Witness Name: HELEN WHATELY
Statement No: 1
Exhibits: HW/1-HW/466
Dated: 30 October 2023

UK COVID-19 INQUIRY

WITNESS STATEMENT OF HELEN WHATELY

I, HELEN WHATELY, Minister of State (Minister for Social Care) in the Department of Health and Social Care, 39 Victoria Street, London SW1H 0EU, will say as follows:

INTRODUCTION

1. I make this statement in response to a request from the UK COVID-19 Inquiry (**the Inquiry**) dated 11 July 2023 under Rule 9 of the Inquiry Rules 2006, asking for a draft witness statement for Module 2 of the Inquiry (ref: M2/DHSC/WHATELY/1) (**the Rule 9 Request**).

2. The Inquiry has specifically asked about the role I played in core political and administrative decision-making with regard to the COVID-19 response while serving as Minister for Care (**Minister**) at the Department of Health and Social Care (**DHSC**) from 13 February 2020 to 16 September 2021, and as Exchequer Secretary (**Secretary**) to HM Treasury between 16 September 2021 to 24 February 2022.

3. The Rule 9 Request defines core decision-making as decisions that were taken by *"the Prime Minister / No.10, the Cabinet Committees and the Lead Government Department"*. As far as possible, I have sought to address the list of issues set out in the Rule 9 Request where they appear to be relevant for understanding core decisions taken in this period. My view, however, is that the Inquiry would benefit from further context and detail on issues beyond those identified within the Rule 9 request. I have therefore included those additional matters below.

4. I understand that corporate statements covering DHSC's formal decision-making structures are being provided to the Inquiry as part of Module 2. Chronologies have been prepared for those witness statements which identify central decision-making during the time in question by the Cabinet Office Briefing Rooms (COBR), senior civil servants and Ministers, as well as specialist agencies and advisors. Supplemental corporate statements also address DHSC's role in guidance and policy advice given to care homes and

Adult Social Care. This statement should therefore be read alongside these other Module 2 statements.

5. This statement is accurate and complete to the best of my knowledge and belief at the time of signing. DHSC continues to work on its involvement in the Inquiry. In the event that additional material is discovered, it will be provided to the Inquiry, and I will be happy to make a supplementary statement if required. Given the volume of material relating to the pandemic I have not been able to review all documents. This statement has been read by Michelle Dyson, Director General for Adult Social Care in DHSC, in the final draft format to check for accuracy and clarity.

OPENING REMARKS

6. I want to provide the Inquiry with full insight into the decisions that I was involved in to help us learn all that we can and be better prepared for any future pandemic.

7. I also know people who lost loved ones during the pandemic, particularly families of people who died in care homes, are following the Inquiry closely. When I can, I want to be able to give them the answers they seek. I know this will not bring back their gran or granddad, mum or dad, husband, wife, sibling or dear friend they lost to COVID-19, nor the time they were unable to spend with their loved one during lockdowns.

8. In working on this statement, I have thought back to the early weeks of the pandemic. Much of my statement draws on written records rather than relying on my recollections. However, it is not hard to recollect the context in which those decisions were made, as we watched COVID-19 take hold in other countries overwhelming their health systems and we entered a global race to secure personal protective equipment (PPE) and COVID-19 tests. We faced uncertainty about how COVID-19 would affect people, the effectiveness of tests and PPE. The clock was also constantly ticking, giving far less than the usual time for developing, scrutinising, and implementing policies.

9. Something I am sure of is that wherever I looked, I saw people doing their utmost to do the right thing, to make the right decisions and to solve the problems encountered at every turn, to save lives and help people get through the pandemic. At every level, from senior civil servants through to front line care workers, people did their very best and in so doing, put in extraordinary hours and effort.

10. I have also reflected on the lessons I have learned from the pandemic. As we came through the first wave of Covid I initiated work to prepare for a potential

second wave. That work drew extensively on the experience of the pandemic so far. Though the second wave was hard, I am confident we were better able to support social care and the NHS workforce as a result. There is a risk as we learn from our Covid experience that we prepare ourselves better for the last pandemic rather than the next one. However, the lessons I reflect on at the end of this submission would stand us in good stead in any event, including to strengthen our care system in normal times.

