gone back to being incredibly slow since the pandemic. That's just life in government.

I don't like it, by the way, I think we should buy stuff quicker but that's --

Q. No, it sounds rather fatalistic, doesn't it?

A. Yes, but he was completely accurate in describing it as normal government procurement. I mean, sometimes this stuff takes even longer.

Q. You say in your statement that one of the other problems with stockpile is it was not spread across the country --

A. Yes.

Q. -- and that the warehouse that held the stockpile had only one main door which slowed the distribution of PPE.

A. Yeah.

Q. So, is this a fair summary, there was no clear record of what was in it?

A. Yeah.

Q. There was a total absence of some PPE, namely gowns, and to boot, there are clear problems getting your hands on it because the warehouse has only got one door?

A. And some of it was out of date once we got our hands on it, yes. Why there wasn't a precise list of what it was in an easily pickable way with a computer system that tell you where different bits of kit were, preferably with photographs attached of an example of it, for instance, as you would have in a modern, efficient storage system, I do not know.

Q. By the time you left office, was there such a list that you were aware of?

A. Yes.

Q. All right.

A. But I still wouldn't say that by the time I left office it was comprehensive, but we were much further along the route and we had pickable PPE stockpiles in lots of locations, and indeed, there was a problem that we ended up overbuying PPE because the PPE demand fell again and we -- and the department, after my time, ended up with too much PPE.

Q. Jeane Freeman told us that she thought that having a rolling stockpile which would entail distributing PPE on a rolling basis to prevent it expiring would help in

the future.

A. Yeah.

Q. Would you agree or disagree with that?

A. I think that's a typically astute observation from Jeane Freeman.

Q. Can you help, or do you know why we didn't have that since it seems to be a relatively simple solution to a problem that we encountered?

A. I have absolutely no idea.

Q. All right. Mr Hancock, from your perspective did England ever run out of PPE for the NHS?

A. As a whole, no, but individual locations did.

Q. So you accept that we came close?

A. We came extremely close. We came within, you know, a small numbers of items on a regular basis during April and May 2020.

Q. All right.

A. By the second wave we were in better shape.

Q. I'd like to just look at perhaps some of those examples. I think you are aware in April 2020 that there were reports that a hospital in North London, Northwick Park had no critical care beds left and in fact there were exhausted nurses wearing bin bags to protect themselves.

I'd just like to call up that article, please. INQ000474608.

It's Thursday 9 April, so an article in The Independent and there are three nurses there wearing their bin bags. Perhaps if we could just scroll through the article, they say they've now been diagnosed with Covid after they were forced to wear bin bags. They were pictured last month amid a shortage of masks, gowns and gloves. And if we scroll down again, I think there may be another photo. Or it may not come up on our screen. There we are it does.

Nurses added:

"There are too many Covid patients coming in to cope with. We've put on our brave smiles but inside we're terrified."

I'm asked to ask you, as the person with ultimate responsibility for health and social care, how did the UK reach the point that healthcare workers are having to wear bin bags?

A. Well, the -- in this instance, I saw these reports and asked whether that hospital had enough PPE and I was told that it had had regular PPE deliveries in the preceding days and that the hospital itself reported back that it had adequate PPE supplies. So all I can do is tell you what I was told at the time and I was immediately on it to try to solve these sorts of problems. But, of course, there were individual

shortages because this was a massive logistical operation under extreme pressure.

Q. Can I ask you when you say, "I was immediately on it to try and solve these problems", what did you actually do? Help us with what you did.

A. So there were some exhibits that explain what happened. The -- I saw these reports. I also heard other reports. I asked the department to get in contact directly with the hospital, and the hospital reported that it had adequate PPE supplies. And this is an example of the fact that within the NHS, within a logistical operation of suddenly having to get PPE out to, effectively, 1.4 million people and social care, there are inevitably problems and challenges.

Obviously the logistical operation is a matter for the NHS. What I was trying to do, and what we effectively did do, was ensure that there was always overall PPE supply. But it got extremely close. Sometimes within hours. And for the people operating that PPE supply chain on the ground, it was incredibly difficult because they'd go from, in normal times, having PPE supplies, you know, coming in at a scheduled rate in an organised way, to suddenly being waiting for the next batch of PPE to arrive before they could distribute it around the hospital. So I'm not

criticising them --

LADY HALLETT: If you could focus on Ms Carey's questions. Essentially, you discover through your officials making enquiries that the hospitals say they have supplies, the nurses say they haven't. Did you just accept that conflict or did you say, "What's going on? Why aren't these supplies --

A. Yes.

LADY HALLETT: -- if they're there, being distributed around the hospital?"

A. Well --

LADY HALLETT: Miss Carey's question was, what did you do?

A. So, I -- the answer to the precise question what I did was, I found out whether that hospital had supplies.

LADY HALLETT: Yes. Then what?

A. My responsibility was not to distribute it within the hospital. I raised and discussed PPE distribution repeatedly with NHS England management and they, too, were extremely keen to ensure that the PPE we had got distributed properly within the NHS system. At the same time we tried to improve the delivery systems, to different hospitals.

LADY HALLETT: But that's a different problem. That is getting the supplies to the hospital.

A. Yes.

LADY HALLETT: Here there seems to be a problem with getting the supplies distributed around the hospital.

A. Around the hospital, absolutely.

LADY HALLETT: Did you do anything about that?

A. The answer is that I spoke to the NHS about that because it was not -- it's not something that I, as Secretary of State, personally, could have done in every hospital. You have to run the system. You have to run -- I run the department and then spoke to the NHS. So effectively it's the management of that hospital who is responsible for getting the PPE supplies out of the -- from where it's received in the hospital out to the parts of the hospital.

MS CAREY: In your statement you say that data about PPE was first incorporated into the Covid dashboard on 21 March 2020, and you were aware certainly by mid-April there was a potential for a "stock out"; does that mean no more stock?

A. Yes.

Q. In relation to gowns.

A. Yeah.

Q. And I'd like to ask you, please, about an email chain just showing how close we came to that.

Can we have on screen INQ000478872. And I don't know if it's possible to expand the table at the bottom.

Let's just see if we can -- thank you very much.

"[Number] of weeks after 10 [April] until stock out."

And if we can look at gowns, no -- no more weeks?

A. Yeah, tell me about it.

Q. 1.9 weeks of aprons, 2 weeks of cleaning equipment, nearly 3 weeks -- and so on, 3 weeks of gloves.

A. Gowns I think at one point we got to within 6 or 7 hours of running out.

Q. Yes. Go back, please, to page 1. There's certainly reference to days, I'm going to ask you about hours in a minute, but:

"... thanks to Emily for the update.

"We have enough gowns to get through tomorrow and enough coming in tomorrow for the next day ...

"No trust has run out and there's been lots of mutual aid (especially in London)."

Ie trusts or hospitals --

A. Helping each other.

Q. -- helping each other out.

Is that the Foreign and Commonwealth Office --

A. Yes.

Q. -- are looking into mutual aid? And:

"... they have cleared a deal with Egypt ...

"The dashboard will show that ... we are out of

stock (we ... have c60k and need to send out c6k)."
And you're relying on a delivery from Amazon, no less, for another 60,000.
Were we running out of gowns to the hour?
A. Yes. We were -- I mean, we were working incredibly hard to make sure that we didn't have a stock out, and we nearly -- we nearly did.
Q. And one of the responses to that was, I think you, effectively, were aware that PHE produced acute shortages guidance on 17 April which allowed for sessional use or reuse of some PPE, including gowns and masks in specified circumstances. Do you remember being asked to approve that guidance?
A. I'm not sure whether I approved it or whether it went through the IPC approvals process.
Q. I can tell you we've seen an email chain, it goes through you and you approved the guidance.
A. Okay.
Q. Do you accept that the failure to have gowns in the PPE stockpile resulted in part for the need for -- that acute shortage of gowns --
A. Yes, of course, if we'd had more gowns at the start -- so that is literally true in the way you ask it.
There's also a broader point, because we have to -- I come back to this point that what matters is -- what

I was responsible for was making sure the system as a whole operated as well as it possibly could to save as many lives as possible. And that was my job. The -- Chris Wormald makes the point that we had about half a billion items in the initial stockpile. We used 15 billion during the pandemic as a whole. It is not feasible to have 15 billion in a stockpile. But it is of course literally true, in the way that you asked the question, that if we'd had 1 million gowns at the start we would have been 1 million further away from running out, which would have been several days, and therefore avoided being this close. But we were this close. And we worked incredibly hard to ensure that there was as much as there was.
Q. Were you aware that that acute shortages guidance caused real upset in particular to the Royal College of Nursing who didn't support the guidance?
A. Yes.
Q. And in relation to the Royal College of Nursing, they were so concerned by April 2020, were you aware that they introduced a -- some guidance to the nurses on the circumstances in which nurses could refuse to treat?
A. Yes.
Q. What did you do when you learnt that the RCN had to go so far as to bring in a refusal to treat guidance?

