Friday, 22 November 2024

(10.00 am)

MR MATT HANCOCK (continued)

LADY HALLETT: We're going to try and get through all the questions, Mr Hancock, so we can finish your evidence this morning in one go.

THE WITNESS: Terrific, thank you.

LADY HALLETT: Mr Jacobs, I think.

Questions from MR JACOBS

MR JACOBS: Good morning, Mr Hancock.

A. Good morning.

Q. Some questions on behalf of the Trades Union Congress. Firstly, on vaccination as a condition of employment.

You were asked questions on this topic yesterday in connection with ethnic minority groups. You described some groups feeling less connected to authorities as you put it and you described the importance of developing trust, using trusted voices and so on.

Does imposing vaccination as a condition of employment not actually work against those factors, so, in relation to groups feeling connected to authorities, you have a mandatory direction from authority with a severe sanction of loss of employment, and it also really abandons attempts at trust and persuasion?

A. Actually the experience that we had with vaccination as a condition of deployment in social care led to the -- exactly the opposite conclusion: vaccination rates increased. And I think most people in employment in care settings understood and understand that part of their responsibility, I suppose, is not to infect the people they're caring for with a potentially deadly disease.

So obviously I understand those concerns, and anybody introducing a vaccination as a condition of deployment should be sensitive to those concerns, but ultimately the imperative of saving lives is more important.

Q. But going back to the focus of my question, Mr Hancock, if you're right to say that there's a problem of some groups feeling less connected to authority, that authority saying, "Take the vaccine or lose your job", the reality is that's going to be a problem, isn't it?

A. Well, the reality is best understood by looking at what happened when we introduced this in social care and exactly the opposite happened. So there were those concerns raised and there were the concerns raised that tens of thousands of people would leave employment. That isn't what happened. And I think it isn't what happened because vaccines -- clinically proven vaccines

are safe and effective and I think the moral obligation to save lives is more important.

You often get this in government, when, you know, where there is a -- when you're looking at the best interests of society as a whole, there are some strong voices who are opposed to something. You know, there's not just people who are hesitant at taking the vaccine but there's some anti-vaxxers who spread misinformation, and there's some people who get very upset at things even though they're the right thing to do.

So I understand the argument but it isn't borne out by evidence.

Q. Well, in terms of evidence and experience, we've heard evidence, for example, from Professor Ball, from a trust in Birmingham, who described vaccination as a condition of employment in healthcare having a very significant impact both on unvaccinated staff but also vaccinated staff who were worried what was going to happen to their colleagues. So do you accept that as a reality of the impact of this sort of measure?

A. Well, this measure wasn't brought in in healthcare. So I understand that some people make those arguments in advance, and say that's what's going to happen, but as I say, when we brought this in in social care, exactly those arguments were advanced and turned out not to be

accurate.

But even if they were accurate, even if there were concerns, the lifesaving imperative has, in my view, an overriding moral value that requires and demands that this policy is the right one. So, of course I understand those concerns and we discussed them and considered them ahead of bringing this in in social care, but they are not borne out by reality, as you put it, and even if there were -- even if they were, you would -- you have to consider the fact that if you don't have this, then you have people who are going into work with a higher chance of, entirely unintentionally, giving somebody in their care a disease that leads to their death. And it is as stark as that. So, for me, this is a -- it's a cut and dried issue, and I'm very, very pleased with how it went in social care, because it went very well.

Q. In terms of the moral imperative that you describe to take the vaccine, do you at least recognise that there may be a moral imperative that points the other way which is with healthcare workers who have been putting their lives on the line through the earliest, most dangerous stages of a pandemic, to say to them, "You are now out of a job unless you take the vaccine" there's also a moral imperative against doing that? It may be

1 something that points both ways?
2 A. As I say, you have to consider all of these things,
3 absolutely. There is a counterargument, but the
4 lifesaving moral imperative absolutely overrides that,
5 not least because vaccinating people who are in these
6 dangerous settings, like working in a hospital, it's
7 good for them as well as good for their patients. So
8 even if you're not -- even if you take away, as you seem
9 to want to, the moral imperative in terms of protecting
10 the lives of people who go into hospital, it's good for
11 staff themselves as well.
12 So, to say there's a balance is accurate, but in
13 this case the scales of that imperative are very heavily
14 weighed in favour of using science to save people's
15 lives.
16 Q. And certainly my clients agreed with that in the sense
17 of promoting use of vaccine, seeking to assist the NHS
18 in achieving high levels of vaccination within staff.
19 But do you think there might be a case for saying that
20 because of the downsides, persuasion and using trust is
21 actually more effective in the round than applying the
22 sanction which you invite the Inquiry to suggest?
23 A. No. I think that if somebody doesn't want to use the
24 science that's available in order to protect the people
25 they care for, then it's entirely appropriate that they

1 should seek employment elsewhere.
2 Q. Is there a lack of balance in your view, Mr Hancock?
3 A. Churchill once said, "I am partial as between the fire
4 brigade and the fire", and that applies in this, I've
5 considered it very deeply and I think the clarity of
6 what is right this issue is absolutely clear.
7 Q. Next topic, please. Nightingale hospitals and staffing.
8 You describe yesterday that the Nightingales were to
9 operate within the auspices of the relevant trust and
10 the trust would be responsible for staffing, if
11 I understand your evidence correctly, and also that
12 Nightingales would be used when the capacity of existing
13 hospitals could stretch no further; is that right?
14 A. Broadly, yeah.
15 Q. If they are to be used in circumstances that existing
16 capacity could really stretch no further, was it ever
17 really realistic to think that at that point the trusts
18 could then provide thousands of staff for thousands of
19 extra beds in additional hospitals?
20 A. Yes, and that is what was planned, and of course it
21 would be difficult, of course it would be challenging,
22 but a combination of bringing more people back into
23 service, for instance those who'd retired, or were
24 working in private healthcare, and also stretching
25 ratios, as we discussed yesterday, the combination of

1 those two things made this doable. I'm not saying it
2 was easy, but it was doable, and it was -- it would have
3 been critical had we not managed to stem the spread of
4 the virus when we did.
5 Q. You say, boldly, yes, Mr Hancock, but we've heard about
6 these being used when staffing ratios in intensive care
7 was already 1:6.
8 A. Yeah.
9 Q. So where do these intensive care specialists appear
10 from?
11 A. Well, the combination, as I said, of bringing people in
12 who, immediately prior to the pandemic, weren't working
13 in healthcare, for instance qualified nurses who had
14 recently retired, plus the --
15 Q. Just to pause you there, Mr Hancock, had they not been
16 brought in already to assist with existing hospital
17 capacity?
18 A. Yes, the combination of bringing those in, them in, and
19 stretching ratios meant that we were able to service
20 more physical capacity. So, as you know, to deliver
21 an effective hospital bed and an effective hospital
22 treatment, you need the staff and you need the physical
23 equipment, and by building the physical hospital and by
24 stretching staff ratios and bringing in more staff, you
25 could therefore enhance the number of beds. So yeah.

1 But my point is, my central point is, I know this
2 was an enormous challenge, but it was doable and to the
3 degree that it was needed in those hospitals which did
4 take patients we did it.
5 MR JACOBS: I think I'm at my time. Thank you, my Lady.
6 Thank you, Mr Hancock.
7 LADY HALLETT: Thank you, Mr Jacobs.
8 Mr Stanton.
9 Mr Stanton is behind you as well, I'm afraid,
10 Mr Hancock.
11 **Questions from MR STANTON**
12 MR STANTON: Good morning, Mr Hancock. I ask questions on
13 behalf of the British Medical Association. I'd like to
14 ask you about staff burnout and the trauma they
15 experienced.
16 A. Yes.
17 Q. The context is the circumstances we heard described
18 yesterday by Professor Fong, and with regard to the fact
19 that survey responses to Professor Fong and his team
20 reported symptoms of serious mental illness, including
21 severe depression, severe anxiety and PTSD among
22 ICU staff at a level of approximately 50%.
23 I recognise from your evidence that you have
24 personally witnessed and experienced those circumstances
25 as well, but I'd like to ask you, were you aware that

1 the levels of trauma experienced by healthcare workers
2 were of that magnitude?
3 **A.** Yes, I was. And, you know, you acknowledge that
4 I witnessed and, to a degree, experienced this, and
5 of course -- and I worked incredibly hard but not nearly
6 in the same way as those who were experiencing this and
7 the death directly, day in, day out, in intensive care.
8 So I'm grateful for your acknowledging that I spent as
9 much time as I could on the wards but it was nothing
10 like those who worked full-time in intensive care.
11 I am aware of the figures that you quote. It was
12 something that we were worried about from the start. It
13 is a consequence of the enormous pressures and the
14 deadly nature of the virus, absolutely.
15 **Q.** Thank you. Can I ask you about the general points at
16 which you became aware that this was such a significant
17 issue, and can I ask how that factored into some of your
18 strategic decision-making, and also engagement with your
19 senior colleagues, and thinking about the period between
20 the first and second waves when healthcare workers, and
21 the NHS generally, desperately needed to recover, and
22 also, from your evidence yesterday, when you described
23 speaking to a doctor in distress, who told you that
24 there must not be a third wave.
25 **A.** So at that point we were worried about a third wave,