MINISTER OF STATE (MINISTER FOR CARE)
DEPARTMENT OF HEALTH AND SOCIAL CARE

STRUCTURE OF THIS STATEMENT

11. This section of my statement covers the period from 13 February 2020 to 16 September 2021, in which I served as Minister of State for Care under Prime Minister Boris Johnson (**the Prime Minister**). Matt Hancock was the Secretary of State for Health and Social Care (**the Secretary of State**) until 16 June 2021, followed by Sajid Javid until the time I left this post.

12. The Inquiry has asked me to explain my involvement in core decision-making rather than day-to-day operational decisions. The latter will be covered by DHSC's corporate statements. For the purposes of this statement, therefore, I have focused on decisions that passed between me and the Secretary of State and, ultimately, were made or approved by the Prime Minister / No.10. I also include what I consider to be key decisions made by the Secretary of State in respect of social care, but which did not involve Prime Ministerial / No.10 approval.

13. In respect of social care, the most significant areas of decision-making between 13 February 2020 to 16 September 2021 were:

- Admissions to care homes;
- Procurement and distribution of PPE;
- Testing;
- Easements to the Care Act 2014;
- Workforce capacity, staff movement and support;
- Visiting;
- NHS support for social care;
- Vaccinations; and
- Funding.

14. To aid the Inquiry and make my statement easier to follow, I have structured my evidence according to these areas of decision-making. In what follows, I set out my portfolio as Minister and make some introductory remarks about

overarching issues that cut across these areas of decision-making. These include the approach taken to social care by DHSC throughout the pandemic, the role of guidance, and the development of data and information as the pandemic progressed. I then discuss the core decisions made in respect of each of the areas identified above and my role in the making of those decisions.

15. From September 2021 to July 2022, I was Exchequer Secretary to the Treasury. During that time, I was not centrally involved in making decisions concerning COVID-19 which would be "core" decisions as I set out below.

RESPONSIBILITIES AS MINISTER AND DHSC'S SOCIAL CARE TEAM

16. Reflecting on the questions asked in the Inquiry's Rule 9 Request, this statement focuses on the social care part of my ministerial brief. Should the Inquiry be interested in any other parts of my portfolio in relation to the pandemic, then I would be happy to provide relevant responses.

17. When I was first appointed as Minister in February 2020, my portfolio as agreed by the Secretary of State (HW/1 - INQ000327765 HW/2 - INQ000327766) consisted of:

- **Adult Social Care** (including finance, workforce, quality and regulation, provider market, contingency planning, carers, and social care reform).
- **Health and Care Integration** (including the Better Care Fund, devolution, personal health budgets, and end of life care).
- **NHS Workforce** (including departmental sponsorship for Health Education England).
- **Dementia, disabilities and long-term conditions**.
- **Abortion**.
- **NHS Continuing Health Care**.

18. From early March 2020, my ministerial role was focused predominantly on the COVID-19 response across the portfolio areas above. COVID-19 responsibilities were formally divided across Ministers, and in July 2020 my portfolio included social care resilience, NHS workforce, and ministerial oversight of the Joint Biosecurity Centre (JBC), the latter until March 2021 (HW/3 INQ000327961; HW/4 - INQ000327984 HW/5 - INQ000328115).

19. Social care comes in many forms, with a range of funding models, provisions for oversight and accountabilities. In very broad terms, DHSC sets the policy and the legal framework for Adult Social Care and is accountable to Parliament for Adult Social Care outcomes. The Ministry of Housing, Communities and Local Government (MHCLG), now the Department for Levelling Up, Housing and Communities (DLUHC), controls overall local government funding and its

distribution to local authorities. The Care Quality Commission (CQC) is the independent regulator of health and social care. Local authorities (of which there are 152) are lynchpins in our social care system, with responsibilities to support self-funders and carers, as well as people whose care is state funded. They are responsible for meeting the care needs of the local population and for the safeguarding of those receiving social care. Local authorities are not "overseen" by central government; but are democratically accountable to their local population.

20. During the pandemic DHSC worked with local authorities, local public health teams and CQC to help care providers and carers. We also considered the range of models of care in the development of guidance, Infection, Prevention and Control ("IPC") measures, testing and so on.