A. Obviously I was -- I spoke to Donna Kinnair at this point and it was understandable that some people would feel uncomfortable with this guidance, because I didn't want to put -- see that guidance in place either. But the challenge was how do you save as many lives as possible. Right? That was the objective here.
And the advice I got, which I signed off, was that, in certain circumstances, reuse of PPE is better than no PPE, and I accepted that point.
Q. I follow the reuse or sessional use of PPE being better than none, but what did it strike you as saying about the way the system had prepared itself and was coping if the Royal College of Nursing have to produce guidance which says to the nurses "At some point, in certain circumstances, you can actually refuse to treat a patient"?
A. Well, the Royal College of Nursing represented one view and my clinical advisers on this, represented by and led by the Chief Nursing Officer, Ruth May, took into account all these considerations and made the best decision that they could based on the -- on saving as many lives as possible.
It's perfectly reasonable for a trade union to take a different view, but that doesn't necessarily mean that they're right. But we talked -- we had a high

quality dialogue throughout this. In fact, Donna Kinnair, as head of the RCN, and I were involved in working together to try to buy more PPE as well. So they were absolutely leaning into trying to solve the problem, and it's totally reasonable for a trade union and the chief nurse responsible for the system as a whole to have different views on how to respond to a very difficult situation.
Q. Did you or anyone else in the department ever discuss the possibility of a widespread refusal to treat by UK healthcare workers?
A. No, I didn't think we -- we didn't expect a refusal to treat to become widespread. And also I was making -- I was in conversation with people on the front line as well, and my sense was that everybody really was trying their very best in very difficult circumstances, and that was the attitude of the whole system.
So whilst there may have been some who took the view of the RCN, actually the vast majority of people were just doing their best in awful circumstances. And frankly that was the attitude of -- within the health system, setting aside the problems that we had in central government, within the health system that was basically the attitude that everybody took all the way through. And I think that's reflected in all of the

paperwork that you've seen.
Q. You make the point a number of times in your statement that whilst you acknowledge there were individual shortages, at no stage there was a national shortage.
A. Yeah.
Q. And can I ask you, Mr Hancock, bluntly, is that really the point? Is it not cold comfort for those that were down to the last hours' worth of masks or gowns or gloves?
A. Well, it is better to be down to the last hour's worth than to run out, and in some places they did run out and that was awful. And my job was to ensure that that happened as little as possible, and nationally we never ran out of it.

In a way, it comes back to this -- the difference between semantics and substance, right? The reason in Inquiry is so valuable to the nation, so important, is to get to the substance of it. So, you know, I don't really get hung up on the semantics of it, what I care about is that in future we need to have better PPE stockpiles, we need to learn the lessons of what went wrong, and this Inquiry, frankly, is at its best when it's focusing on that, and that's what really matters.
Q. I didn't ask you about semantics, Mr Hancock. I was asking you or making the point that although nationally

there was available PPE, that's not particularly helpful, is it, to the healthcare workers that had to struggle on and reuse PPE. It's not semantics, is it? Are you trying to present a rosier picture of the PPE position than was in fact the case given the evidence that we've shown you?
A. No, I'm not, I'm being absolutely clear about what happened and what lessons we need to draw for the future. What happened was there were individual stock outs in individual places, there was not a national stock out. In a way, one of the lessons we can draw is even if there isn't a national stock out, there still are problems in local areas and, therefore, not running out isn't good enough, we need to make sure PPE is widely available, easy to get hold of.

So the point I'm making, and the reason I'm making it emphatically, is that what matters is the substance of being able to protect lives, and that's what we cared about in the health department and spent, you know, every hour that we possibly could solving that problem. Now, how does that feel to the nurse on the ground? Well, what they care about is: is there PPE for me today?
Q. Yeah.
A. Yeah. And that's what I cared about. And the best --

the role I could play, and the responsibility we had as a department, as opposed to the responsibility of an individual hospital chief executive to do the distribution within a hospital, our responsibility was to make sure that there was as much PPE available as possible in the almost impossible global circumstances of the sharp rise in demand.
Q. From your perspective, was there any link in your mind between shortages of PPE and the rising rates of people who were acquiring Covid in hospitals?
A. That is a very important question. I don't know the answer to that. I have seen evidence that there were no recorded deaths as a consequence but I've also seen evidence to the contrary. And that is a -- that's a research question.
Q. No, and I follow that, I take the point that statistics may or may not ever be able to determine --
A. Yes, it's a bit like asymptomatic transmission.
Q. I know, but that's why I wanted to know from your perspective whether you were worried that there was in fact that link?
A. Oh, I worried about -- I worried about it. Whether it actually happened or not, I don't know. But I worried -- of course I worried about it.
Q. Can we have a look, please, at the rates of nosocomial

infection.

And can I ask, please, that it's put on screen INQ000348633_11.

This is a PHE document looking at deaths -- well, the rate of hospital-acquired infection and indeed the deaths that may have flowed from that.
A. Yes.
Q. And to help you, they've covered the whole time and then they've covered the waves. Just looking at the whole time period, HOHA, hospital-onset, hospital-acquired.
A. Yeah.
Q. All right. And I'm not going to ask about hospital-onset, suspected -- but from -- this purpose, across the whole period there were nearly 30,000 cases of hospital-onset, hospital-acquired Covid, of which 9,854 people died, 33%, and the average age of people that died was 75.

And if you just look at the waves. Wave 1, over 8,500 cases and 3,000 deaths. And if we just look at wave 2, a far higher proportion of cases, 21,000 it jumps up to, 6,000 deaths, although the proportion overall is about a third, if I can put it like that.

Again, the mean age of the people dying in both waves is 75.

On any view, they are shocking statistics, are

they not?
A. Absolutely.
Q. You said earlier this morning that hospitals are dangerous places to be in pandemics?
A. Yeah.
Q. I suspect this is what you had in mind when you made that observation.
A. Yeah.
Q. It might have struck many in this room as a rather curious thing to say that the very place people go to get better --
A. Yes.
Q. -- in fact is the place where they get infection and may, indeed, in fact go on to die?
A. Yes.
Q. Help us, please, at what stage did you become aware of the risks of hospital-acquired Covid?
A. The moment I heard that there was a new infectious disease, January 2020.
Q. January -- right.
A. It's not like I became aware of it, it's obvious. I was involved in efforts to reduce nosocomial infection before Covid from other diseases. Nosocomial infections is a very serious problem in health systems everywhere but the NHS has a particular problem with it, if you

think back to the MRSA scandals, et cetera.
Q. I'm not suggesting it solely affects Covid and we're well aware --
A. But also the question -- you asked the question, "When did you become aware?", and my answer is it wasn't like somebody wrote me a note and said, "This is going to be a problem", it was just like, well, obviously we are going to have a problem with this.
Q. Okay. So when you became aware of the new disease in January 2020 and ergo the risk, at the very least, of nosocomial infection, what did you actually do to try, as best you could, mitigate that risk?
A. Well, we were aware of it from the start and tackling nosocomial infection is clearly a responsibility of the NHS. Making sure, for instance, that the hospital PPE guidance, as opposed to the guidance to the general public, was precautionary, was an important part of it, and again, these are discussions I would have had with Simon Stevens as part of the quad process because preventing nosocomial infection is a key responsibility of the NHS.
Q. But what did you actually say to him to say, "I want to get on top of this as best I can"?
A. I'm not sure I would have phrased it like that. I would have said, "We need to tackle this". He put in place

a lead for tackling nosocomial infection. We had the IPC guidance itself is a major -- was a major step in tackling nosocomial infection. And then when we got to testing, we introduced testing in hospitals as soon as we had the tests available to do so.

But just to give a flavour of it. One example of the problems that we faced and the cultural problem of tackling nosocomial infection in the NHS is this: when I brought in -- when we got to enough tests and we talked about increasing testing in the NHS, some hospitals said they did not want to test their staff because they might find too many staff with Covid. And my response to that is, if you have staff with Covid, we need to know that so that they can go home and stop infecting patients, but some hospitals refused to bring in testing for their staff, and the NHS at the centre, NHS England pushed incredibly hard to get testing to everybody.

But the fact that somebody might say, we're not going to test because what's that going to do to our shift patterns if people have to go home, is an example of, in my view, a cultural problem within the NHS that it simply does not do enough to tackle nosocomial infection. And I'd been worried about that from before the pandemic and that is something that I raised

from January 2020 onwards but, again, the responsibility for dealing with that lies with the NHS. Because you can't -- you know, that -- tackling nosocomial infection involves decisions that filter all the way down to what happens on every individual ward.
Q. When you got reports that there were some hospitals saying they didn't want to do the testing lest it reduce their ability to staff, what did you do about it?
A. I was -- I was deeply frustrated about it. I tried to bring in -- I had meetings with, obviously, Simon Stevens but also Pauline Philip and Ruth May. We -- in the end we brought in protocols to require it but the take up of testing was piecemeal and slow within hospitals, slower than it should have been.
Q. The Inquiry has heard evidence that in fact people wanted the test because it might enhance the numbers of staff because if, in fact, they weren't Covid-positive they could come back to work. Did you hear evidence of that, as well?
A. Yes, absolutely, that was a big part of the drive, yeah.
Q. You've mentioned there the importance of IPC measures in trying to tackle nosocomial infection --
A. Yeah.
Q. -- and I think you're aware, Mr Hancock, that the Inquiry had a number of spotlight hospitals that

were asked about these matters. Watford, for example, said they couldn't maintain 2 metres between bed spaces and had to use curtains because of the layout of the estate.

A. Yes.

Q. They didn't have ward ventilation that was appropriate, so had to use mobile HEPA filters.

A. Yes.

Q. They didn't have separate entrances. They didn't have waiting areas that could be segregated. They had shared bathroom facilities that couldn't be segregated. They didn't have enough single rooms.

A. Absolutely.

Q. Clearly the NHS estate covers, old, new, and everything in between.

A. Yeah.

Q. For the older estates --

A. Yeah.

Q. -- how practical was it from your perspective to ask them to rely on IPC when they had absolutely no possibility of being able to implement half the IPC measures?

A. Well, it's absolutely critical that these things are improved. You mentioned Watford hospital, and as an example of the things that I did to try to solve this

and other problems, is I commissioned a new hospital for Watford, and so Watford hospital is now being rebuilt as part of the New Hospital Programme. So that's one very, literally, concrete example of efforts to make this better in the future.