1 because it had taken us so long to win the argument for
2 the necessary lockdown the second time around. And
3 thankfully, because of the vaccine, that wasn't -- that
4 didn't happen. And that was -- well, thank goodness for
5 that.
6 The -- we put in place measures as much as we
7 could, and as early as we could. This included, for
8 instance, introducing well-being and recovery areas
9 where possible, supporting hospitals to do that. That
10 was really a hospital-by-hospital decision rather than
11 one that we implemented directly.
12 I spoke to the BMA and other unions regularly
13 throughout this, throughout this period, in order to
14 understand these pressures and see what we could do.
15 There were contractual changes in some places in order
16 to try to make sure that the problems were mitigated but
17 it was very much mitigation because of, you know, what
18 was effectively a wartime attitude in the intensive care
19 and other settings across the NHS.
20 **Q.** Thank you.
21 Could I ask you about the sort of -- type of
22 support and the strategic way in which that support was
23 put in place. And just taking an extreme example,
24 obviously where you had a single individual who would be
25 experiencing mental health issues --

1 **A.** Yes.
2 **Q.** -- that is absolutely for the employer to deal with, and
3 deal with at that level. When you have issues at this
4 level, reports of approximately 50% of staff
5 experiencing severe anxiety, et cetera, do you think
6 a more central role and leadership was required, not
7 necessarily from you, but NHS England, for example?
8 **A.** Yes, so there's absolutely a need for national measures
9 when -- as well as local measures when there's something
10 of this scale. For instance, NHS England put in place
11 a first port of call phone line, essentially, you know,
12 an emergency mental health phone line for NHS staff, and
13 it was something that the chief people officer in
14 NHS England was engaged on and very concerned about.
15 You're right to say that the formal accountability
16 was with NHS England rather than the department, because
17 NHS England -- but the individual employer is,
18 of course, the trust, the GP surgery, or the local NHS
19 institution.
20 So, there was a need for national and local
21 measures, and if there's further things that can be put
22 in place earlier in the future then I think that the BMA
23 is very well placed to recommend them.
24 **Q.** Thank you.
25 Final question, Mr Hancock. How can we avoid this

1 level of trauma in future pandemics, future health
2 emergencies?
3 **A.** The absolute number one thing that we can do to avoid
4 this sort of trauma for NHS staff is to bring in
5 lockdown measures early in response to a pandemic level
6 pathogen. And I think that those who understand the
7 consequence of waiting before bringing in measures that
8 are going to be necessary, need to unite to win that
9 argument.
10 There are still people making the argument that
11 lockdown wasn't necessary or in future we should try to
12 do without it. I think that is false, wrong and
13 dangerous and we should -- and the case needs to
14 continue to be made so that should a pandemic potential
15 pathogen hit, which could happen at any time, we're
16 ready.
17 And I come back to the doctrine that I set out in
18 the first module, which I think is -- has yet to be
19 challenged, there needs to be a national debate in my
20 view about how we respond immediately, and, again, the
21 BMA will play an important role in that.
22 **MR STANTON:** Thank you, Mr Hancock.
23 Thank you, my Lady.
24 **LADY HALLETT:** Mr Wagner.
25 Mr Wagner's over there.

Questions from MR WAGNER

MR WAGNER: Good morning, Mr Hancock. I ask questions on behalf of Clinically Vulnerable Families.

I have two areas to ask you about. The first is shielding. You say in your statement that you in your view shielding saved many hundreds of thousands of lives; is that fair?

A. Yes, it's very, very difficult to estimate, but it was a huge programme and I think it's likely to be in that order of magnitude.

Q. Is that based on any scientific study or is it --

A. Yes, it's based on -- it's my best estimate based on the number of people who were in the shielding programme, the risks that they face should they catch Covid, which, of course, by its nature was much higher than the general population, and the likely reduction in the -- in transmission amongst those who were shielding. But it's very hard to know for sure.

Q. So is that your estimate or is it -- is it somebody has given you that estimate?

A. There was some internal work done before I left office, but the -- because the -- the statistical challenge is, because there isn't a control group because we chose to support everybody rather than have a control group, is not possible to get an estimate that the government is

happy to put its imprimatur to because there's -- because these statistics are very hard, actually, to assess.

Q. I want to ask you about what might have been done differently to improve the shielding programme. Just picking up on some evidence you gave yesterday, would you agree that by definition the clinically extremely vulnerable group who were involved in the shielding programme would also have to access healthcare settings, particularly hospitals quite a bit more than your average member of the population?

A. Yes, absolutely, that is -- by the nature of the group, that is likely to be true.

Q. And you said in evidence yesterday that hospitals are dangerous places in pandemics, the estimate is that more people caught Covid in hospitals than almost any other setting and that's often forgotten.

A. Yes.

Q. I just want to ask you about the combination of those factors. Wasn't there a problem with shielding that you were protecting people at home --

A. Yes.

Q. -- but they were also the people who were having to go to hospitals, and wasn't it the case that, in a sense, that you were protecting people from the frying pan at

home but sending them into the fire in hospitals and therefore not really giving protection at all?

A. No, that's -- I think -- I was agreeing with you until the last bit. When a pandemic hits you don't have a choice between no pandemic and the actions that you take. You have a choice between how to minimise the impact of a pandemic. So, in a way, it comes back to the last answer that I gave to the BMA which is we need to make sure that we have a doctrine that brings in lockdown as early -- as soon as you know that you're going to have to do it, you should bring it in. And that is a hard judgment to know that you're going to need NPIs but as soon as you do, there is no benefit and no tradeoff from not bringing them in immediately.

This is particularly important and acute for those who are clinically extremely vulnerable to whatever pathogen has come along.

But to argue that shielding didn't work because the people who were shielded needed hospital treatment, they were going to need hospital treatment anyway. So what shielding did was protect them as much as possible from infection in the community, but the best thing to do to protect them from -- in hospital is reduce nosocomial infection and reduce the overall level of infection across the country.

So it absolutely doesn't follow logically that because people who are shielding have to go to hospital therefore you shouldn't do shielding; that's not true.

Q. Well, that wasn't what I was putting; it was more about how to improve the programme.

A. Okay.

Q. And when you get into hospitals, if you can't improve things like ventilation, you know, testing, those sorts of things in the early days, doesn't it make the shielding programme much less effective for that group, taken overall?

A. No, because you have to protect people who are clinically extremely vulnerable from community-acquired infection and from hospital-acquired infection and to say that shielding is only a partial solution is reasonable, but to say that it is no solution because it can't be the whole solution is false.

Q. So you'll agree it's only part of a picture which has to include protecting people in healthcare settings as well?

A. Absolutely.

Q. Just in relation to shielding from the perspective of the shielded. Dr Catherine Finnis of CVF gave evidence to this Inquiry that many of those advised to shield felt that the messaging was frightening and the effect

1 was in one sense to disempower people by impressing on
2 them the need to shield without providing them with
3 sufficient information about the risks of Covid-19 and
4 the steps that could be taken to manage them.
5 Would you agree, Mr Hancock, with the evidence of
6 Professor McBride, the CMO for Northern Ireland, and I'm
7 quoting, that "The approach that was taken in good faith
8 initially did not fully think through the loss of agency
9 and the loss of control that people would experience"?
10 **A.** So I take that evidence seriously but I also have to
11 counterbalance it with the strong evidence we got of the
12 support for the communications that we put out to those
13 who were shielding, directly communicating with them.
14 I wrote a number of times to the shielding population
15 and their GPs were encouraged to follow up.
16 So there were very strong voices on the other side
17 as well, and when you're dealing with a group of up to
18 2 million people who are clinically extremely
19 vulnerable, the virus itself is extremely frightening.
20 The -- it's the virus that's frightening because it's
21 killing people. Being able to communicate effectively
22 is incredibly important and, hence, writing directly and
23 I took personal trouble to make sure those letters were
24 as empathetic as possible, understanding these concerns.
25 However, the question you've always got to ask is:

1 what is the alternative? And I understand the point
2 about agency, and we didn't make any of the shielding
3 measures required, they were advice, and we were clear
4 that it was advice, and therefore agency was retained
5 but I understand the impact of being told by the
6 Secretary of State or the Chief Medical Officer that
7 this is what you are recommended to do. So we always
8 sought to strike that balance.
9 With respect to improving the shielding programme,
10 I absolutely think that we should go over it and discuss
11 it and be prepared to make it better next time round, as
12 we did throughout -- we reiterated many times during the
13 pandemic to try to improve this. But I think it would
14 be wrong just to take the view of one side of this
15 debate when, in fact, amongst those who are clinically
16 vulnerable there was, essentially, a spectrum of views
17 all the way through from "Tell me exactly what I ought
18 to do" to "Don't tell me what to do, I'll work it out
19 for myself", and there's every view in between.
20 **Q.** Do you agree, just going back to that question, that one
21 area that could be improved was empowering people more
22 with information. So, for example, giving them good
23 information about what kind of mask they could wear
24 in -- to go out into the community, ventilation, that
25 sort of thing, to make it just a bit more empowering for

1 people who didn't want to just stay in their homes if
2 they could avoid it?
3 **A.** We tried to do that as much as possible, yes. But
4 you've got to remember, again, that the responsibility
5 that I had towards the shielding population was not only
6 to ensure that we got that population right -- and
7 Jenny Harries did a huge amount of high quality work to
8 do that and we expanded it over time -- but also to take
9 into account the response from all those who are
10 shielding not just those who were vocal and in campaign
11 groups.
12 And -- you know, my -- I was always focused on the
13 fact that my responsibility was to society as a whole,
14 and in particular to those who are most vulnerable, and
15 therefore tried to get as broad a range of feedback as
16 possible.
17 **Q.** Finally, on DNACPRs (do not attempt CPR) orders.
18 CVF is concerned that there remain people to this
19 day who may not be aware that a DNACPR notice was issued
20 for them during the pandemic. For that reason, and to
21 restore trust and confidence in the advance care
22 planning process more widely, CVF has been advocating
23 for a systemic review of all DNACPRs put in place in
24 early 2020 and that the notes of all the formerly
25 shielded people from 2020 be reviewed.