21. I also had responsibility for DHSC's policy in respect of the Adult Social Care workforce. Most of the social care workforce are care workers who are not subject to professional regulation. Other roles include registered managers and the regulated professions: nurses, occupational therapists, and social workers. DHSC's role is to work on policies to develop the size and skills of the social care workforce, working with the Home Office on immigration policy for social care workers and with DWP on support for job seekers to apply for social care roles, along with promoting social care careers. Local authorities are responsible in law for ensuring there is sufficient workforce capacity and capability of trained and qualified staff, and care providers are responsible for employing and developing their own workforce.

22. In March 2020, DHSC's social care team consisted of 89 full time employees primarily working on social care policy. This team was led by an experienced Director, Rosamond (Ros) Roughton, who was promoted to Director General in April 2020 and who reported to the Permanent Secretary until her departure in July 2020. Ros was subsequently replaced by Michelle Dyson. The demands of the pandemic meant the social care team expanded rapidly. By September 2021, there were 301 full time employees.

DECISION-MAKING STRUCTURES AND SOURCES OF INFORMATION

23. In normal times, decision-making in DHSC is largely carried out through submissions to the Secretary of State and other DHSC Ministers. A submission will set out an issue, advice, and recommendations. A senior official will sign off the advice and recommendation before it reaches the relevant Minister(s). Some submissions are commissioned by Ministers to provide specific information or advice. All decisions are formally attributed to the Secretary of State, and the procedure takes one of two forms – either:

23.1. The relevant junior minister will receive a submission, consider it, and make a decision. This is then passed on to the Secretary of State for him to issue a formal decision; or

23.2. A submission will go to the junior minister and the Secretary of State simultaneously, usually for reasons of expediency. Whether the Secretary of State waits for the junior minister's decision before making their own formal decision will depend on the particular circumstances.

24. In my experience, Ministers receive a significant number of submissions and briefings most working days which are allocated to the minister's "box". The private office staff act as gatekeepers, prioritising submissions to be reviewed, sending back submissions which are sent without the information the minister will need to make a decision, and filtering or flagging briefings. Ministers and private offices may also be copied into other Ministers' submissions or discussions to give them an opportunity to contribute to the decision-making process. Being copied in does not mean, however, that the submission is necessarily included in your box.

Meetings with the Cabinet Office / No. 10

25. In the first year of the pandemic I attended meetings with the Prime Minister, First Secretary of State (Dominic Raab) and the Cabinet Office to discuss the COVID-19 response. I was usually asked to attend those meetings to present or discuss policy for adult social care specifically or where other departments' policies were likely to impact social care, for example:

25.1. An Adult Social Care Strategy meeting held on 13 April 2020 with the First Secretary of State, Secretary of State for Health, and Chancellor of the Exchequer on the testing of care home staff (HW/6 - **INQ000327832**; HW/7 - **INQ000327834**).

25.2. A meeting held on 28 April 2020 with the Prime Minister, First Secretary of State, Secretary of State for Health, Chancellor of the Exchequer and Chancellor of the Duchy of Lancaster on reducing infections in care homes on 28 April 2020 (HW/8 - **INQ000327862**; HW/9 - **INQ000327866**).

25.3. COVID-19 Dashboard meetings held on 14 May 2020, 14 October 2020 and 4 November 2020 with the Prime Minister, Secretary of State for Health and Chancellor of the Exchequer to discuss the statistics for hospitals and care homes, including admissions, workforce capacity, testing and self-isolation (HW/10 - INQ000088624; HW/11 - **INQ000328000**; HW/12 - **INQ000328003**).

25.4. A deep-dive meeting led by the First Secretary of State on 6 May 2020 focusing on care homes and nosocomial transmission (HW/13 - INQ000327876; HW/14 - INQ000327877).

25.5. A meeting held on 26 May 2020 led by the Prime Minister focusing on the delivery of IPC training to care home staff, PPE and testing within care homes 21 May 2020 (HW/15 - INQ000327906; HW/16 - INQ000327915).