Q. You say that -- in relation to nosocomial infections you have been asked about any concerns that you were made aware of regarding adequacy of ventilation in hospitals.

A. Yes.

Q. You say, "I was highly concerned about IPC in hospitals including appropriate ventilation though this was of course a matter for the NHS".

A. Yeah.

Q. What did you do, if anything, to ask NHS leaders about improving ventilation in those settings, particularly in the older estate?

A. Well, that would've formed part of my discussions that I mentioned with the NHS leadership.

Q. But what did you actually do apart from discussing it with them?

A. The NHS was statutorily independent and so in asking or pushing them to do things, that was my responsibility. They were responsible. That's why -- so these questions are incredibly important and absolutely proper to ask the chief executive of the NHS.

Q. You've said that a number of times.

A. But that's because it's the answer.

Q. There may be many, though, that think that you as the head of the Department of Health and Social Care, these are appropriate questions for you to answer as well.

A. Yes --

Q. They are not suggesting -- let me just finish, please.

No one is suggesting, Mr Hancock, that you can walk down to Watford General and hand them over a bag of gowns or a roll of aprons, I understand that, but I do want to ask you about the practical steps you took as minister to ensure that these problems weren't happening.

A. Yes.

Q. That's why I'm asking you.

A. Yes, I understand that but I'm giving you answers because they are the truth. So I did all of those things. All the way from -- I actually did go down to an ambulance station in Deptford and personally helped move some of the PPE kit but, obviously, me doing that is not going to solve this problem, all the way through to rebuilding Watford General Hospital. But the day-to-day operational independence of the NHS means that whilst I could do everything I could within my remit, the responsibility for nosocomial infection

minimisation in the NHS is a matter for the NHS, and I'm sorry to keep coming to it, but that's because the accountabilities were clear.

You know, we've heard in other parts of the Inquiry, problems of muddied accountability. I'm being clear about the accountability. Now, as it happens, also, I'm not fatalistic about this either, because I thought that that statutory independence was wrong because I -- all I could do was push and ask, and therefore I drafted the bill, which became the health and social care act 2023 which revoked that statutory independence.

So, in a sense, that's another answer to your question, and certainly will help, I think, in the future.

But running systems of 1.4 million people through a filter of statutory independence is a challenge. But I say none of this to criticise Simon Stevens who did an absolutely brilliant job. I simply say it as an accurate answer to your question that many of them are -- would appropriately be directed to the person who was accountable for taking these decisions. And he, I'm sure, would say, rightly, that many of those responsibilities were for individual chief executives of individual hospitals, many of which he didn't have

statutory authority to direct. And that has been changed since the pandemic as part of the Act as well.

So the -- I'm simply being as clear as I can about the way that the system ran. It doesn't mean I didn't feel it. I felt it deeply.

Q. It's not that, but I'm sure he would say there were others under him, cells, no doubt, call them what you will, but doesn't the buck stop with you, Mr Hancock?

A. Yeah, that's why I'm answering the questions.

Q. Can I ask you this then, please. Was the need to improve ventilation in hospitals and healthcare settings an area of focus for the Department of Health and Social Care, not just the NHS?

A. Yes, yes. Also -- but all I can do is repeat the situation as it was. I can only explain how the system was run.

Q. Okay. A different, perhaps, aspect to IPC measures. Universal mask wearing was brought in on 5 June 2020. Masks for hospital staff, face coverings for visitors and outpatients. Do you think in the event of a future pandemic universal mask wearing in hospital settings should be brought in earlier?

A. It should be brought in immediately and supplies need to be ready preferably in each hospital to make that possible.

Q. Finally in relation to this topic, you've mentioned there supplies. The Inquiry has heard a great deal of evidence about FFP3 masks not fitting a diverse range of face types, ethnicities, indeed even not fitting women. When did that particular problem come to your attention?

A. It came to my attention at some point in the middle of the first wave, I think, or maybe a bit later than that. And -- but I in fact -- well, I attended a fit test with a number of ethnic minority nurses and saw for myself the difficulties that were caused by stock being, essentially, designed around one ethnicity.

Q. No, I -- so you became aware of it. It perhaps matters not precisely when it was in the first wave. I'm going to ask you again. Did you do anything about broadening the types of --

A. Yes.

Q. What did you do about it?

A. Again, my answer is the same. I raised this issue with the NHS.

Q. When you left office, as far as you were concerned, was there a more diverse range of FFP3 masks available?

A. I think so but I wouldn't be able to say whether it was fully adequate or not.

Q. Sticking with the issue of equalities or, indeed, inequalities, I suspect. You are aware, I think, that

certainly older people were more at risk but there was also a greater risk of severe Covid and, indeed, mortality for people from a black, Asian and minority ethnic community?

A. Yes.

Q. I think you were aware of that from about April 2020 when you said there was SAGE advice given to you identifying risk factors of which gender, ethnicity, obesity and, indeed, age were mentioned?

A. Well, there was --

Q. Can I ask the question.

A. Sorry, I thought --

Q. It's all right. The question I wanted to ask you was this. You became aware of it and you said you wanted the SAGE documents to be published. Do you know whether in fact those SAGE documents were published so that the public could see the people who may be at greater risk?

A. Yes.

Q. All right. Christopher Whitty has told us that those from black, Asian and minority ethnic communities, particularly in the first wave, black ethnicity were people of higher risk, south Asian ethnicity at greater risk in the second wave, they were more likely to get Covid severely, infection was more likely to lead to mortality.

Were you aware of those findings as a result of the PHE review in June 2020?

A. I was aware of this long before then, and the thing I was going to say when you asked the first part of your previous question was that the -- this wasn't just about the statistical and scientific reports whether from SAGE or from PHE. The first four doctors to die were all from ethnic minority backgrounds and several had come to the UK in order to work in the NHS. So I felt it very strongly. I saw it. And so yes, it came through in those officials reports but that PHE report came through long after this became absolutely crystal clear that this was a major problem.

Q. You say in your statement that your understanding that Covid-19 affected people according to various characteristics of which ethnicity was one was at the forefront of your mind throughout?

A. Yeah.

Q. But I am going to ask you what did you actually do about that?

A. The first thing I did was try to stop the spread of the various.

Q. Right. Was that through the IPC measures --

A. And lockdown.

Q. -- as we've discussed -- and lockdown.

A. Yes.
Q. Did you take any specific steps to address or try to address the disproportionate impact in the hospital settings on people of BAME origin?
A. Before the pandemic I had given a speech about institutional racism within the NHS. It is something that I was already worried about. The ability to tackle something deep-seated like that is very hard but I had raised the issue and brought in a series of measures essentially about empowering people to speak up.

I mean, before that in my time in government I'd been involved in this issue for instance when we did -- I introduced name-blind applications to the Civil Service. So this is an area that I care about, I knew about, and I was worried about. So I was highly alert to it when the first deaths of doctors were all people from ethnic minority backgrounds.

What I could -- given my responsibilities as opposed to the NHS's responsibilities, my responsibility was to make sure that people got -- that this was reduced as much as possible. The single biggest thing I could do was make sure that lockdown was strong enough. That was the best way to save lives across the board. There are a combination of sociological and, potentially, clinical reasons for this. And what the --

the next stage that we took was to try to understand how much of this problem was due to -- directly due to, if you like, a different genetic response to Covid according to ethnicity and how much of it was due to sociological situation, for instance the fact that more people exposed to the public in hospitals, like hospital porters and nurses, have a higher -- a much higher proportion are -- of people giving that public service are from ethnic minority backgrounds, and that was the purpose of the PHE report, and then the further work that was done by Minister Badenoch to try to get to the bottom of it.

What I'm trying to say is, I was absolutely aware of this problem. It's work I had already -- it's an area I'd already done work on before the pandemic and clearly it is a significant problem that needs to be addressed.

Q. Can I ask you about two WhatsApps, please, that you were involved in, in a chain with Helen Whately, who was the minister for social care at the time. This is in June 2020, so it's around -- just before, I think, the publication of the PHE review. Helen Whately says:

"One more thing on the NHS workforce -- I think the BAME next steps proposed are important but don't go far enough. There's systematic racism in some

parts of the NHS, as seen in the NHSBT."
A. Yes.
Q. Do you know what NHSBT stood for?
A. Yes, that's NHS blood and transplant --
Q. Thank you.
A. -- and they had recently -- it's all in the public domain -- in 2019 they had been involved in a significant -- there'd been an uncovering of racism within NHSBT.
Q. She says:

"Now could be a good moment it kick off a proper piece of work to investigate and tackle it."

You say:

"Yes, agree 100%."

A. Yes.
Q. Were you agreeing there to the systematic racism or the need --
A. Yes. Both.
Q. Thank you.

"Can you make that happen."

And Helen Whately says she would be delighted to. She's "on it."

Can I flash forward a year, please, to the end or nearer the end of this chain. 5 June 2020, so just before you leave office, you make reference to an E and

D glossary published by the NHS. You ask her:

"What do you think of this?"

She says:

"Odd, and not something the NHS should be doing -- no reason to have an NHS definition of colonialism ..."

She says:

"I hadn't seen it before. I do sense there's a gap between the approach the NHS has been taking on racism and inequality and the stance from no. 10/Kemi."

Who I think was the minister working on inequalities?

A. Minister Badenoch, yes.
Q. You say:

"Yes. Problem is there is a racism problem in the NHS. But I'm pretty sure this hard left stuff is not the way to tackle it."

A. Yes.
Q. She says:

"... agree. One to discuss after the recess?"