1 Do you recall any consideration being given to
2 that kind of review and would you support that going
3 forward?
4 **A.** I certainly think a review like that should be looked
5 at, because it's obvious that there were cases when DNR
6 notices were wrongly applied and I think the issue of
7 consent is so important here.
8 To answer your question specifically about whether
9 we looked at this, I can't recall us looking at a review
10 like that, because our absolutely prime motivation was
11 to stop that from happening in the first instance, and
12 I'd left office by the time we were in a position then
13 to do the review and look-back. But now, of course,
14 we're no longer in a pandemic and so now would be
15 an appropriate moment to consider doing that.
16 **MR WAGNER:** Thank you. Those are my questions.
17 **LADY HALLETT:** Thank you, Mr Wagner.
18 Ms Polaschek, who is sitting beside Mr Wagner.
19 **Questions from MS POLASCHEK**
20 **MS POLASCHEK:** Thank you.
21 I ask questions on behalf of 13 Pregnancy, Baby
22 and Parent Organisations, and I have one topic of
23 questions, on one of their key concerns, the visiting
24 restrictions which impacted women and pregnant people
25 but also new mothers, the newly bereaved and their

1 families when having support and healthcare.
2 Is it right that you were made aware, including
3 for example in a meeting with the charity Bliss on
4 7 September 2020, that a core concern amongst these
5 groups was that many hospitals were implementing the
6 visiting restrictions very differently and therefore
7 creating, in effect, a postcode lottery and, in turn,
8 anxiety amongst many women and pregnant people about
9 what support they would be allowed?
10 A. Yes. And more so than that, my first meeting on this
11 subject that I can recall and have found the evidence
12 from was in June 2020 and I was concerned to get the
13 balance right from the start.
14 There is a balance here between protecting people
15 from infection and the very, very strong need for
16 companionship in birth or bereavement, but this was
17 a concern, I remember the meeting with Bliss and,
18 I think, Alicia Kearns MP.
19 Q. Thank you. And it's right that initial drafts of
20 nationwide visiting guidance, which were later published
21 in December 2020, were shared with your private
22 secretary, and that visiting guidance would have imposed
23 obligations on NHS trusts to implement with immediate
24 effect women having access to a support person at all
25 times during the maternity journey. Were you supportive

1 of that policy direction?
2 A. Yes, I was, and one of my advisers in particular I asked
3 to stay close to this to make sure that it -- that I was
4 continued to be properly advised on it.
5 Q. Were you made aware that there was resistance from the
6 Royal College of Midwives and the Royal College of
7 Obstetricians and Gynaecologists to those initial drafts
8 and that, consequently, amendments to the draft guidance
9 resulted in those directions to NHS trusts being toned
10 down?
11 A. Yes. As I say, there was a balance in this argument and
12 we had to take into account the balance and the need to
13 mitigate the spread of the disease.
14 I come back to the point that hospitals are
15 dangerous places in pandemics but nevertheless I was
16 very keen that we get a set of guidance out that was
17 appropriate and supported by those like the groups that
18 you represent.
19 Q. But just to be clear, did you then understand as
20 a result that that NHS visiting guidance continued to
21 allow for localised variation and therefore maintained,
22 in effect, the postcode lottery?
23 A. Yes, the argument in favour of that was that during the
24 autumn of 2020, the level of disease was very different
25 in different parts of the country, and there may be

1 areas, for instance, that were in the higher tiers of
2 what was then the tiering system, where a lack of
3 visitors altogether was appropriate in extremis.
4 I understand there's some groups who think that
5 that should never be the case, but this was the debate
6 and we had to take all considerations into account, but
7 I was broadly on the side of ensure there's a -- and
8 ensure a companion -- a single companion can make a huge
9 difference, and that was the side of the debate I was
10 on.
11 Q. And just coming to that balance, Mr Hancock, the Inquiry
12 has heard evidence from Gill Walton of The Royal College
13 of Midwives, who was frank that one of the reasons her
14 union did not endorse even the toned down version of
15 that guidance was because of the perceived risk to staff
16 from Covid-19 infection. And her evidence specifically
17 was that testing and greater access to PPE earlier, for
18 both support partners and staff, absolutely and, she
19 said, definitely would have facilitated further
20 visiting.
21 We've talked generally about PPE shortages and
22 you've given evidence on that, but were you aware of
23 those specific concerns about PPE shortages in maternity
24 care?
25 A. I wasn't at the time but I am now. I would say, with

1 respect both to PPE and especially with testing, there
2 are many, many examples of things that can be done
3 better if you can expand your testing fast enough.
4 That's why I was -- had my shoulder to the wheel on that
5 in a very public way, to try to make the expansion of
6 testing happen as early as possible. And this is just
7 one heart-rending example of why it's important.
8 Q. I think you've said that you weren't aware of those at
9 the time, so -- those concerns about PPE and maternity
10 care, so does it follow that you didn't discuss any
11 specific steps that the NHS could have taken at the time
12 to allay those concerns of midwives and other maternity
13 staff in order to try to open up visiting for the
14 impacted women you've identified?
15 A. Well, the truth is that we went into this without
16 a testing system, right, and so it simply wasn't
17 an available choice. There was a clinical ordering of
18 prioritisation for tests. My job was not to effect that
19 clinical prioritisation, which companions for women
20 giving birth would have been one example of, my job was
21 to expand the number of tests available so we could get
22 as far down that list as possible.
23 The first -- so the first time I engaged on this
24 subject was in June 2020, as that testing became more
25 widely available and as we came out of the first stage

1 of lockdown. But engaging on it any earlier, without
2 the testing to be able to expand that and without -- and
3 with severe shortages in PPE, wouldn't have -- I don't
4 think -- even with hindsight, wouldn't have made much
5 difference.
6 **MS POLASCHEK:** Thank you, Mr Hancock.
7 My Lady, those are my questions.
8 **LADY HALLETT:** Thank you.
9 Mr Burton.
10 Mr Burton is over there.
11 **Questions from MR BURTON KC**
12 **MR BURTON:** Good morning, Mr Hancock, I ask questions on
13 behalf of the Disability Charities Consortium who speak
14 on behalf of some 17 million disabled people in the UK.
15 In October 2020, the Chancellor of the Duchy of
16 Lancaster, Sir Right Honourable Michael Gove MP, wrote
17 to you and other secretaries of state asking on behalf
18 of the Prime Minister for greater ambition in tackling
19 the terrible disparities highlighted by the pandemic.
20 In that letter Michael Gove said this:
21 [As read] "I want to draw your attention to the
22 Prime Minister's request to departments to consider
23 options from proving outcomes for those with
24 disabilities ahead of a future Covid-O discussion.
25 This is also extremely important work. I expect

1 Secretary of State to work with their departments to
2 bring much more ambitious and far-reaching proposals
3 to that discussion as per the Prime Minister's steer.
4 The Prime Minister has clearly directed his ministers
5 to engage with this issue fully and develop a strong
6 package of interventions. If we do, then I have
7 complete confidence that this committee and our
8 government can move the dial and prevent a replication
9 of disproportionate impacts in the second wave."
10 Mr Hancock, what did you do by way of bringing
11 much more ambitious and far-reaching proposals to
12 prevent a replication of disproportionate impacts on
13 disabled people in the second wave?
14 **A.** Thank you. So this was obviously an incredibly
15 important subject. I agree with the sentiments
16 expressed by Michael in that letter. And the answer is
17 the shielding programme was the core to the response
18 from the health department. We anticipated from
19 January 2020 that people with disabilities may be more
20 likely to be clinically extremely vulnerable to Covid
21 and more likely to be badly affected and the evidence,
22 sadly, bore that out. There was a disproportionate
23 impact in the first wave.
24 In the summer and autumn of 2020 we expanded the
25 clinically extremely vulnerable list and the shielding

1 list as a consequence, in order that a wider range of
2 people got more of that -- the support that came with
3 that package.
4 The other thing that I did personally was ensure
5 that people living with disabilities were higher up the
6 prioritisation by -- for vaccines, by accepting the JCVI
7 advice, clinical advice, on the prioritisation of
8 vaccines. So that was another important action that
9 happened that autumn.
10 **Q.** Mr Hancock, just on the first of those, is it not
11 correct that in relation to the CEV list, it's correct
12 that people with Down's syndrome were added to that list
13 in Autumn 2020, but no other disabled people were added
14 to that list, were they?
15 **A.** More disabled people were, not by group but by
16 identification of more individuals. So the -- you're
17 right to say that the criteria didn't expand but the
18 data work to find more people who needed to be within
19 the existing criteria meant that the list as a whole
20 grew quite considerably over the autumn.
21 **Q.** Do you mean the CV list rather than the CEV list?
22 **A.** I mean the shielding list.
23 **Q.** I'm grateful. My next question is about mortality
24 rates. In October 2020, the ONS established that
25 6 in 10 deaths that occurred between March

1 and July 2020, ie the first wave, were of disabled
2 people. That rate of disparity remained for the second
3 wave, even when controlled for matters such as residence
4 type, geography, socioeconomic and demographic factors,
5 healthcare characteristics, and indeed vaccination
6 status, and disabled people therefore remained at
7 a greater risk, a much greater risk of death than
8 non-disabled people.
9 In light of that, do you believe your department
10 did enough to reduce disproportionate impacts on
11 disabled people ahead of the second wave?
12 **A.** We did everything we could, and the challenge is that
13 the virus itself was more aggressive against people
14 living with disabilities. And that is a sad fact --
15 **Q.** Mr Hancock --
16 **A.** -- in the same way that it was more aggressive against
17 people who were older. So, absolutely, we took action
18 to reduce the total number of people affected and the
19 disparities, but the disparities were a result of the
20 nature of the virus.
21 **Q.** So you're saying disabled people were clinically more
22 likely to die from Covid-19 than non-disabled people?
23 **A.** That is the clear evidence from the data, yes.
24 **Q.** Would you be able to assist us with what evidence you're
25 referring to, Mr Hancock?