26. As well as the Ministers referred to above, these meetings were also attended by other senior Ministers (such as the Secretary of State for MHCLG, Minister of State for the Cabinet Office), senior civil servants including the Cabinet Secretary and Permanent Secretary for DHSC, Special Advisors, the Chief Medical Officer (CMO), the Chief Scientific Adviser (CSA), and the Chief Executive Officer for NHS England.

Ministerial meetings

27. In March, four Ministerial Implementation Groups (MIGs) were established to support COBR, including a healthcare committee (HMIG) chaired by the Secretary of State for Health and Social Care. I attended HMIGs and represented DHSC at other MIGs on a number of occasions. The HMIGs were usually attended by Ministers from multiple departments, including the Secretaries of State for MHCLG, Cabinet Office, DEFRA and DWP. Senior members of DHSC also attended, as well as the Chief Executive of the NHS.

28. The MIG system was replaced on 29 May 2020 with two Cabinet Committees, COVID-Operations (COVID-O) and COVID-Strategy (COVID-S). Explanations of these are set out in paragraphs 76 and 77 of Sir Christopher Wormald's Third Witness Statement to the inquiry. My diary indicates that I attended 11 COVID-O meetings, usually alongside the Secretary of State.

29. My role in these meetings would vary depending on the agenda for discussion. For example, on the topic of restricting staff movement, I presented policy proposals to No.10 and the Cabinet Office (HW/17 - INQ000328033; HW/18 - INQ000328034; HW/19 - INQ000328035; HW/20 - INQ000328036; HW/21 - INQ000090180). I also presented policy proposals on care home visiting (HW/22 - INQ000091078). For other issues, such as shielding packages, the presentation of the policy would be led by another departmental minister, and I would provide my reasons for agreeing with or opposing the policy, or suggestions to improve it (HW/23 - INQ000327962 HW/24 - INQ000327963; HW/25 - INQ000051409; HW/26 - INQ000055934; HW/27 - INQ000083685).

30. These meetings brought Ministers together to share their departmental perspectives to improve policy. Overall, I believe these worked well. For example, when Ministers were discussing who would be considered a "key worker" for school attendance, I was able to advocate for care workers to be on the list.

DHSC meetings

31. At the outset of the pandemic, the Secretary of State organised daily morning meetings involving the CMO, PHE and Ministers to provide updates on the situation and preparedness: see for example (HW/28 - INQ000233747). I attended these where appropriate.

32. From mid-February to the end of July 2020, the Secretary of State also hosted weekly COVID-19 meetings attended primarily by DHSC Ministers and staff to provide updates on issues such as PPE supplies, NHS and workforce, social care: see for example (HW/29 - **INQ000327868**; HW/30 - **INQ000327867**; HW/31 - **INQ000327927** HW/32 **INQ000327928**).

33. Between June 2020 and May 2021, I usually attended regular JCB 'Gold meetings': see for example (HW/33 **INQ000327995**; HW/34 - **INQ000328061**; HW/35 - **INQ000328069**). These meetings were chaired by the Secretary of State to review data and inform decisions on 'tiering' and the consequent NPIs. These meetings were the culmination of a well-organised process to make decisions based on data and local intelligence. The list of attendees brought together a range of perspectives including public health and local authority representatives.

34. I also held Adult Social Care COVID-19 oversight meetings attended by Rosamond Roughton, Jenny Harries (DCMO), the Adult Social Care team, PHE and sometimes Ministers from MHCLG and the Cabinet Office to specifically discuss operational issues and the implementation of policy related to Adult Social Care: see for example (HW/36 - **INQ000327810**; HW/37 - **INQ000327842**).

Adult Social Care Stakeholder Engagement

35. Prior to my time as Minister, DHSC established weekly meetings with stakeholders who represented the Adult Social Care Sector, including care home representatives. An Adult Social Care '**National Steering Group**' was created to coordinate the response from social care providers around the country to COVID-19. This included DHSC, MHCLG, NHS England and NHS England and NHS Improvement (NHSE/I), CQC, PHE, the Devolved Administrations, and stakeholders such as the Local Government Association,

the Association of Directors of Adult Social Security and the Care Provider Alliance. Meetings ran from 5 February 2020 to 11 March 2020 and were composed of senior civil servants and leaders of the relevant organisations.