Now, Mr Hancock, I want to be clear about how that racism problem that you are seemingly acknowledging in those messages --

A. Yes.

Q. -- actually played out in the healthcare system's response to the pandemic. So not the wider issue?
A. I understand. As you can see, a year earlier we were discussing the problem of institutional racism in the NHS. Fast forward and one of the things the NHS has brought out is an equality and diversity guide, which if I remember it, had a glossary of terms that effectively followed a hard left critical race theory ideology.

My strong view is that racism was a problem and is best tackled by treating each individual as a person and being -- and treating the colour of their skin the same way as you would consider the colour of someone's eyes. Of course you need positive support to ensure that past barriers are removed, and -- but the problem is if you then -- if you instead start to try to treat people where the community they're from is more important than their individual personal capabilities, hopes and dreams, then you will end up making the problem worse not better. So that is what I -- that is an explanation of what I mean by that exchange.
Q. What I wanted to know, though, was, there may be many wider systemic problems in the NHS but can you think of a practical way that played out? We've looked at PPE not being sufficiently diverse --
A. Right, so --

Q. -- can you give another example how that racism affected the healthcare system's response?
A. In who is promoted to what roles.
Q. How did that affect the response of the health system to Covid?
A. Well, there are far, far fewer people from minority ethnic backgrounds promoted to senior roles within the NHS and when there is whistle-blowing by somebody from an ethnic minority background they are not taken as seriously in many instances. I could give examples but --
Q. We've heard lots.
A. The solution to that is positive support from people who may be from -- who are from backgrounds that have been affected, but also ensuring that the system treats everybody as an individual irrespective of the colour of their skin and the community that they come from. And the practical consequence of this is that there were far more people from ethnic minority backgrounds in the junior ranks within the NHS who are more likely to come into contact with patients and therefore more likely to catch Covid. And therefore there were more hospitalisations and more deaths as a result of this. So that's one example.

But it's something that needs to be sorted out

whether there's a pandemic or not.
Q. Can I ask about perhaps an allied topic. And that is vaccination as a condition of deployment, or VCOD, as it's called. I see you raise your eyes there.

I just want to spend a moment or two looking at this and we haven't, so that you know, featured majorly on this in the evidence to date.
A. Okay.
Q. So just take your time, please, Mr Hancock. I think the idea that there should be mandatory vaccinations for those working in healthcare and social care settings started to be discussed in cabinet, I think in March of 2021, and we note it's brought in in social care, and after you left there were plans to bring it in healthcare, all right? So some of this doesn't necessarily involve you.

But go back to the beginning, please. Can I ask, please, that we look on screen at INQ000092064, which should be a Covid-O meeting minute from the 17 March.
A. 2021?
Q. 2021, yeah. All right. And it starts with obviously bringing it in in social care but there are issues here which will impinge upon the decision to roll it out to NHS staff, all right? That's why I'm asking you about it.

And you can see there as you discussed VCOD in health and social care issues settings you said that:

"... this was a moral and practical issue. The moral case was clear, that carers should take all reasonable and proportionate steps to keep those they are caring for safe. There were also significant practical questions which were important and difficult. ... [DHSC] was proposing to bring into force the vaccination of staff at care homes for the over 65s as a ... first step."

All right? For you, what was the moral case for bringing in VCOD?
A. The moral case is that -- as it's set out here, if you are employed to care for others then you should take reasonable steps to ensure you are not harming those in your care. A clinically proven vaccine is a reasonable step that should be expected. I'm not in favour of -- we're not talking about vaccinating -- requiring vaccinations for everybody, we are talking -- I'm talking about requiring vaccinations for all those who then choose, through their employment, to put themselves in close proximity with people who may be very vulnerable to disease.

This -- as you say, this didn't come into force. I think that's a mistake. We did -- I did bring it in

in social care. I was persuaded to do social care first and then the NHS later. I regret that. We should have done it all at the same time. It should apply for flu vaccines as well and it's an irony that the very first meeting we had on Coronavirus right at the start of January 2020 was in fact a meeting about bringing in vaccination as a condition of deployment for flu in order to save lives and reduce winter pressures on the NHS.

Q. Putting aside your regret now that you didn't roll it out across both health and social care, we can see further down in the minute that you made the point there that in the NHS this was much less of an issue with over 90% of those in patient-facing roles having been vaccinated, figures are lower in London but climbing, but they were lower in social care. So that's one side of the argument.

The minister I think for care, if we go over the page, please, addresses some of the potential inequalities issues, which is why I wanted to ask you about it. She made the point:

"It would be important to address the fairness of why this policy was being applied to certain carer groups and not others."

Go down again. The policy could create

a challenge for the workforce where there's already significant vacancies.

And down again, please, to (e):

"Black, Asian and Minority Ethnic ... communities' hesitancy should not be underestimated and so, to mitigate this, the handing needed to be clear. The legislative proposals would feel authoritarian, so it was important to have families and trusted local voices in the sector ..."

So clearly a concern that it might impact on BAME communities.

Reflecting on the minister of care's observations there, do you agree with her statement the government needed to involve trusted local voices early on, if you're thinking about bringing in mandatory vaccinations of health and social care staff?

A. Yes.

Q. How might that in fact be rolled out, do you envisage? How do we bring in those voices?

A. Well, we actually had a lot of experience of doing that in the wider vaccination programme. For instance, one of the things we found was most effective in increasing vaccination rates amongst people from black, Asian and minority ethnic communities was to ensure that those doing the vaccinating and organising the vaccinating

were also from those communities, to help people feel safe.

The reasons for higher hesitancy amongst communities that feel -- that don't feel as connected to the authorities is widely reported and it's important to take it into account. The attitude that we had was that we shouldn't think of communities who were more hesitant as hard to reach, we should have the humility to accept that it's that the government and the authorities look more distant to some communities. And that's -- as government, that's our problem, not theirs.

And so there's lots of practical steps that you can then take, and all the work that Minister Zahawi led in the vaccine rollout to increase uptake amongst BAME communities could equally be applied within health and care settings.

Now, as it happened, the concerns over staff leaving didn't materialise. People did take the jab. And it brings me back to this point that we understood that were -- there would be concerns, but that doesn't make it anything -- any less a rational policy to require people who are caring for others to protect those others as much as is reasonably possible.

And if you look at point (a), Helen's point here is in fact we should have been doing it for the NHS as

well. She was saying that it might look -- why is this policy being applied to certain carer groups and not others? What she means there is: what on earth are we doing only doing this in social care? We need to be doing this in the NHS as well, where the problems, including of nosocomial infection, were, if anything, worse than in social care.

So, I was pushing for it for flu at the start of the pandemic. I pushed for it for both. I accepted, in the sort of practical necessity that happens in government sometimes, that it was better to do it in social care than in the NHS, and after I left they dropped it within the NHS. I think that's a mistake and it should be changed.

Q. All right. Do I take it then that in the event of a future pandemic, once there is a vaccine you would advocate for mandatory vaccinations for health and social care staff?

A. I would do that, and I would do it right from the -- right from the start. You know we made vaccinations available to people in -- working in health and social care as part of wave 1, right at the start. And I would make it mandatory as soon as there is a -- enough clinically validated vaccines.

Q. Final topic, please, if I may, before our afternoon

break. Can I ask you, please, about the monitoring of deaths of healthcare workers from Covid-19. From your perspective, was any department or organisation actually monitoring the deaths?

A. Yes.

Q. And who was that, please?

A. There wasn't right at the start -- but I would -- I got individual reports and then I set up a system for monitoring that and I can't remember whether it was NHS England or PHE who put that system in place. But at my instigation that was done, yeah.

Q. There is further work, I think that you asked to be done, in relation to investigations into deaths of healthcare workers.

And can we have up on screen, please, INQ000474567.

In May 2020 you wrote to Jeremy Hunt, who was the chair of the Health and Social Care Select Committee. You'd obviously been before them. And you undertook to confirm to the committee whether it was the HSIB that should be involved in investigation of death.

And if we scroll down the screen, you say you've looked into the best approach and you've set in place a process for medical examiners to review the deaths of health and social care workers from Covid. Whenever the

medical examiner becomes aware of a health and social care worker having died and believes there a is reason to suspect that the staff fatality was due to Coronavirus, there will be a process to notify the employer of the deceased member of staff.

A. Right.

Q. Do you know why there wasn't any investigation process in place prior to you making this clear in the letter to Mr Hunt?

A. No.

Q. We know that in due course the Department of Health published some guidance on this process and, to cut a long story short, if I may, Mr Hancock, by 2022 the National Medical Examiner's report stated that they had looked at, I think, 474 deaths, some which will be social care, some of which will be healthcare workers, and concluded that 357 of those cases, the healthcare worker had been exposed to Covid at work.

The Inquiry has heard evidence that reporting through the HSC under the RIDDOR, or Reporting of Injuries, Diseases and Dangerous Occurrence Regulations, to give it its formal title, that there was underreporting.

Now, were you aware of underreporting through the RIDDOR process?

A. I'm not surprised that there -- if there's been a finding of underreport --

Q. It's not quite what I asked you. I asked you whether you were aware that there had been a finding --

A. There's a deep statistical answer to that question, which is that none of this reporting was accurate at the start of the pandemic.

Q. Yes.

A. And underreporting is much more likely than overreporting in these circumstances. And as a trained statistician, I'd understand that the statistics you were given are only a guide to the actual underlying truth. And so I suppose I would have taken it as read that there'd be a degree of underreporting and that that needed to be improved over time, hence putting in a system.

Q. All right. Do you think then by the time you left office there was an adequate way of knowing how many people died and, if so, whether they had in fact acquired Covid or a future disease at work?

A. I'd say we had an improved estimation process, but because of the impossibility of knowing for sure the source of an infection, in fact, it -- the numbers are unknowable, and I would caution against spurious accuracy in this example.