1 **A.** Yes, I'm very happy to write afterwards with it.
2 I haven't got it to hand.
3 **MR BURTON:** I'm most grateful.
4 Thank you very much, my Lady.
5 **LADY HALLETT:** Thank you, Mr Burton.
6 Mr Pezzani.
7 He's over there, just along from Mr Burton.
8 **Questions from MR PEZZANI**
9 **MR PEZZANI:** Thank you, my Lady.
10 Mr Hancock, I ask questions on behalf of Mind, the
11 mental health charity.
12 The context of my question is this. Firstly, at
13 paragraph 4 of your fifth witness statement you say, the
14 single most important fact about the NHS in the pandemic
15 is that it was never overwhelmed, although of course you
16 do qualify that by saying that demand never exceeded
17 capacity across the UK as a whole.
18 **A.** As a whole, absolutely.
19 **Q.** The second part of the context to my question is the
20 witness statement of Saffron Cordery, who is the deputy
21 chief executive of the NHS Providers organisation, in
22 which she says at paragraph 206:
23 "Throughout the course of the relevant period,
24 trust leaders highlighted to us that mental health
25 services for children and young people faced

1 a significant treatment gap prior to the pandemic in
2 addition to demand stemming from the pandemic."
3 **A.** Yes.
4 **Q.** And at paragraph 209 of the same statement she describes
5 how in May 2021 NHS providers conducted a survey of
6 chairs and chief executives of mental health and
7 learning disability trusts that provide mental health
8 services for children and young people. The findings of
9 that survey include that 85% of respondents said they
10 could not meet demand for children and young people's
11 eating disorder services, and two-thirds said they were
12 not able to meet demand for community services and
13 inpatient services.
14 **A.** Yes.
15 **Q.** So my question is, in specific relation to children and
16 young people's mental health inpatient capacity, do you
17 maintain that the NHS was never overwhelmed during the
18 relevant period?
19 **A.** Well, what I'd say to that is that this was a problem
20 well before the pandemic and in the 2018 long-term plan
21 we increased the budget for mental health services
22 faster than the NHS budget as a whole and, within that,
23 for children and young people's services the fastest
24 still. So this is a clear and significant problem in
25 the NHS. It remains so today irrespective of Covid.

1 So I would say that these services were not
2 overwhelmed by Covid, they were already under very
3 significant pressure before the pandemic.
4 **MR PEZZANI:** I'm grateful, thank you.
5 Thank you, my Lady.
6 **LADY HALLETT:** Thank you, Mr Pezzani.
7 Ms Hannett.
8 Ms Hannett is behind Mr Pezzani.
9 **Questions from MS HANNETT KC**
10 **MS HANNETT:** Mr Hancock, I ask questions on behalf of the
11 Long Covid groups. We're very grateful to Counsel to
12 the Inquiry who has already raised most of the issues
13 with you that we wished to raise already.
14 I have one remaining question. We know that
15 healthcare workers are disproportionately affected by
16 Covid-19 and so are also likely to be disproportionately
17 impacted by Long Covid. As you've already confirmed
18 with Counsel to the Inquiry, even now there's no data
19 being collected on the prevalence of Long Covid amongst
20 healthcare workers.
21 You've already stated there should be data
22 collected on the incidence of healthcare workers with
23 Long Covid. Do you agree that collecting data on staff
24 absence due to Long Covid would have been helpful in
25 order to understand the overall capacity of the

1 healthcare system?
2 **A.** Yes, I do, yes.
3 **Q.** And do you agree that that would also have been helpful
4 to have that data for all staff with Long Covid, whether
5 they're agency staff, privately employed staff, casual
6 workers, non-clinical staff, ie even those not directly
7 employed by the NHS?
8 **A.** Yes, and collecting the data in these circumstances for
9 those not, as you say, not directly employed by the NHS
10 is always more challenging, for instance we discussed
11 private pharmacy services yesterday in a slightly
12 different context, but I strongly agree.
13 **MS HANNETT:** Thank you.
14 Thank you, my Lady.
15 **LADY HALLETT:** Thank you, Ms Hannett.
16 Mr Simblet, who is just there.
17 **Questions from MR SIMBLET KC**
18 **MR SIMBLET:** Good morning, Mr Hancock. These questions are
19 on behalf of the Covid Airborne Transmission Alliance,
20 or CATA, which has been referred to already in the
21 questioning yesterday. It's an organisation of
22 healthcare workers and others who came together during
23 the pandemic because they were concerned about the need
24 to protect healthcare workers from Covid's airborne
25 nature and they therefore had concerns also about

1 appropriate protective equipment.
2 And I've got three questions on the types of masks
3 provided to healthcare workers.
4 A. Okay.
5 Q. Now, my first question is about the feedback that you
6 sought from healthcare workers in the context of
7 paragraph 137 of your fifth witness statement where you
8 mention the National Social Partnership Forum, which you
9 say is the established mechanism for the department to
10 discuss issues affecting staff, brings together the
11 department, main healthcare trade unions, NHS employers
12 arm's length body partners, and you say:
13 "The forum discussed issues relating to PPE
14 regularly and particularly how staff concerns could be
15 addressed."
16 So, what were the outcomes of those deliberations
17 on PPE, how were the staff concerns over the level of
18 protection dealt with, and were those concerns
19 adequately addressed in the forum?
20 A. Well, it's a good question whether they were adequately
21 addressed, but they were addressed. The amount of
22 IPC -- sorry, the amount of PPE was effectively
23 determined by the IPC process which I took as read, as
24 clinical advice. Of course, the availability of the
25 higher-end masks was extremely tight at the start of the

1 pandemic and had we, for instance, specified FFP3 masks
2 right from the get-go, there would have been a risk that
3 in extremely high-risk settings there would not have
4 been the availability of those masks had they been used
5 across the board when the lower-grade masks were
6 available more widely.
7 So those sorts of tradeoffs do need to be
8 considered but I think that -- but that was the formal
9 process.
10 I think I also say in my witness statement, there
11 was also, obviously, informal and other advice that we
12 took. The formal process was only -- the formal forum
13 was only part of the way that we understood feedback on
14 this basis.
15 Q. Right. Well, I'll move on to the next question which is
16 about the data you were provided with. And, again, in
17 the same witness statement, paragraphs 115 to 116, you
18 state that data on nosocomial infections was
19 consistently used to inform policy --
20 A. Yeah.
21 Q. -- identifying outliers and implementing best practice.
22 A. Yeah.
23 Q. And you say that you discussed nosocomial infections
24 frequently with Sir Simon Stevens and Dame Ruth May.
25 A. Yes.

1 Q. And that in June 2020 you "pushed for us to look at data
2 on the impact of use of masks in hospitals on
3 infections"?
4 A. Yes.
5 Q. Now, you've given in your statement two examples of
6 that. One, a meeting on 11 June, of which in fact the
7 minutes, which we don't need to go into, say -- it's
8 headlined the "SOS nosocomial infections meeting on
9 11 June".
10 A. Right.
11 Q. And then in November 2020, so five months or so later,
12 there was a discussion with Amanda Pritchard and
13 Ruth May. And so my question is this: from your
14 evidence yesterday, ie your understanding was that FFP3
15 masks provide a higher degree of protection than FRSMs,
16 this would appear to be particularly important as
17 an issue. Can you say what data you were provided with
18 about masks and their impacts and how did that data
19 affect what you did?
20 A. Yes, there was regular updates of data on those matters.
21 You quote two meetings. There were many other
22 discussions in between that, both formally and
23 informally, and I think the reason that the June meeting
24 is quoted is because around that time I pushed hard for,
25 and succeeded in getting, the agreement of the NHS to

1 insists on masks for everybody in hospital in all
2 settings where there might be a risk to patients.
3 So that was a -- there was a strengthening of that
4 advice which I worked on with Ruth May, as you say.
5 So in the paperwork there's -- there are the
6 examples. I don't have them to hand today.
7 Q. Yes, all right. And then thirdly, and this goes back to
8 a question you were asked in Module 2 by Mr Stanton who
9 has asked you questions this morning for the British
10 Medical Association, and it's this. Given that FFP3
11 masks are, in your view, the best protection against
12 an airborne virus and there being evidence that Covid
13 was airborne, there was a stop order placed on the
14 purchase of such masks in June 2020. And you were asked
15 why that was. You didn't know the answer at that point.
16 Do you know the answer now?
17 A. No, I don't. I would bring -- I would bring one other
18 thing to your attention. FFP3 masks are not the best
19 protection against Covid. The best protection against
20 Covid is to stop the virus in its tracks by bringing in
21 lockdown measures --
22 Q. Well --
23 LADY HALLETT: We understand that argument, Mr Hancock,
24 we're talking about protection --
25 (*Unclear: multiple speakers*)