36. In March, the National Steering Group was replaced by a senior leaders' group called the **National Adult Social Care and COVID-19 Group**. Representatives included the NHS, CQC, Local Government Association (LGA), PHE, as well as Carers UK, the Care Provider Alliance, and the Association of Directors Adult Social Services (ADASS). The role of the group was to inform the development and implementation of DHSC's response to COVID-19 in Adult Social Care and advise on action to support local authorities and providers. It also acted as a conduit for communications from the sector into government, and vice versa. The group met weekly from 6 March 2020 to 17 June 2020.

37. In June 2020 we launched the **Adult Social Care Taskforce**, building on the National Adult Social Care and COVID-19 Group. The Taskforce was set up to oversee the delivery of (i) the April Action Plan for social care (HW/38 - INQ000279924) and (ii) the May Support Policy for care homes (HW/39 - INQ000106440). I was involved in the decision to set up this taskforce, which sought to learn lessons from the first wave of the virus and widen the level of sector involvement.

38. The Taskforce was chaired by Sir David Pearson, former President of ADASS, who reported to me as Minister for Care. Eight advisory groups were established to explore specific areas of social care.[1] The Taskforce considered the provision of PPE, COVID-19 testing arrangements, the winter flu vaccination programme, infection prevention and control, issues of funding, issues relating to the workforce and unpaid family carers, and how best to restrict the movement of people between care and health settings.

39. At this time DHSC was inundated with increased volumes of correspondence from stakeholders, MPs and members of the public. In March 2020 alone the department received 8382 pieces of correspondence compared to 2488 in March 2019. This inevitably resulted in significant delays in correspondence being seen and answered. I did not generally see these letters/emails until many months later. I believe they will have been processed by the correspondence unit, but that team was clearly having to process an exceptional volume of correspondence. Later on we established a process to prioritise correspondence which would need a particularly prompt response, but it took some time for the team to work through the backlog. Both during the pandemic and in normal times, as a Minister I make sure I have stakeholder

[1] Those areas being: (1) Ethnic groups and ethnic communities, (2) carers, (3) good practice, guidance and innovation, (4) mental health and wellbeing, (5) older people and people living with dementia, (6) people with learning disabilities and autistic people, (7) self-directed support, and (8) workforce.

groups (as described above) to keep me in touch, and officials also have contacts with stakeholders which inform their advice to Ministers. For example, I established several forums which gave me regular and direct contact with care providers as well as representative groups for carers and care users. This enabled me to hear first-hand the challenges they were facing and feed that into decision making. I held monthly roundtables with care providers and representative organisations[2], monthly roundtables with those representing people living in retirement communities and Government supported living[3] and monthly meetings with a group of care user representatives[4]. I held several roundtables with representatives of the social care workforce[5] and tried to visit (virtually) some individual establishments every month so I could hear from frontline staff and care home residents or carers where possible. I attended roundtables with local authorities jointly with my Ministerial counterpart from MHCLG and held a number of discussions with Directors of Adult Social Care and Directors of Public health.

40. I established several forums to have direct personal contact with social care provider representatives, major providers and care user groups. For example, I had regular virtual meetings with a group of provider representatives and major providers, and regular meetings with a group of care user representatives and care users which included Age UK, Shared Lives (who provide supportive placements for those (largely under 65) in people's homes), Carers UK, TLAP etc. I spoke to care worker representatives such as UNISON and UNITE, and also Skills for Care. I had smaller group or individual virtual meetings with specific stakeholders, such as ADASS, Age UK and MENCAP. And I did 'virtual visits' with care providers (given in-person visits were not permitted) and also met with unpaid carers[6]. I also had a number of ad-hoc meetings with care organisations and providers[7].

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[2] Including the Care Providers Alliance, National Care Forum, National Care Association, UK Homecare Association, Associated Retirement Communities Operators, Shared Lives Plus, Registered Nursing Home Association, Association of Mental Health Providers, Care England, Care UK, Age UK, British Association of Social Workers, SOLACE, Mencap, and Voluntary Organisations Disability Group.

[3] Including Retirement Housing Group, Home Builders Federation, McCarthy & Stone, Churchill Retirement Living, LifeStory Group, Association of Retirement Housing Managers, Housing Learning and Improvement Network, Associated Retirement Community Operators, and DLUHC.