So, for instance, the paper that you brought up earlier that had the exact number of deaths from hospital-acquired infection, you know, that -- that is the reported number. It is an estimate. Because whether somebody acquired an infection in hospital or in the community is not always clear. And I would suggest that 4 degrees of accuracy down to the individual single figure is not appropriate. There needs to be a degree of rounding in those estimates and an acceptance that sometimes you don't know where an infection has come from.

Q. No, I follow that, but the hospital-acquired -- or hospital-onset, hospital-acquired was for those people who had tested positive 15 days after their admission to hospital, and PHE were pretty certain that if you were getting tested positive 15 days in, you'd caught it in the hospital. That's why I focused not on the suspected, not on the probables, but on those where there was pretty good certainty that you'd got it in the hospital.

I don't want anyone to misunderstand you, are you quibbling with the figures that were provided by PHE about the number of people that caught and indeed died from it?

A. I'm not -- I wouldn't quibble. What I'd say is that, in

understanding all of these things, you have to understand that there is a degree of uncertainty over all of the figures.

You know, we had the same with how do you measure deaths from Covid or deaths with Covid and at what point is there a cut-off from having had Covid to dying, because Covid was underreported on death certificates.

So all of these things, all of these statistical techniques are the -- are your -- are the best way, and we improved them over time, but they're effectively the best way of trying to measure something rather than an absolute concrete figure.

MS CAREY: Would that be a convenient moment?

LADY HALLETT: Certainly. I shall return at 3.05.

(2.50 pm)

(A short break)

(3.05 pm)

LADY HALLETT: Ms Carey.

MS CAREY: Thank you, my Lady.

Mr Hancock, can we discuss briefly the shielding programme. Just so that you know, we've heard from Professor Whitty and a number of others about how it was set up, who made the list, who didn't make the list. I'm not going to ask you about that, all right.

A. Yes.

Q. But I think one of the points that make in your statement is that there were difficulties certainly at the beginning linking data between various either government departments or computer systems to enable you to contact the individuals that were going onto the shielding list. All right?

And you say in your statement that you were ultimately required to issue four notices under the control of patient information regulations to help the NHS share the relevant data. Is that right?

A. Yes.

Q. All right.

And in the run-up to the issuing of those notices, could we have a look on screen, please, at INQ000478857.

13 March 2020, so just before we go into lockdown:

"[Secretary of State] is happy with all approaches.

"1. He is happy [for] NHS direct" --

A. No, "happy to direct".

Q. Sorry, you're quite right.

"... happy to direct [NHS Direct] to collect, analyse and disseminate data to DHSC and NHSX through ..."

A. Section 254, yeah.

Q. Yes. And the notice under the control of patient

information.

"2. He agrees not to explore regulations at this stage under GDPR.

"3. He agrees to extend the data opt out for 6 months. He has asked for more advice about if he can delay indefinitely."

I just want your help with that final bullet. What were you trying to achieve, if I can put it like that?

A. Okay, so the four copy notices, of which one was very significantly the most important, were put in place to allow the NHS to use data more effectively and to share data through any secure platform, whereas previously the rules had -- had the effect of requiring data shared across the NHS to be done so on NHS systems. So NHS has its own email address -- email system, for instance, whereas there's perfectly adequate ones that can be -- that are much better and much more secure, that could be brought in from outside.

So the effect of the copy notice, what we did was we wrote it on -- it ended up on two sides of A4, to get down to the front line to say: you can share data properly, effectively, so long as it's on a secure system. But it doesn't have to be according to the unbelievably complicated rules that had grown up in the

past.

Q. So this was to help the shielding letters go out?

A. Yes. So with the shielding letters, that was specifically about allowing the data to be shared between DWP and the NHS.

And "NHSD" here is NHS Digital, who have the statutory responsibility for protection of data in the NHS.

Q. But the referencing to opting out and asking to delay indefinitely, what were you trying to achieve there?

A. Oh I wanted this new system which was going to be much more effective, and turned out to be much more effective, to be permanent.

Q. Right.

A. And it's a mistake that it was rolled back. And actually there is legislation in front of Parliament now to allow us to get back to where we were in the pandemic when the effective use of data, in a modern way, was much -- was the best it's ever been in the NHS, and then unfortunately it has sort of encroached backwards again.

Q. All right. Do you think the inability to share data easily without a copy notice hampered the ability of the healthcare system to respond?

A. Well, we put in place pretty early, so Matthew Gould, the head of NHSX, and Simon Madden, who wrote this note,

did incredible work early on to spot that this was going to be a problem and then to get across it. There were some instances, like putting together the shielding list, where there were -- it was a practical problem, and so there were concrete use cases for it, but they had spotted early enough that this was absolutely necessary. And it went on to, for instance, underpin the effectiveness of the vaccine programme.

Q. A number of witnesses have spoken about either paucity or total absence of data in various respects, often in relation to ethnicity collection and the like, and have urged upon her Ladyship to consider making data recommendations.

A. Yes.

Q. Do you have any data recommendation to make?

A. Oh --

Q. What is it, please?

A. Yes, please. Can I -- I'm going to answer off the top of my head but I would be very happy to write afterwards because it's a subject I feel very strongly about, because I think the NHS can only operate effectively if it had has much more modern and effective data sharing systems.

Q. Can I ask you to focus your answer on the pandemic response.

A. Yes. Yes, I'll give you two concrete examples.

One is the collection of data for management purposes, which we've discussed in relation to understanding how many beds the NHS effectively has. That system has improved a huge amount and last year the NHS let a contract to allow for that to be done much more widely across the NHS.

So, in a way, there it's: keep pushing and using modern data better. Using data -- keep using data better in a modern way.

But the area that's most important is the ability for anybody who needs it, who has the consent to see it, can see somebody's individual data to be able to treat them and see all the other treatments that they've had. That includes ethnicity data but also all of the data that's pertinent to that treatment. And that is needed in normal times but, by God, it's critical in a pandemic.

The third area is data -- I said two, I know, but the third is also important which is use of data properly for the organisation of provision of services. So, for instance, telling people when they can come. The whole 111 First system that we talked about, being able to turn that initial phone call into an appointment and make sure that the medical records and the doctor or

nurse or appropriate clinician is there and a room booked or a place booked for that to happen, that is essentially a data issue and unless you essentially completely free up the use of data within the NHS, we are never going to solve that problem.

Q. Can I come back to shielding, please.

A. Yes.

Q. We know that DHSC was one of a number of departments that fed into the shielding programme as it was rolled out, but from the department's perspective and your perspective as minster, did you make any steps to try and ascertain whether the shielding programme worked in the sense that it prevented the most vulnerable people from becoming infected?

A. Yes, there was work done to assess the impact of the shielding programme. There is another difficulty of measurement here, because there was not a control group, as in everybody who we thought needed shielding we put into the shielding programme. We didn't hold a group back and say we won't apply the same support to them because then we can measure that, as would you in, for instance, a clinical trial. That means that it is harder to measure.

That emphatically does not mean that it wasn't a success, and I've seen some paperwork put before

the Inquiry which implies that the shielding programme wasn't effective. That is completely untrue. There is no reasonable assessment of the shielding programme that can find that if you give people support and ask them to protect themselves from interactions with others then they are anything but less likely to die of Covid. And, of course, there were higher -- a higher proportion of deaths amongst the shielded population than there were amongst the population at large and that's because they were vulnerable. That's who was brought into the shielding programme.

Q. All right. You made reference there to the Inquiry seeing some paperwork that implied the shielding programme wasn't effective. That's not quite an accurate representation of what Professor Snooks told us. But can I ask you, do you think the high level of hospital transmission, or hospital-acquired Covid, undermined the efficacy of shielding because if you put a vulnerable person into hospital where they're more likely to catch it, you are thereby infecting the very person you wanted to protect.

That's what she was driving at, so "untrue" might be perhaps an unfair characterisation.

A. Well, except because you can't conclude this, therefore it didn't save lives. That was my reading of it and is

not accurate.

If that wasn't the intended interpretation then that's good.

The answer to your question is "no". Because without shielding, unfortunately, because of the extent of nosocomial infection, people going into hospital would be even more badly affected because you'd still have the hospital-acquired infections but you'd have more community-acquired infections. And also shielding did mean that GPs knew which of their patients were regarded by the data to be most likely to be vulnerable, and therefore who they needed to give extra support to, and protect from potential risk of infection.

So no, I don't think that hospital-acquired infections, they were obviously a bad thing but they didn't undermine shielding at all.

Q. And finally on shielding, were you involved in any discussions about specific measures that might address the heightened risk for the clinically vulnerable who had to attend healthcare appointments?

A. The which risk? The hospital risk?

Q. Yes, the heightened -- I said heightened risk.

A. The heightened risk?

Q. Let me ask you go again. Were you involved in any discussions about the specific measures that might

address the heightened risk that clinically vulnerable people faced when going to healthcare appointments?

A. Not that I can recall.

Q. You mentioned GPs and shielding. Clearly the rollout of the shielding programme had another -- added a burden to them in that regard because they had to monitor the list. Can I ask you about a different aspect of GP response, and I think the BMA wrote to you on 18 May.

Can we have a look at INQ000097897, please.

We're in May '21 here, Mr Hancock --

A. Yes.

Q. -- and the BMA wrote to you expressing widespread anger, frustration and disappointment of the GP workforce and requesting a meeting with you.

A. Yeah.

Q. And if you scroll down the screen, please, can you see the paragraph beginning "Despite the incredible work done by GPs"?

A. Yeah.

Q. "... and their teams over the last year to care for our patients ... do not feel supported ... This feeling is further exacerbated by sections of the media reporting that practices are to blame for not seeing all patients in face-to-face consultations. Practices have been open to their patients throughout the pandemic, and at least

half of all appointments have been delivered in person. This is something that should be celebrated", but instead the profession feels let down and demoralised at the suggestion that they are failing their patients.