1 **MR SIMBLET:** Within masks, within the field of masks.
2 **A.** Within the field of masks FFP3 masks aren't the most
3 effective, there are stronger masks as well. So this
4 isn't a binary question. I have no idea why -- if or
5 why a stop notice was put in place and if I had seen it
6 I doubt I would have approved it, but I haven't seen the
7 paperwork.
8 **Q.** Well, you've answered the question. Thank you very
9 much.
10 **LADY HALLETT:** Did you say yesterday, Mr Hancock, that you
11 understood the IPC guidance took into account the factor
12 of supply? Because that is not consistent with the
13 evidence I heard from people who were on the IPC
14 committee.
15 **A.** Well, my understanding is it took into account the
16 real-world situation that we were in. So for
17 instance --
18 **LADY HALLETT:** Well, where did you get that impression?
19 **A.** That's my recollection from the discussions I had at the
20 time, my Lady.
21 **LADY HALLETT:** With whom? Can you remember?
22 **A.** Well, I discussed these matters primarily with Ruth May,
23 Simon Stevens and Chris Whitty and Donna Kinnair, they
24 were the four people I would have relied on for this --
25 on this sort of issue.

1 **LADY HALLETT:** So it wouldn't have been the people directly
2 providing the IPC guidance?
3 **A.** No, because that guidance was provided to me through --
4 in particular through Ruth May.
5 **LADY HALLETT:** So your impression was -- I am not using the
6 term pejoratively, but it was second-hand?
7 **A.** It was indirect, yes.
8 But an apposite example is the point about
9 FFP3 masks. If there's only a certain number, then that
10 sort of guidance would take into account the places
11 where they were most in need and could save most lives.
12 That was my understanding of it. If that understanding
13 is incorrect, that was the impression that I had.
14 And there may be a difference between what was
15 considered formally and what was broadly taken into
16 account in these decisions. The paperwork will only
17 show part of the -- part of that.
18 **LADY HALLETT:** Thank you.
19 Who is next? Ms Sen Gupta.
20 Over there.
21 **Questions from MS SEN GUPTA KC**
22 **MS SEN GUPTA:** Thank you, my Lady.
23 Mr Hancock, I represent the Frontline Migrant
24 Health Workers Group. Our client's members include
25 outsourced non-clinical workers, not directly employed

1 by the NHS.
2 **A.** Yeah.
3 **Q.** And largely from ethnic minority and migrant
4 backgrounds, such as hospital cleaners, porters,
5 security guards and medical couriers, and clinical
6 nursing and healthcare assistant staff, all of whom are
7 from a migrant background.
8 Mr Hancock, my clients and their members have
9 numerous questions for you in relation to your conduct
10 during the pandemic. However, in deference to
11 her Ladyship and the Inquiry team, we restrict our
12 questions today to those we've been given permission to
13 ask you, updated to reflect your oral evidence so far.
14 From your answers yesterday, it appears clear
15 that, at least from the spring of 2020, you were aware
16 that migrant healthcare workers were suffering
17 disproportionately high infection and mortality rates;
18 is that right?
19 **A.** Yeah, that's right, and I cared a huge amount for it.
20 I think that the non-clinical employees working in NHS
21 settings are often overlooked in these debates, and
22 those who you represent deserve a stronger voice. And
23 so I was very worried about it, yes.
24 **Q.** Thank you, Mr Hancock. You were worried about it. What
25 practical steps did you take to address your worry?

1 **A.** Well, the most important thing we could do was bring
2 down infection rates in hospitals. Hence, for instance,
3 the IPC measures that we've discussed, that first came
4 in in March 2020, took into account the risk of
5 asymptomatic transmission in the way that they didn't
6 amongst wider society. That's one example but there
7 were others.
8 **Q.** That's not specific to migrant healthcare workers
9 though, is it, Mr Hancock? What specific steps did you
10 take focused on that group?
11 **A.** I took steps focused on all those who worked in the NHS,
12 especially in those roles where the voice may not be as
13 strong because they may not have the same
14 representation. And my -- as with the discussion
15 yesterday on issues of ethnicity in the NHS, my attitude
16 was not to try to prioritise one group or community over
17 another, it was to try to support all those in those
18 roles, no matter and irrespective of the colour of their
19 skin or where they were born.
20 **Q.** Thank you, Mr Hancock. You've referred to steps, and
21 I'll ask again, what specific steps did you take in that
22 regard?
23 **A.** Absolutely central to this was bringing in lockdown
24 measures. I know that I keep repeating it but it is
25 absolutely core to how you can respond to a problem like

1 this.
2 The second is bringing in PPE measures that took
3 into account the risk of asymptomatic transmission
4 within hospitals that I've just mentioned.
5 The third was supporting research into how the
6 disease spread. So this was critical and in fact goes
7 to the questions we've just been discussing from the
8 Covid-19 Airborne Transmission Alliance, because in the
9 early days we did not understand how it was transmitted
10 and there was a presumption that transmission was more
11 based on touch than on aerosol. And when the research
12 came to light to show the importance of aerosol
13 transmission, we again took steps related to that.
14 So this was a core part of trying to reduce
15 nosocomial infection but it's a very difficult problem
16 to crack.
17 **Q.** Mr Hancock, do you accept that migrant healthcare
18 workers, who had precarious immigration status, were
19 more vulnerable to employer pressure to work in
20 higher-risk environments than their non-migrant
21 colleagues?
22 **A.** I can absolutely see how that could be the case, yes.
23 **Q.** As the Minister for Health, what practical steps did you
24 take to address that?
25 **A.** Well, as I say, even before the pandemic I was worried

1 about this, and I had taken steps to highlight it to the
2 NHS as employers, including publicly describing what
3 I wanted to see and in introducing, encouraging the NHS
4 to introduce, a chief people officer for the first time,
5 who, as it happened, herself was from a migrant
6 background, but that's less important than the fact she
7 took action within the NHS to try to tackle this
8 problem.
9 But I'm afraid to say, I have to tell you in all
10 honesty, there is still a huge amount to do on this
11 agenda.
12 **Q.** Mr Hancock, when the pandemic hit in early 2020, around
13 half the UK's hospital sites had outsourced ancillary
14 services, including for cleaners, caterers, security
15 staff. And those workers invariably worked for minimum
16 wage and, as outsourced workers, did not have the
17 employment protections of NHS employed staff.
18 As the Minister for Health, what practical steps
19 did you take to protect these particularly vulnerable
20 workers?
21 **A.** Well, one step, for instance, was to support the
22 increase in the minimum wage and the introduction of the
23 national living wage, which I campaigned for again
24 before the pandemic. That's one example.
25 The second is that in discussing people issues

1 within the NHS, I was always at pains to take into
2 account those not directly employed. This wasn't always
3 the natural inclination of employers within the NHS, and
4 in fact yesterday's discussion around pharmacists not
5 employed directly by the NHS is one example: where
6 I said pharmacists should get support as a whole, and
7 then the system turned that into pharmacists directly
8 employed should get support, and within three days
9 I'd managed to change that back again to my original
10 instruction. This is -- you know, that's one granular
11 example I reiterate because it's front of mind, but
12 there's endless things like that that you have to do if
13 you want to support people who are themselves supported
14 by the organisation that you represent.
15 **Q.** Mr Hancock, PPE. You told her Ladyship yesterday "our
16 responsibility was to make sure that there was as much
17 PPE available as possible"?
18 **A.** Yes.
19 **Q.** You also said "preventing nosocomial infection is a key
20 responsibility [for] the NHS"?
21 **A.** Yes.
22 **Q.** Outsourced workers dealing with NHS patients, both in
23 NHS and private hospitals, reported that they were not
24 provided with adequate PPE. As the Minister for Health,
25 what efforts did you make to ensure that outsourced

1 workers in hospitals were provided with appropriate or
2 indeed any PPE?
3 **A.** Well, again, my responsibility was to ensure that there
4 was PPE broadly available and that, as a nation, we
5 didn't run out. The -- of course the distribution of
6 that matters, and ensuring the policy supports and
7 allows for the distribution of PPE to all those who are
8 vulnerable and need it was important.
9 One example of this is that we set up PPE supply
10 chains from the government to organisations, including
11 many of those who employ those you represent, who before
12 the pandemic would have bought their PPE entirely
13 privately.
14 So, you know, in normal times, most organisations
15 buy PPE as a normal purchase with no intervention from
16 the government whatsoever. And before the pandemic the
17 NHS Supply Chain supplied only the state-owned NHS
18 hospitals, about 250 of them.
19 We expanded that to include around 60-70,000
20 organisations to which the state supplied PPE. So
21 that's one of many examples.
22 **MS SEN GUPTA:** Thank you, Mr Hancock.
23 Thank you, my Lady.
24 **LADY HALLETT:** Thank you, Ms Sen Gupta.
25 Ms Woodward, who is at the back there.