[4] Including Think Local Act Personal, Living your dream consultancy, Inclusion London, Coalition for Collaborative Care, Disability Rights UK, SCIE, Spectrum Centre for Independent Living, Race Equality Foundation, Independent Living Strategy Group, Social Care Future, Alzheimers Society, and InControl.

[5] British Association of Social Workers, GMB, Royal College of Nursing, Royal College of Occupational Therapists, NACAS, and Unison,

[6] My diary shows, for example, a virtual visit to Beckside Care home on 9 December 2020, and another on 8 October 2020; on 15 October 2020 to South Shields and Sunderland; and visits to unpaid carers in February 2021.

[7] For example, I met with CERA care on 3 April, the 10 April and the 14 April 2020; with carers and people with lived experience of care on 11 February 2021 and 15 April 2020.

Advice from PHE and clinicians

41. Throughout the pandemic, I was provided with advice and support from PHE and the Office of the CMO, as well as from NHS England. The majority of guidance about IPC was issued by PHE. PHE, along with one of the DCMOs at that time (Jenny Harries), provided briefings and advice to me and to DHSC officials to inform policy decisions. The PHE lead for Social Care provided expert input during regular calls and meetings with the Adult Social Care team. These took place on a daily basis during the first six months of the pandemic.

DECISION-MAKING AS MINISTER OF STATE FOR SOCIAL CARE

42. This section of my statement covers my role as Minister for Care in core decisions taken between 13 February 2020 and 16 September 2021.

Ramping up the Adult Social Care pandemic response within DHSC and with local authorities

43. I was appointed Minister of State for Care on 14 February 2020. At that time the official UK position on COVID-19 was that the risk to the public remained moderate, and the advice being given to the public was to self-isolate immediately for 14 days, even if symptoms were minor (HW/40 - **INQ000327763**). On 12 February, the CMO had made a public statement about a new patient in England testing positive for COVID-19, bringing the total number of cases in the UK to nine (HW/41 - **INQ000327764**). SAGE had concluded that neither travel restrictions within the UK nor prevention of mass gatherings would be effective in limiting transmission (HW/42 - INQ000106109).

44. The initial ministerial induction was carried out as normal, bringing me up to speed on the major areas of my portfolio. Another minister within DHSC was the lead junior minister for COVID-19 at that time. That said, as concern about COVID-19 grew, I wanted to be assured that the social care sector was prepared in the event the virus became widespread in England. I therefore asked about the responsibilities of DHSC for Social Care in the event of a pandemic and about our preparedness. I discovered that for social care, DHSC and MHCLG looked to local authorities to lead the response for social care, backed up with support from the centre – and that local authorities should all have pandemic response plans.

45. I asked to see the local authority pandemic response plans. After several requests I received two plans on or around 3 March 2020 (HW/43 - **INQ000327771**; HW/44 - **INQ000327772**; HW/45 - **INQ000327770**). I did not

consider them adequate (HW/46 INQ000327768). I flagged my concerns to the Secretary of State who asked me to put *"some serious drive into getting them [the plans] into a credible position"* (HW/47 - INQ000327767).

46. Following this exchange, I agreed with Ros Roughton a process for reviewing local authority plans alongside MHCLG and ex-Directors of Adult Social Care, who were asked to provide support on an ad hoc basis. The intention was to identify a small number of good plans to share as a template for other local authorities. However, in the event this did not prove possible given the pace at which the pandemic progressed, and the lack of comprehensive plans being provided to DHSC by local authorities.

47. On 4 March 2020 I met Ros Roughton to discuss ramping up the Department's social care/COVID response (HW/48 - INQ000327773; HW/49 - INQ000327774). She proposed our response should include five areas of work: (1) social care guidance; (2) communications with stakeholders (i.e. care homes, home care providers, local authorities) and central government; (3) working with local authorities and the MHCLG on contingency plans; (4) the social care workforce; and (5) exploring the need for Care Act easements.