A. Yes.

Q. Had you or the department been involved in blaming, in any way, GPs for what is perceived to be a lack of face-to-face consultations?

A. No, on the contrary. I was and am a strong supporter of virtual consultations. There were discussions in the media about the requirement to have more face-to-face GP appointments. I didn't subscribe to that view, whatsoever, and in fact went out of my way to make the case for online consultations, and still do. It doesn't matter -- it's more important in a pandemic but it should still be a core part of the service that GPs provide to provide online and telephone services.

So I agreed with this -- I agreed with the thrust of what Richard Vautrey was saying here but obviously I didn't agree at all with the political spin that he puts on it. And, actually, that didn't accord with my widespread discussions with GPs on the ground, for instance the royal college or GPs in my constituency but, you know, the BMA GP committee is a particular beast.

Q. Do you think, though, that in the strong support given by you and others to virtual consultations that led to a perception that face-to-face appointments had been stopped?

A. No, I don't think that's fair at all. There were some media reports saying we want more face-to-face consultations and I was saying no, we want more -- there are too many face-to-face consultations. So I wasn't say that at all, no.

Q. So although you were encouraging virtual appointments, you were not trying to discourage face-to-face or say that there weren't any face-to-face; have I understood you correctly?

A. That's right, and the worry expressed, which I understand, in this paragraph was a worry about, as he puts it, sections of the media who were making this argument and I thought that the argument that GP appointments ought to be face-to-face and there's a sort of values-based argument I thought that was a load of rubbish.

Q. I understand that you disagree with the sentiment but people's perception might be a different matter. Did you hear reports of people perceiving that GPs were not open for face-to-face consultations?

A. Yes, of course.

Q. And what do you think caused that perception, given that you acknowledge that you heard about it?
A. There was a push to have more virtual consultations and that was the right thing. So there was some push-back against a change in the right direction. If you -- but this happens often when you're trying to change something. The point about this letter is I was, essentially, in agreement with where Richard was coming from.
Q. All right. In the rollout or increased use of virtual consultations, can you help with what consideration was given to those that may not be able to access either a telephone or --
A. Yeah.
Q. Let me finish, please -- particularly perhaps those who are unfamiliar with virtual appointments, those for whom English is not their first language, those who have poor internet connectivity, and the like, what did you do to try and address those particular impacts?
A. Well, the first thing I did was increase the use of non-face-to-face and virtual appointments because increasing virtual appointments frees up space for people who want face-to-face appointments. So the argument that you put I understand, has been levelled at me many times in my enthusiasm for supporting people in

the NHS where they are and what's convenient to them, which often means virtual appointments, but it doesn't always mean virtual appointments. There are always going to be some people who need to have a face-to-face appointment either because of the nature of their medical problem or because they may never use a computer.

The point is that if you have a more efficient system using modern technology you free up space for more of that rather than less. I'm totally against an online-only system whilst being very enthusiastic about the availability of online.

Q. Sticking with primary care, can I ask you about pharmacies, please. We have heard evidence that the national PPE supply was not accessible to community pharmacists, they couldn't get FFP3 masks, they couldn't access the PPE portal until August 2020. Do you know why there was a delay in allowing community pharmacists access to that PPE portal?
A. They were -- it's a very good question. The -- and as you'll know from the paperwork, I pushed for them to have that access, and eventually that happened. In a world of highly-constrained PPE availability we had to be careful to ensure it got to where it was most needed and there's a hierarchy of that. But I wanted it to be

available to pharmacists.

Also, you've got to remember that pharmacists are private businesses and outside of the pandemic of course they buy their own protective equipment in the same way that most social care providers are private businesses, and before the pandemic they buy their own equipment. So the government was not the only provider of PPE in this situation.

Obviously for the state-owned hospital system, the core NHS, we were, although hospitals buying their own PPE without NHS England or the central government having anything to do with it is a good thing, not a bad thing in these circumstances. So there's a balance to be struck between about who the state provides for and also how, given, we, as the state, have limited access, how that is then distributed.

Q. So is the answer that in times of constrained supply, community pharmacists, rightly or wrongly, were deemed to be lower in the priority for people that needed access to the PPE portal?
A. That is accurate. Yes.
Q. And another aspect of pharmacy that I want to ask you about is the life assurance scheme.

Now, Mr Hancock, you wanted from very early on all staff to be included in the life assurance scheme --

A. Yes.
Q. -- and you made that clear in an email, I don't need to call it up, back on 11 April.
A. Right.
Q. The scheme is then rolled out on 27 April and pharmacies in a hospital or GP setting were included but those in community pharmacy certainly felt that they were excluded and Sir Christopher Wormald didn't disagree about that. If you, back on the 11th, said, "All pharmacy staff to be included", can you help with why, when the scheme was announced, they weren't or it wasn't made explicitly clear that they weren't included?
A. Didn't we clear that up shortly afterwards?
Q. Yes, you did, but that's not what I am asking. We'll come to the clear up in a moment.
A. If you want the -- I'm going to give you the brutally honest answer to this with some trepidation because of our earlier discussion about accountabilities, Chair. The pharmacy contract is managed by NHS England. In order to maximise taxpayer value for money, NHS England is, by tradition, really very tight on pharmacists -- I am a big supporter of community pharmacy -- and there is, therefore, inbuilt into NHS England senior management a lack of enthusiasm for giving more to community pharmacists than they absolutely have to and

that's borne of the fact that their main relationship is a contractual negotiation and that, I think, is probably the reason that they did it this way.

But I've tried to describe that in a way that doesn't -- that is an explanation rather than trying to you know ...

Q. Can I just ask you about that. I asked Sir Chris Wormald and he said that the reason they weren't initially included was because it wasn't agreed by the Treasury, nothing to do with NHS England. Were you aware that the decision -- that all pharmacies -- and it ended up only being pharmacists and GPs in hospitals was a Treasury_related decision? It sounded like you're saying --

A. I wasn't aware of it. But I -- in the dynamic of how hard we pushed, that will have been the end -- that will have been the last thing on the list, I would have thought, from an NHS England point of view.

Q. So -- there is a disconnect, if I can put it like that, between what he told us and what you told us and what I want to ask you about is the effect on the pharmacists --

A. Yeah.

Q. -- because clearly -- you're right, within three days you'd made it clear it was to apply to all of them, but

we've heard evidence, particularly from the National Pharmacy Association, that even three-day wait for them was demoralising, demotivating, and they think that effectively community pharmacists are being treated as an afterthought?

A. Yeah, so my impression of the system, and if there's a Treasury element to this as well then you'll see that in the paperwork -- I wasn't aware of that or at least I don't recollect it. But you're absolutely right, my sense was also that the system was not looking after community pharmacists enough. That was my feeling too. And hence I changed it as soon as I could. But it was -- that's a -- it's -- that is a classic of how decisions get put together in those situations. You know, you become Secretary of State and you think, "My God, I'm responsible for £150 billion budget" and then you find there's all sorts of constraints on what you can do because others have different views and attitudes and this is an example of that.

Q. If your impression of the system was that pharmacies were something of an afterthought and yet you're encouraging people to go to your pharmacies to pick up medication for those that are clinically vulnerable and shielding, go there rather than going to a GP for medication, why weren't pharmacists higher up in your

mind and the mind of the department?

A. No, you completely misunderstood my last answer. They were absolutely top of my mind. But I couldn't necessarily drive that through the system.

Q. Well, if it's a misunderstanding then it's mine. Is your evidence, Mr Hancock, that they weren't an afterthought as far as you were concerned?

A. Not as far as I was concerned, but they evidently were as far as the system was concerned because of how that announcement came out. If you take it through the evidence that we've been looking at in the last couple of minutes, I said it should be all pharmacies.

Q. You did, yes.

A. The report -- the answer -- the formal documentation came out saying it was only the NHS pharmacies. I -- once I found that out I would have been -- I would have probably expressed my frustration in Anglo-Saxon terms and said, "I'm going to sort this out" and so I got on the -- the next time I was in front of the -- in public I made clear that this was going to everybody and I would have had to fix it.

Now, that sort of problem is meat and drink in Whitehall, it happens all the time. And you just -- it's just part of the daily life of an active minister that you have to go and fix problems all the time and

then take accountability for the system as a whole.

Q. Can I move on to Long Covid, please. We have heard evidence that it was known at the start of the pandemic it was likely there would be long-term effects caused by the virus even if we didn't know precisely what they were, how severe they would be and how many people might contract Long Covid.

A. Yeah.

Q. Were you made aware there would be some long-term effects even if the precise nature of the effects were not known at that stage?

A. Yes, I recall discussing this with Chris Whitty in January 2020.

Q. Right, okay. And given that it was known that there would be some, what, if anything, did you decide to do to try and work out what they were, how they could be managed, how they could be treated?

A. Yeah. So, obviously, before there were any Covid cases there was nothing that you could do about this, and the only thing you could do is try to reduce the number of Covid cases, ie bringing in a lockdown.

By around May/June 2020, I was aware of this being a problem, not least because it affected people close to my heart. My mother still suffers from Long Covid from that first wave. So this is very -- this is close to my

heart. So in around June I convened experts and the NHS and others to try to understand what we knew by then. This, of course -- June is only two months after the peak of the first wave so people's slow recovery was only just becoming evident and the -- and then there was a whole -- we established a Long Covid clinic.

Q. I'm going to come on to those. Just to help you, in fact it was in May 2020 that you asked Sir Simon Stevens to develop plans for provision of those suffering with Long Covid.