1 **Questions from MS WOODWARD**
2 **MS WOODWARD:** Thank you, Mr Hancock, I ask questions on
3 behalf of Covid-19 Bereaved Families for Justice Cymru,
4 and my question is about communications with the
5 devolved nations and it relates to evidence that
6 Frank Atherton, the CMO for Wales, gave to the Inquiry
7 during this module.
8 The transcript of Dr Atherton's evidence can be
9 found at tab 62 of your bundle, Mr Hancock, and for
10 others' reference it's PHT000000108.
11 I'm afraid I'm going to have to read out a length
12 of Dr Atherton's evidence to you to give my question
13 context.
14 When asked about instances where the approach in
15 Wales diverged from the approach in England, Dr Atherton
16 said this:
17 "Testing was a bit of an issue, the testing
18 strategies generally ... Although information on the
19 public health basis flowed very smoothly, I think,
20 between the chief medical officers, sometimes ...
21 because the work was being undertaken so rapidly ...
22 policy leads at UK level in England, let's say, didn't
23 communicate as rapidly as I would have liked with
24 colleagues who were working on similar issues in Wales
25 and that did lead, I think, to some divergence and

1 some difficulties in keeping up with what everybody
2 was doing."
3 When he was asked about a solution to that
4 communication issue, Dr Atherton said:
5 "I think in the same way that chief medical
6 officers met and continued to meet regularly, there
7 needs to be more communication between policy
8 officials, policy leads, between the four nations.
9 I think to some degree that is already happening but
10 that would make far more sense.
11 "It's very difficult in the heat of a pandemic
12 ... because work was often being directed by, say, the
13 Secretary of State at UK level and it was very
14 difficult, I think, for policy officials there to
15 always remember to link up as closely as they might
16 with policy leads in the other devolved nations. It's
17 something we need to continually work at as civil
18 servants ..."
19 We can see from this passage that, in relation to
20 testing, Dr Atherton appears to suggest that there were
21 delays in information being communicated from policy
22 leads at the UK level in England, including the
23 Secretary of State, to those working on similar issues
24 in Wales, and that this led to divergence and
25 difficulties in testing policy between the nations.

1 My question is this, Mr Hancock.
2 Do you agree that these communication difficulties
3 were as a result of delays from the UK Government,
4 including yourself?
5 **A.** Well, I agree with precisely with the statement as read
6 out from the CMO for Wales. Your interpretation isn't
7 quite right, because it's true that there could be
8 decisions that I had to make very rapidly as the
9 UK Secretary of State, some of which would involve --
10 have an impact on devolved issues because my role was
11 both as the Secretary of State across the UK and
12 directly responsible for the operation of -- the
13 strategic operation of the NHS in England rather than
14 across the UK as a whole, but what he said, and I think
15 is right, is that there was good quality communication
16 with CMO -- between the CMOs.
17 There was also high quality communication amongst
18 ministers. We had a -- exactly as he set out and
19 recommended, we had a weekly Zoom meeting. I personally
20 went, at the start of the pandemic, in anticipation of
21 this problem, to go and visit each of the other three
22 ministers, and we had an excellent rapport, which can be
23 seen on the WhatsApp channel that we communicated on
24 very, very frequently.
25 The point that he's making is that at -- it's

1 amongst policy officials, maybe that needs to be
2 strengthened too. Personally I can't -- I'm not sure
3 what communications there were at that level. I -- you
4 know, we had policy officials sit in on those weekly
5 calls as well, but I'm sure that it can be improved.
6 The point he was making about decisions by the
7 Secretary of State, sometimes I had to make very rapid
8 decisions and that, therefore, inevitably makes this
9 sort of communication harder, and that is absolutely
10 true.
11 **Q.** Mr Hancock, from your perspective, what were the
12 challenges that you faced, personally, or that you were
13 aware of from your team, in communicating effectively
14 and quickly with the Welsh Government, if we set aside
15 the fact that of course some decisions were being made
16 by yourself very quickly?
17 **A.** Yes, so personally I didn't find difficulties at the --
18 when decisions and discussions were happening at the
19 ministerial level. I had an excellent relationship with
20 Vaughan Gething, who was the health minister for almost
21 all of the time, and we would speak or message directly
22 if we needed to or we'd communicate in more formal
23 settings, including the weekly meeting.
24 And I would say that we supported each other
25 through -- both going through similarly extremely

1 challenging circumstances and having to make enormous
2 decisions in -- between unpalatable options.
3 Whether there could then, at the next level down,
4 be better communication, if that is the evidence of the
5 CMO in Wales then I wouldn't dispute it.
6 To give an example of that in substance, one of
7 the particular challenges between England and Wales was
8 the provision of testing at the border because, for many
9 people, their closest testing site might be on the other
10 side of the border, for instance the data integrations
11 between the NHS in England and Wales are -- were poor
12 and need to be radically improved because if you live
13 in, say, Chester and work in Wrexham, your data needs to
14 move from one to the other.
15 As it happens, I had a flu jab in Wrexham earlier
16 this week and I'm a patient in England and who knows
17 whether that data will make it on to my medical record,
18 my English medical record.
19 So -- but those are -- that's a highly technical
20 specific example but that is the level of detail that
21 we'd get into.
22 **MS WOODWARD:** Thank you, Mr Hancock.
23 Thank you, my Lady, those are my questions.
24 **LADY HALLETT:** Thank you.
25 Mr Weatherby.

1 **Questions from MR WEATHERBY KC**
2 **MR WEATHERBY:** Good morning, Mr Hancock. I ask questions on
3 behalf of the Covid-19 Bereaved Families for Justice UK.
4 The first topic was covered by Ms Carey yesterday,
5 asymptomatic transmission, and I think you agreed that
6 decision and policy-making in that respect should have
7 proceeded on a precautionary basis. Have I understood
8 that right?
9 **A.** Yes, and should in future.
10 **Q.** And should in future. What I wasn't so clear about is
11 whether you accepted that as Secretary of State, looking
12 back on it, you should have ensured that in fact that is
13 what happened?
14 **A.** My challenge, looking back on it, is that I was facing
15 a global consensus to the contrary. I pushed hard. One
16 of the challenges you have as Secretary of State is that
17 you have to work out where you can push and how far you
18 can go. Reflecting on it, of course it would have been
19 far better --
20 **Q.** Yes.
21 **A.** -- if we'd had that presumption.
22 **Q.** You were acting on an absence of evidence or what was
23 being told to you there was an absence of evidence?
24 **A.** But I know looking back, if I really searched for what
25 I really felt and knew at the time, I had a strong

1 instinct that this was the problem.
2 **Q.** Yes.
3 **A.** The problem is, looking back, if I had simply said there
4 was asymptomatic transmission, clinicians, right up to
5 the World Health Organisation, would have said you don't
6 have the evidence for that, Secretary of State.
7 **Q.** Yes, but that's the point, Mr Hancock, isn't it? We're
8 talking about an absence of evidence --
9 **A.** Absolutely.
10 **Q.** -- rather than evidence of absence.
11 **A.** And generally --
12 **Q.** And that was your role as Secretary of State to push
13 back and say that?
14 **A.** And generally my approach was to take the reasonable
15 worst-case scenario.
16 **Q.** Yes.
17 **A.** And the reasonable worst-case scenario should have
18 included the possibility of --
19 **Q.** It should.
20 **A.** -- asymptomatic transmission.
21 **Q.** Let me take this one step further. In terms of aerosol
22 or airborne transmission, would you also agree, going
23 forward, that the learning point is that with a newly
24 emerging respiratory disease, the same should apply?
25 **A.** Yes, absolutely, for a respiratory disease, yes.

1 **Q.** Thank you. Topic 2, capacity, and again you've been
2 asked a lot of questions about this so I can deal with
3 this quickly, and about the need to increase capacity
4 and the evidence you've already given about Nightingale
5 hospitals.
6 In Module 1 the Inquiry heard from
7 Professor Sally Davies, the CMO until shortly before the
8 pandemic, who told us that, and I'm quoting:
9 "Compared to similar countries, per 100,000
10 population we were at the bottom of the table on
11 numbers of doctors, numbers of nurses, number of beds,
12 number of ITUs, number of respirators and
13 ventilators."
14 Do you agree that those were all key factors in
15 the capacity problem in the NHS and why you needed to
16 increase NHS capacity after the pandemic struck?
17 **A.** Yes. My response to that is that that is absolutely
18 true, it's one of the reasons I campaigned for the
19 10,000 extra beds in the summer of 2020 ahead of
20 the second wave and --
21 **Q.** Can we focus on the position effectively at
22 1 January 2020 --
23 **A.** Okay.
24 **Q.** -- and what happened then?
25 **A.** Yes, I was going on to say we were in the middle of

1 expanding those numbers very radically from the time
2 when Sally left office. For instance, I'd committed, in
3 2019, to 50,000 more nurses. That has now been
4 delivered but I'm strongly on the record in favour of
5 exactly that argument, yes.
6 **Q.** Thank you. And if we hadn't been bottom of the table in
7 respect to those matters, the need for the extra
8 capacity that you then applied your mind to would at the
9 very least have been mitigated, wouldn't it?
10 **A.** I think "mitigated" is a good word because I would still
11 argue in favour of it as an insurance policy.
12 **Q.** Yes, so again the answer is "yes"?
13 **A.** Yes, it is, yes. Very much so.
14 **Q.** Third topic. Visiting arrangements. And again, a lot
15 of this, a lot of the points I was going to ask you
16 about have already been dealt with so I shan't repeat
17 those, but really one specific point.
18 The Inquiry has heard quite a bit of evidence
19 about the problems of restrictions on support and
20 visiting for those with learning disabilities and that
21 includes the individual referred to by Ms Carey in the
22 questioning she asked you about Susie Sullivan who had
23 Down's syndrome and whose family I represent.
24 **A.** Yes.
25 **Q.** Do you agree that, from the outset, guidance on visiting