A. Right.

Q. When you said you wanted him to develop plans for providing for those suffering, what were you talking about, financial provision, medical provision, pastoral support? What were you thinking about?

A. Yes, primarily medical provision, primarily medical provision, but across the board. So if that was in May 2020, you know, this is less than four weeks after the peak. So people couldn't have presented with Long Covid, longer than four weeks after infection. And so that will have been in anticipation of there being Long Covid as a concept, if you like. And it was definitely before there was a name "Long Covid" that I was pushing to ensure we were ready to support those who got it.

Q. We know you set up the roundtables. I don't need to ask you about those. That detail is set out in your statement, Mr Hancock. But you did identify that further research may be needed and in particular you asked for further research on those that were not hospitalised but still got Long Covid. Why did you ask for research to be done to that cohort of sufferers?

A. Because the evidence was that the severity of your first bout of Covid was not correlated with your likelihood of long-term symptoms, my mother included, she was not hospitalised and we're four years later and she still suffers the effects. And so the early research showed that there didn't appear such a correlation between severity and longevity of the Covid problems. And so just analysing the impact of Long Covid from people who are hospitalised missed a whole load of the patients.

Q. Now, you mentioned Long Covid clinics. When they were announced or launched there was initially, I think, 40 clinics in November 2020, and by June, 11 June, so just before you left office, now 80 clinics were up and running. But why were Long Covid clinics decided to be the best option for England? Can you help with that?

A. The reason is that Long Covid presents in a very wide array of ways and part of the problem with the research was, unlike Covid itself, there was not a clear and

simple presentation. My best understanding of it is that Long Covid is often where the neurological elements of the Covid viral impact are long-standing, are more -- are a bigger thing than the immediate impact which was essentially respiratory. And neurological conditions are by their nature much more difficult to research, and so it was needed to have a cohort to study to see these broad presentations of Long Covid.

There's another aspect as well, which is that I thought if I just said to the NHS, "Just look after" -- you know, "Make sure you look out for Long Covid", it would have just gone into the ether and nothing would have happened, whereas if you have specific Long Covid budgets with specific dedicated clinical and other staff, and a specific budget, including a research budget, then you will actually get some action that you can -- that's trackable and you can follow.

Q. So were you actually involved, then, in saying you wanted X million, or whatever it was, spent on Long Covid research and X million on Long Covid clinics?

A. So it will have come from within the NHS budget. So it will have been -- Simon will have found the budget for it, I think and -- but -- and so his decision over exactly how much to put into it. What I was doing was

driving action on the NHS side of the fence.

It comes back to the discussion we've had a number of times, what do you as Secretary of State if something is an NHS responsibility? The answer is, in this case, I convened a roundtable, I pushed Sir Simon Stevens and then -- but he took the action.

Q. Right, so in this example you asked for there to be greater funding for research and clinics and you said to him, over to him, and he did it. Did you monitor to ensure he had put into place that which you had envisaged?

A. Yes, there were a series of meetings and, in fact, I visited some of the Long Covid clinics.

Q. Whilst you were Secretary of State, were you aware if there was any monitoring of the number of healthcare workers who contracted Long Covid?

A. I think there was but I haven't got the evidence in front of me.

Q. No, we're not sure that there was, actually, that data in fact --

A. If there wasn't, there should have been.

Q. Well, that's why I was going to ask.

A. Yeah.

Q. Why do you say there should have been that data collected?

A. Because you'd want to know what the impact is on the NHS workforce.
Q. By the time you left office, do you know whether that data had been collected?
A. I don't know.
Q. Would you suggest that should be a matter for NHS England, or it should be collected --
A. Yeah, it's their workforce.
Q. All right. Does it follow from what you've said, then, that whilst you were Secretary of State you weren't able to assess the extent of absence in the health and social care system that was caused by Long Covid?
A. No, that would have been matter for the Chief People Officer of the NHS, Prerana Issar, who was absolutely brilliant and I do recall talking to her about this subject.

The other thing to say in this space is not only did I follow up with the NHS but I also received submissions from the various Long Covid support groups who felt that not enough was being done. So I knew that there was a sense that not enough was being done and I was pushing the NHS to do more, and they did do more, and opened more clinics and did the research.
Q. Finally this please, recommendations.

If you had to give a recommendation to

her Ladyship as to how to improve the healthcare system that is not related to lockdown, Mr Hancock, what would your recommendation be?
A. Well, I think in normal times having the NHS run at less than 100% capacity will increase the resilience of the -- in the NHS.
Q. Can I pause you there. That's a political decision as to how to fund the NHS and how they choose to run at capacity and it might be outwith her Ladyship's remit to say we should have 10,000 more beds or whatever it be.
A. Most of these decisions are essentially political decisions -- deciding to lock down is a political decision -- in the finest sense that politics is how we make decisions in this country at the highest level. The Inquiry is surely able to make any recommendations it should choose.

The second thing is about use of data. My view is that the NHS will only survive if it gets better at the use of data, and in a pandemic that's even more important. For the three -- in the three areas that I suggested and indeed research, a fourth. And I would hope there would be recommendations on that because we did, in the -- we do have this example of the COPI notices and, within the NHS, the vaccine rollout as well, as high, high quality data improvements that have

not been repeated since. So we should learn from them.

And then I suppose the third is the ability to surge. You know, we put together an ability to surge in realtime but a more considered structured plan to be able to surge NHS capacity would be valuable. You know, if there were, God forbid, a pandemic to hit tomorrow, of course we'd be able to do it better because the people involved would be able to use the learnings from last time. But if we can find ways to make that more thought through and programmatic, if you like, then that would be a good thing.

MS CAREY: Mr Hancock, thank you, that's all the questions I ask.

My Lady, there may be some time for some --

LADY HALLETT: Thank you, certainly, and I gather, Mr Thomas, you'd quite like to get some questions in this afternoon. And you're not attending remotely unless you are a hologram, are you!

Questions from PROFESSOR THOMAS KC

PROFESSOR THOMAS: Good afternoon, Mr Hancock.

Just to remind you, we've met before, I represent FEMHO, the Federation of Ethnic Minority Healthcare Organisations.

My Lady, just so that you can follow my questioning, I'm actually going to start with my sixth

question, because that piggybacks on some of the questions --

LADY HALLETT: Thank you.

PROFESSOR THOMAS: -- and I'll revert back to the order.

Can I just correct you, Mr Hancock, on something you said earlier. I think it's my duty to do so.

You said in your evidence that the first four doctors who died were doctors of colour. It was ten. It was the first ten doctors. And it's important that I correct you on that. Do you accept that?
A. I accept -- I'm sure that you have the evidence for that. The first four -- it was -- my point, I suppose, is an even stronger one, which is that when I saw that the first four were, I knew that there was -- we had a major problem.
Q. Yes. And then six follows, the next six were black and brown. Okay.

When we met during Module 2, we were in fact in agreement about, to use your words, the long-standing issue of racism within the NHS, which you told us was an issue that you were heavily involved in and one that you'd been concerned about well before the pandemic and you have just been speaking to Ms Carey about the speech that you gave and so on.

Can I ask you this. In the light of the evidence

to this module from impact witnesses and experts, and of your own concern about racism within the NHS prior to the pandemic, I'm sure we can agree on this, that structural racism is likely to have been a contributing factor to the disproportionate impact on ethnic minority workers and patients. Can we agree on that?

A. Yes, we can. Yes.

Q. Mr Hancock, if that is right though, then the assertion you made earlier to Ms Carey, and I'm summarising here so forgive me because it's a summary of what you were saying, effectively that by working and trying to lock down to prevent the spread, so, you know, not specifically targeting but going for the whole, treating everyone as one mass unit, irrespective of race, that fails to address, does it not, the systemic nature of the problem? Because systemic racism operates through institutional structures, policies and practices that perpetrate unequal outcomes for minority groups.

Would you not agree with that?

A. I would agree with the thrust of it, but I'd say that the solution to that is to treat everybody as an individual. The solution to that is not to segregate society into communities, it is -- but it is to address precisely those -- the barriers that you talk about.

Q. But, Mr Hancock, just if I may just push back slightly

on what you've said, respectfully.

You see, addressing these disparities requires tailored, equity-focused measures not a colour blind approach that ignores underlying structural barriers. Take, for example, the example that you gave earlier which, with respect, oversimplifies the problem. You will agree with this, surely, that eye colour has no historical, social or systemic impact on a person's opportunities. You will agree with that?

A. Yes.

Q. But race and colour does. Race and colour is well documented to influence people's experience and lived experience. So you can't compare the two.

A. No. Absolutely not. But I do want to live in a world where I could. And that's the point. And in fact in your -- in the earlier part of your statement just then, you said you can't be colour blind not taking into account the barriers that people face. In fact my answer was we need to remove those barriers. So I feel very strongly about this, in agreement to -- with the essence of what you're saying.

Q. All right. I'll come back on to the questions and let me see if I can get through these questions as quickly as I can.

I want to turn to the question of staff ratios and

risk assessment. You approved the dilution of critical care staff ratios to manage Covid-19 patients.

Question, were you aware of or seek reassurance from Simon Stevens on whether specific risk assessments were to be conducted to evaluate the impact of this decision on the safety and well-being of healthcare workers from black, Asian and minority ethnic communities who were overrepresented, proportionately, in frontline workers?

A. Well, I think it would have been impossible accurately to make that sort of assessment for two reasons. The first is, at that stage in the pandemic we didn't know what the impact was going to be, because it was a completely novel virus. And the second reason is that we had to make these decision incredibly quickly, and to hold up a decision whilst doing a full risk assessment would have led to, in my assessment, much worse outcomes overall.

Q. Mr Hancock, in hindsight would you recommend additional safeguards and measures to ensure that such decisions did not disproportionately impact black, Asian and minority ethnic healthcare workers in the future?

A. I would recommend that the disproportionate impact is taken into account in making those sorts of decisions according to what is likely to save most lives.

Q. Would you agree with this, that periodic targeted

reviews of frontline staff, feedback, would have been an additional safeguard and something to consider going forward?

A. Yes, and I tried to put that in place before the pandemic. In fact it was one of the things that I was working on after the speech that I mentioned in 2019. I think that's very important.

I mean, after all, break -- you know, breaking down the barriers that you talk about is not -- it's not a glib thing, there's a whole series of policy that need to be put in place to make that happen.

Q. Before deciding to stretch staff ratios in critical care settings, did you consult with the Chief Nursing Officer or any other senior medical advisers or NHS England about the impact and potential strain on NHS workers, what that strain would be?

A. Absolutely, yes. It was front of mind.

Q. I want to turn now to PPE.

In your witness statement you acknowledge challenges in the supply of PPE. Chris Wormald gave evidence to this Inquiry in Module 1 admitting that the department had stopped PPE that would be suitable for ethnic minority healthcare workers in smaller quantities. Were you aware of this?

A. I became aware of it. I wasn't aware of it at the

start.
Q. When did it come to your attention and what if any action did you take?
A. I'm not exactly sure. It will have been some time in the first half of 2020. And the action that I took was to require that the PPE we were buying was the right PPE for the workforce that we had in the NHS, which is disproportionately from an ethnic minority background.
Q. Were you aware that healthcare workers from black, Asian and minority ethnic backgrounds faced additional challenges sourcing and being provided with adequate and appropriate PPE?
A. Yes. And in fact I went to a fit test where the nurse doing the fit test was from -- was black and I could see -- physically see for myself the challenges of mask fitting. She was doing a fit test for me.
Q. Tell me this, when did you become aware of this, when did it become apparent?
A. Again, in the first half of 2020. I can't remember an exact date.
Q. What steps did you take to ensure that healthcare workers, particularly those from minority backgrounds, received adequate and high quality PPE in a timely manner?
A. Well, I gave the instruction to start buying PPE in

January 2020. So it was something that I was aware of and acting on from before -- well before the pandemic hit the UK.
Q. So what happened then? Why didn't -- why were there still problems in the pipeline?
A. Well, how long have you got? I mean, there's the problems of the fact that we had a stockpile that couldn't easily be picked. The fact that the demand for PPE shot up both in the UK, when we brought in the IPC measures, but then also globally, because this was a global pandemic, buying PPE became more difficult. Even with a -- even if we'd had a stockpile twice the size, that still would have been less than 10% of what we needed over the entire pandemic.

So, you know, there's a whole -- there's a huge amount of detail on what I did to procure the PPE, as much PPE as we could get our hands on. And, you know, I'm -- the department's criticised for buying too much PPE, for buying too little PPE, to buying too much PPE too expensively. What we were trying to do was save as many lives as possible.
Q. Well, I think, in fairness, it was also criticised for buying the wrong PPE?
A. Absolutely. And the stockpiling having the wrong PPE in it. So all these things.

Q. Let me move on. To what extent was PPE availability monitored with specific attention to black, Asian and minority ethnic healthcare workers?
A. Well, I'm not sure it was monitored enough at the start, and that monitoring got better over time. And one of the key lessons is we need to make sure that the PPE that is stockpiled and then bought in any future pandemic fits the workforce that we have.
Q. I think we can agree on the next question, but let me put it to you in any event. We can agree that black, Asian and minority ethnic healthcare workers were more likely to be on the front line in patient-facing roles, and were disproportionately affected by a lack of suitable PPE; can we agree on that?
A. We can certainly agree on the first half of it. And there's excellent evidence from, for instance, Ben Goldacre, who did very good statistical work on this, but I also -- I also saw it for myself. I was a big champion of the workforce of the NHS and, in particular, those from ethnic minority backgrounds and also those from whatever ethnic background who'd come to the UK in order to serve in the NHS, yes.
Q. Would you also agree that there was a lack of adequate consideration for variation of facial features between ethnicities?

A. Yes.
Q. And this standardised PPE was not providing -- well, I think you've already touched upon it.
A. Yes, yes, yes. Yes, I strongly agree with you.
Q. To whom and/or to which bodies would you attribute the responsibility for the lack of suitable PPE available for minority workers?
A. Well, the stockpile was managed by PHE. But they reported into the department.
Q. Let me come to my final question. And I want to be forward facing and look to lessons for the future. In the light of your firsthand experience and engagement with healthcare workers during the pandemic, what do you think can and should be done to reduce inequalities for black, Asian and minority ethnic healthcare workers in the event of a future pandemic?
A. There's so many things that need to be done.

I think that the HR systems of the NHS need to be colour blind, for instance making sure that when people go for promotion that that is done on entirely on merit. I think there are practical things that can be done, like the PPE that we've talked about but including extra support, mentoring for members -- for members of the team from an ethnic minority background. But bigger than all of those things is a culture and a culture

change. Because people love the NHS, and I love the NHS, we are cautious about criticising it, but this is an issue that need to be resolved within the NHS because the NHS couldn't exist without its ethnic minority workforce and doesn't do enough to support them.

Q. Can I just touch on one thing you said there, and I'm going to come back to the colour blind. Same point, you can't have a colour blind system where you have structural barriers; would you agree?

A. Yes, you've got to -- but the answer to that is to break down the barriers. That's my --

Q. So that comes first. That has to come first before you can have a colour blind system?

A. Exactly.

PROFESSOR THOMAS: My Lady, I think I'm within time.

LADY HALLETT: Thank you very much.

Thank you, Mr Thomas.

Mr Jory, do you want to get your questions in tonight?

Questions from MR JORY KC

MR JORY: Good afternoon, Mr Hancock, I ask questions on behalf of the Independent Ambulance Association.

It appears that neither the independent ambulance sector nor the College of Paramedics were consulted regarding Covid measures prior to their imposition in

early 2020. The College of Paramedics sought guidance in a letter they wrote directly to you on 20 March 2020.

I've got the reference for that but we don't need to perhaps look at it.

There was no specific response from you or your department but can I make clear, she and we attach no criticism given the circumstances at the time, but when the college did receive guidance from Public Health England this did not seem to take into account the unique challenges of working in an ambulance.

Now, I summarise, but I hope fairly what appears to be your general view expressed here to Counsel to the Inquiry, Ms Carey, this morning, that guidance was often created by politicians and administrators when perhaps there should have been more thought given to practitioners and clinicians.

So my question is this. In seeking to formulate practical measures and guidance for any future pandemic and insofar as it affects the ambulance service, would you agree that it is essential that the ambulance sector, ie those actually working at the coalface, and including the independent ambulance workers and paramedics who contributed so much in supporting the NHS during the pandemic, that they be consulted in formulating such measures and guidance?

A. Well, yes, of course the sector should be consulted. I would challenge -- even though I have my criticisms of how some things worked within the health system, I would challenge the question that practitioners were not involved in the design of much of the guidance. I think -- I'm not sure that's right. I can't answer for whether any one individual organisation was consulted for guidance that I wasn't involved in but, generally, there's a vital need to consult people on the ground, both through organisations and directly.

But in the case of a pandemic, often you have to bring things in much, much quicker than you would normally. So instead of a typical, you know, three-month consultation period you might convene an immediate roundtable on -- virtually, and then try to make a decision based on immediate feedback.

So, of course, there were -- there have to be accelerations of normal procedures and I'm very sorry I didn't reply to the letter but 20 March 2020 was in the middle of when we were bringing in lockdown so I would have been exceptionally busy.

Q. As we said, there was no criticism attached to that, but thank you very much.

A. Thank you.

MR JORY: My Lady, thank you.

LADY HALLETT: Thank you, Mr Jory, very grateful.

I think we'll just see if we can slip in Ms Morris.

Questions from MS MORRIS KC

MS MORRIS: I ask questions on behalf of the Royal College of Nursing. A question about data. The rates of infection, self-isolation and death amongst health and care staff would have been key indicators of the effectiveness of the government's approach to those workers and their working conditions and therefore systematic collection of data on those matters was required. You are nodding, agreeing with me?

A. Yes.

Q. So what did you do to ensure that the government had data as to the impact of the pandemic on health and social care workers?

A. So I required the collection of that data and I publicised it. It wasn't there at the start and I made that happen. I totally agree with your question.

Q. When did you make sure it was collected?

A. It was April 2020 when the number of -- when the first significant number of deaths were starting to happen.

Q. And as to infection rates?

A. And the infection rates, of course, depended on the availability of tests, and so in the early days before

I expanded the testing capacity very significantly, it was -- measurement of infection rates amongst hospital staff was much harder. But as soon as we had the tests to do it, which was probably May 2020, we got on and did that. But as I said, it was actually very hard to drive the increase in testing across the NHS.

Q. And something that didn't require testing, measurement of self-isolation rates. When did you introduce that collection of data?

A. I don't recall the exact -- an exact date but obviously that is also very important.

LADY HALLETT: Thank you, Ms Morris.

Unless there is anybody who is desperate to get away, I think Mr Hancock has had quite a long day. Just check there is nobody who has got 3 or 5 minutes that they want to get in tonight.

THE WITNESS: I'm here as long as you like, Chair.

LADY HALLETT: I know, but it's been a long day. I'm afraid we have to come back tomorrow. Too many people wish to ask you questions, and so we have an hour and a half, a couple of hours left I'm afraid.

So, 10 o'clock tomorrow please.

(4.02 pm)

(The hearing adjourned until 10.00 am, on Friday, 22 November 2024)

INDEX