1 arrangements during the pandemic should have contained
2 specific provision for people who needed additional
3 support, including those with Down's, those with
4 learning disabilities, those with dementia, in order to
5 ensure their safety and well-being so far as was
6 possible?
7 **A.** Yes, what I'd say is that these rules were drafted very
8 rapidly and one of the important pieces of work that
9 could be done ahead of the next pandemic is to draft
10 such rules so they're on the shelf, so to speak, so much
11 more nuanced rules can be put into place very rapidly
12 with appropriate consultation whilst we've got time to
13 do it.
14 **Q.** Yes, well, no doubt that's a very sensible suggestion,
15 Mr Hancock. But why wasn't that done prior to this
16 pandemic?
17 **A.** Because the anticipation of a pandemic -- we've been
18 through that in Module 1. There wasn't -- there were
19 huge amounts of areas where there wasn't work done.
20 **Q.** Were you aware of the problems created by the
21 restrictions on visitation for those needing support or
22 those with learning disabilities? Did you become aware
23 of that during the pandemic?
24 **A.** I did and I'd worked hard on the question of support for
25 those with learning difficulties and inpatient settings,

1 in particular, ahead of the pandemic so it was an area
2 that I was well versed in.
3 **Q.** Okay, but once the pandemic was on us and these problems
4 arose, did you become aware that the visiting
5 restrictions were having such a deleterious effect on
6 people who needed this kind of support? Did you become
7 aware of that?
8 **A.** I can't remember being presented with specific evidence
9 of individual cases and the debate was more at a higher
10 level about the balance between the spread of the virus
11 and the need for visiting, much as in the case of
12 maternity.
13 **Q.** I don't want to be unfair and you had an awful lot on
14 your plate, but do you think you should have been aware
15 of it?
16 **A.** Well, this would have been brought to me as a policy
17 issue rather than individual cases which would have,
18 rightly, been the responsibility of those on the ground.
19 **Q.** Yes, and do you think the policy problems should have
20 been brought to you?
21 **A.** Well, at that time, the team had a very difficult task
22 to do to work out which issues needed to be brought to
23 my attention because I was -- if you're working
24 an 18-hour day there was still a massive limitation on
25 bandwidth, so these decisions did have to be taken and

1 probably appropriate to be taken at a junior ministerial
2 level.
3 **Q.** Is the real answer yes, this was a real problem,
4 a problem that we've heard really affects the welfare
5 and mortality rates of people with learning
6 disabilities? Is the answer yes, it should have been
7 brought to your attention?
8 **A.** The easy answer for me to sit here and say would be
9 "yes". What I've been at pains to do during this
10 Inquiry is to try to explain what it's really like and,
11 in this instance, I think if a civil servant had made
12 a decision that this sort of matter would go to the
13 minister of care, I think that would have been
14 an appropriate decision.
15 **Q.** So it should have gone to somebody else?
16 **A.** There's a ministerial team for a reason. If you try to
17 put every decision through the Secretary of State,
18 decisions just don't get made.
19 **Q.** I'll move on. Topic 4 and back to 111 services.
20 I think that you've already confirmed that part of the
21 reassurance to the public underlying the Stay at Home
22 messaging was that those who needed NHS care could
23 continue to access the NHS, including online and through
24 first point of contact 111. And the devolved services,
25 similar services. Is that correct?

1 A. Yes.
2 Q. And by way of example, and it's just one example, one of
3 the families that I represent, her father followed the
4 guidance, attempted many times to call 111, each time it
5 took several hours to get through, his health
6 deteriorated, each time he was told to remain at home.
7 And that's quite a typical report from family members.
8 A. Yeah.
9 Q. Now plainly the plan relied on 111 being able to cope
10 with the increased levels of demand. I'm not going to
11 take you to that because Ms Carey did yesterday, but the
12 plan -- the messaging and the reassurance for Stay at
13 Home relied on 111 being able to cope with the increased
14 level of demand --
15 A. But not only on 111. So this brings to the point about
16 the NHS as a whole being there. So 111 is, of course,
17 a vital service and was --
18 Q. First point of contact, your words.
19 A. And weighed upon heavily. However 999 remained
20 available and didn't have the same outages. So people
21 who were facing an acute problem could switch from
22 calling 111 to calling 999 if necessary.
23 Q. Right. Well, let's focus on the first point of contact,
24 the service that you were advising the public to use as
25 the first point of contact unless they had, for example,

1 serious immediate life-threatening problems, in which
2 case they would phone 999. Okay? So let's focus
3 on 111.
4 And I think you're agreeing with me, I'll put it
5 again, that the plan relied on 111 being able to cope
6 with the increased level of demand?
7 A. No, I repeat my previous answer that 111 was one service
8 within a range of services, and your request to focus
9 only on 111 is not appropriate in the question that you
10 give because you have to look at the services provided
11 by the NHS as a whole.
12 Q. Right. Well, I'm not going to ask the question yet
13 again but I am concentrating --
14 A. You can, but I'll give you the same answer. The point
15 is you're concentrating on 111. My point is that if you
16 have a life-threatening condition and you can't get
17 through on 111, you call 999, and that is very broadly
18 known.
19 Q. Noted. We've been through that.
20 Is it correct there was no emergency pandemic
21 planning around the use of 111, including no planning
22 for increasing the capacity of 111 services?
23 A. I don't know that for sure but I wouldn't be surprised
24 if that was true because 111 was brought in after the
25 pandemic plan was written in 2011.

1 Q. Yesterday you gave evidence regarding some consideration
2 of delaying the Stay at Home message by 24 to 48 hours
3 to allow more time for the 111 system, and no doubt the
4 999 system as well, to get more ready, yes?
5 A. Yes, that's right.
6 Q. Can you help what could have been done in 24 hours or
7 48 hours to cope with the surge that Ms Carey took you
8 through yesterday?
9 A. Well, again, this is an operational question for
10 Sir Simon Stevens. He, in the COBR meeting, suggested
11 that delay for these operational reasons and it was
12 taken into account.
13 To give examples of what could have been done:
14 firstly, there would have been more time to draft
15 scripts, because 111 relies on scripts for call handlers
16 to follow, to give them guidance of how to answer
17 questions. In the end there was a matter of hours and
18 those scripts were put together overnight as opposed to
19 having 24 to 48 hours to write them.
20 The second thing is that the operation to
21 expand 111 and bring in more call centres --
22 Q. Yes.
23 A. -- could have been -- would have had 24 to 48 hours more
24 notice to put in place. So those two examples.
25 Q. Okay. But you're not sensibly suggesting that 24 hours

1 or even 48 hours would have made a material difference
2 to getting robust and appropriate scripts together,
3 never mind call centres and further staff; you're not
4 sensibly suggesting that, are you?
5 A. Well, the question implies an easy world of being able
6 to do what you fancy. That isn't what happens in
7 a pandemic. The reality is that everything -- nothing
8 is done perfectly, everything is done to people's best
9 ability.
10 And as I say anyway, the Prime Minister then made
11 the judgment not to wait that period, understanding and
12 taking into mind the operational improvements that could
13 have been made. It wouldn't have been perfect, even
14 after 24 or 48 hours, as you imply, but it would have
15 been easier operationally, but we decided not to do that
16 and, with hindsight, I think that was the right
17 decision.
18 Q. Well, so far as we can see from the disclosed material
19 it wasn't until May that you considered whether the 111
20 service had been able to cope with the demand that was
21 immediately put on it by this policy, and it was in the
22 middle of May that you caused to be conducted a deep
23 dive regarding 111 capacity, and that appears to have
24 come out of a Quad discussion on 18 May. Does that
25 sound right to you in terms of the timing?

1 A. No. The work to enhance and support 111 was immediate
2 from the middle of March, when that COBR discussion took
3 place and, before that, in anticipation that there be
4 a huge surge of questions, and there was immediate work
5 to support 111 during that period, that again was led by
6 the NHS, by NHS England. That work was successful.
7 By May we were able to then look back to understand what
8 had happened as opposed to the hand-to-mouth immediate
9 response.
10 Q. I follow. In fact, it was a result of that deep dive
11 that you ended up being informed on, I think 22 May, of
12 the 40% of 111 calls that had gone unanswered in
13 March 2020, as we heard yesterday. Does that accord
14 with your recollection?
15 A. I have no reason to doubt that.
16 Q. Yes. Sticking with 111 for a moment. My next point.
17 The quality of the service. Again, you were referred to
18 the Healthcare Safety Investigation Branch investigation
19 published in September of 2022. And you referred to it
20 yesterday in evidence with regard to the strong
21 messaging which may have discouraged some people from
22 seeking treatment. But it's not that point I want to
23 ask you about.
24 The same report made a number of critical findings
25 in relation to the 111 service, including that the Covid

1 Response Service, which was an add-on, if you like, to
2 the 111 service --
3 A. Yes.
4 Q. -- it didn't function as intended --
5 A. Yes.
6 Q. -- and that there were basic deficiencies in the advice
7 and that callers were not asked about comorbidities and
8 there was comment about the needs of specific groups
9 such as those with learning disabilities or whose first
10 language wasn't English. Are you aware of those
11 criticisms of the 111 service by the HSIB?
12 A. Yes. I think you have to set them against the fact
13 that, thank God we had 111 in the first place, and it
14 did an amazing amount of work. The correct thing to do
15 is to thank those who worked in 111 for their service
16 and be grateful that we had it and then to seek to
17 improve the response in the future.
18 Q. Yes.
19 A. I think the point that you make specifically about the
20 pandemic response line is an important one that
21 I haven't seen drawn out yet in any of the discussion,
22 which was that there was a PHE contract for a pandemic
23 response line in anticipation of the need for a phone
24 line, and it did not integrate well, and one of the
25 lessons should be to be ready to expand 111 with draft

1 scripts that could draw from the learnings from the
2 pandemic.
3 Q. I've no doubt you are right that's a lesson that can be
4 drawn, but before we get to that, can you help us that
5 during your time as Secretary of State what quality
6 assurance mechanisms were put in place so that you could
7 be satisfied, as Secretary of State, of the quality and
8 functioning of the 111 service?
9 A. Well the 111 service was contracted by NHS England so it
10 would be their responsibility to do that. What I say,
11 though, is that, again, this was put in place very
12 rapidly, in short order, and just as we were earlier
13 discussing, you've got to take 111 in its context with
14 the 999 and, of course, physical services and being able
15 to call your GP, and the other side, there's also now
16 much more widespread online availability of information,
17 and for many people not being able to reach 111 would
18 lead them to search on the NHS website. We saw that
19 journey many times as well.
20 So you've got to see the information provision in
21 the round rather than simply looking at one sentence.
22 Q. Can I ask you to focus on the question. The question
23 was that this is a big part of your policy of Stay at
24 Home. It's one of the mechanisms to underpin that
25 policy. I entirely understand that it's been rolled out

1 very rapidly. But you need to roll out quality
2 assurance rapidly as well, don't you, because otherwise
3 you may roll out something which doesn't work as, in
4 fact, to some extent, seems to have been what happened
5 here?
6 A. I repeat my previous answer which is that the question
7 implies a world of time and easy consideration which is
8 simply not the world that anybody inhabits when they're
9 trying to respond to a pandemic. This was a deadly
10 pathogen and we were bringing in measures from
11 January 2020 with enormous rapidity, and I'm very
12 grateful for those who did that work and did it so well.
13 Can it be improved? Of course it can, as anything
14 done in a massive hurry can be improved, as it was
15 during the pandemic.
16 Q. So the lesson is to have a plan for services like 111
17 including a surge capacity plan --
18 A. Precisely, yes.
19 Q. -- but also a plan to quality assure it so that you know
20 that you're actually not wasting your time?
21 A. Well, that implies that there's a binary between putting
22 up stuff that is useful and putting up nothing at all.
23 Actually, putting together scripts very rapidly, putting
24 things on the internet, on the website very rapidly, and
25 then improving them iteratively is in practice what you

1 do in these circumstances. There isn't -- there may be
2 time for somebody like the CMO or another qualified
3 clinician to look over prepared documents that are
4 prepared in a very, very short window of time, of course
5 you can do a formal quality assurance later, but in many
6 cases we had to do things far, far faster than we would
7 do in normal circumstances, and if you don't take that
8 into account then the point you're making doesn't really
9 make sense.
10 **Q.** Well, the question was actually aimed at how you
11 optimise the services that you were able to provide,
12 even given the lack of planning and the lack of
13 capacity.
14 **A.** Yes.
15 **Q.** So having no assurance meant that you simply didn't know
16 whether these services were working properly or
17 optimally in the circumstances.
18 **A.** Well, firstly, there was not no assurance, because
19 senior clinicians looked at these materials before they
20 went out. And secondly, the way that the world works in
21 practice is that you get the best information you can
22 out, if you have to move very rapidly, and then you
23 improve it over time. It is not a sequential process
24 with the benefit of time.
25 Now is the moment to do the work that requires

1 time and use time to consult with bodies. Now is the
2 moment to --
3 **Q.** As you correctly said, we discussed that in Module 1.
4 The next topic, DNACPRs. Again, you were asked
5 a number of questions yesterday about this. And you
6 stated that you were aware from early April 2020 that
7 there were concerns being raised about the inappropriate
8 imposition of DNACPRs, and potentially blanket orders,
9 and this is something that chimes with well over 400 of
10 the family members that I represent, who have raised
11 such concerns.
12 This was an issue, wasn't it, that was on your
13 radar long before April of 2020 because in May of
14 2019 --
15 **A.** Yeah.
16 **Q.** -- there was the NHS learning disability mortality
17 review, sometimes referred to as the LeDeR, and that had
18 identified a whole host, about 19, instances where
19 learning disabilities or Down's syndrome were given as
20 a rationale for a DNACPR order.
21 **A.** Yes.
22 **Q.** And you knew about that, didn't you, because in fact --
23 **A.** Not only did I know about it, I acted on it at the time
24 absolutely and --
25 **Q.** I'm coming to that.

1 **A.** Right.
2 **Q.** So on 12 February of 2020 the government, your
3 department, issued a response to that report, and in
4 that report -- I'll give the reference just for the
5 record. It's INQ000474478. And in that report, at
6 paragraph 2.47, your department describes the problem
7 that I've just raised as being "completely
8 unacceptable"?
9 **A.** Yes, that was my view.
10 **Q.** And that will be your view?
11 **A.** Very strongly held, yeah.
12 **Q.** Yes. And as a result of that, the action that was
13 taken, so far as I understand it, was that the
14 department wrote to trusts to say that this needed to be
15 addressed?
16 **A.** Yes, I think that was done again by my -- by the junior
17 minister, but it was something that I was --
18 **Q.** Sighted on?
19 **A.** Yes.
20 **Q.** Indeed. Now we come to April, literally two months
21 later.
22 **A.** Yeah.
23 **Q.** And other problems, but similar problems in some cases,
24 materialised in respect of Covid patients.
25 **A.** Yes.

1 **Q.** And so yesterday you told us that you'd acted again
2 in April and you made a number of public statements.
3 But in fact, apart from that, nothing else was done
4 until October, when the CQC started to investigate and
5 report on the DNACPR issues. That's the reality, isn't
6 it?
7 **A.** No.
8 **Q.** No?
9 **A.** No.
10 **Q.** Okay. Well --
11 **A.** The reality is that as soon as I heard about this being
12 a potential problem and these concerns being raised with
13 me, I immediately acted because I feel so strongly about
14 this, and I went public on it, including using the
15 platform of the daily press conference to reiterate the
16 total unacceptability of this. And I discussed it with
17 the NHS leadership, whose responsibility it was to stop
18 it from happening.
19 **Q.** Sir Simon Stevens?
20 **A.** Yes.
21 **Q.** Well, I can help you with this because what in actual
22 fact happens in early September or by early September,
23 David Davis MP raises a question about a number of
24 allegedly inappropriate DNACPRs, and that prompted
25 an email discussion which refers to you having a meeting

1 with Sir Simon about this issue.
2 And in that email correspondence, which was at
3 tab 61 of your evidence bundle, INQ000478907 for the
4 record, it's clear that there was still no data
5 available to assess the scale of the problem or to
6 monitor any progress held by either the DHSC or
7 NHS England.
8 So, yes, you'd written in February to the NHS
9 trusts, yes, you'd used your public platform to
10 recognise the issue, but then nothing had been done
11 apparently to monitor or collect data or again assurance
12 about whether the problem is continuing or how it had
13 been dealt with. That's the reality, isn't it?
14 **A.** No. The reality is that when this issue was highlighted
15 I didn't use my public platform to discuss the issue,
16 whatever the word was. I used my public platform to
17 instruct that this was entirely unacceptable. There is
18 no reason that the department would have data on this
19 because it's a question within the NHS, and I took it up
20 with the NHS.
21 I'm afraid we come to the division of
22 responsibilities between the NHS and the department.
23 The departmental position was extremely and vocally
24 clear, and then when it was again brought to my
25 attention I took further action. So the -- that's what

1 I did and that was what I was accountable for.
2 I absolutely -- looking back, I took the action that
3 I ought to have taken and there is no -- there is
4 absolutely no reason why anybody should put in place one
5 of these measures without a properly consented process.
6 **Q.** Well, I've put the point to you. The Inquiry has the
7 documents. But no monitoring, no data, no assurance,
8 and that's what happens in early September and that's
9 what triggers the CQC having a look at the issue.
10 That's the reality, isn't it?
11 **A.** The reality is that I raised this matter with those who
12 were properly appropriate for ensuring that it didn't
13 happen.
14 **MR WEATHERBY:** I'm out of time.
15 **LADY HALLETT:** Thank you very much, Mr Weatherby.
16 Ms Carey, any further questions from you?
17 **MS CAREY:** No, my Lady, I have had an opportunity to look at
18 the transcript overnight and there's nothing I need to
19 clarify, thank you.
20 **LADY HALLETT:** Thank you very much.
21 Mr Hancock, that completes the questions we have
22 for you in this module although I'm afraid I do know
23 that we are going to be asking you questions in another.
24 Thank you for your help so far.
25 **THE WITNESS:** Thank you very much.

1 **(The witness withdrew)**
2 **LADY HALLETT:** Very well, noon on Monday.
3 **(11.40 am)**
4 **(The hearing adjourned until 12.00 noon**
5 **on Monday, 25 November 2024)**
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