48. Around this time, I agreed with Ros Roughton that we needed to build up the capacity of the Adult Social Care team within DHSC to carry out this workload. Ros restructured the Adult Social Care team into a new COVID-19 response organisation structure and started to recruit into the team, bringing in staff from other parts of DHSC, other departments and drawing on people with relevant experience, for instance, former directors of adult social services and former Chief Nurse Jane Cummings. By September 2021, the Adult Social Care team had expanded to 301 members of staff.

49. On 6 March 2020 I met with the Secretary of State, Permanent Secretary, DCMOs, and Ros Roughton and agreed for the following areas to be worked on (HW/50 - INQ000049530):

    (a) Workforce – the need to ensure sufficient staffing during a pandemic so that safe care could be provided.
    (b) Financial support – the need to provide financial support from central government to local government so that they could then distribute that money to social care providers to meet the needs of the pandemic.
    (c) Data – there was insufficient data at the start of the pandemic about who provided social care and in which locations.
    (d) Support for non-COVID illnesses – many of those receiving social care required medical support and nursing care for their pre-existing conditions. We wanted to make sure that support continued during a pandemic.

(e) The provision of PPE and other medical equipment/supplies (such as additional oxygen).
(f) Local Resilience Forum readiness.
(g) Collaboration with providers.
(h) Communications.
(i) Drafting a Coronavirus Bill to enable measures to be put in place quickly to allow relaxation of the statutory obligations of local authorities during the pandemic and to allow appropriate public health measures to be taken in response to the pandemic.

50. I understand that on 6 March 2023 Ros Roughton received a third local authority pandemic plan from Norfolk County Council, following a stakeholder meeting that day with CQC, ADASS, local authority representatives and other sector stakeholders (HW/51 - **INQ000327775**).

51. On 11 March 2020, the Secretary of State, Ros Roughton, DCMOs, DHSC officials and I attended a social care meeting, where Ros provided an update on the work taking place with MHCLG to access Local Resilience Forum (LRF) plans (HW/52 - **INQ000328131**).

52. On 14 March 2020, the Secretary of State for Housing, Communities and Local Government (MHCLG) wrote to the Secretary of State for Health and Social Care proposing Local Authority Chief Executives, Directors of Adult Social Services (DASS) and local NHS representatives should map the social care provision in their localities (including workforce numbers, supplies, care providers, contact details and bank details in the event money had to be provided to them). Planners from the Ministry of Defence would be assigned to each group to assist with in shaping and refining the stress testing of these documents (HW/53 - **INQ000327776**; HW/54 - **INQ000327777** HW/55 - **INQ000327778**).

53. On 16 March 2020 the Prime Minister hosted a roundtable in No.10 bringing together several local authority chief executives, DASSs and Directors of Public Health to discuss the COVID-19 response for social care. The group discussed what support local authorities would need to provide continuity of service provision for vulnerable adults, funding, workforce, and guidance (HW/56 - **INQ000327779**).

54. On 24 April 2020, No.10 commissioned a plan to reduce infections in care homes, which included developing local authority led resilience plans for each care home (HW/57 - **INQ000327861**; HW/9 - **INQ000327866**). I received an update on 5 May 2020 setting out the work that DHSC and MHCLG had done on developing a framework for local authority care home resilience plans (HW/59 - **INQ000327878**).

55. On 8 May 2020 a report produced by ADASS titled *'Proposals to support Directors of Adult Social Care and local areas to prepare now for a future flu pandemic'* was sent to my private office email. This had been written in March 2018 (HW/60 - INQ000213018).

56. The Resilience Plan proposal was incorporated into the Adult Social Care Plan and Infection Control Fund support package announced on 14 May 2020 (HW/61 - **INQ000327898**). As part of the package, we asked all local authority Chief Executives with social care responsibilities to provide a return setting out the number of care homes where support was being delivered to, what further support was required, and confirmation that local authorities were carrying out a daily review of local care providers. I recollect this in part reflected feedback I was receiving that there was wide variation between local authorities in the level of support care providers were receiving.

Adult Social Care Data

57. In early March 2020 I started to hear about residents dying from COVID-19 in care homes. I was deeply concerned, and I asked officials to provide me with figures, but this data was not available. The fact that I could not get timely, accurate data on COVID-19 deaths in social care was a stark contrast to healthcare; deaths data from NHS hospitals was provided daily. I was sure care homes were being hit hard, but we did not have the figures. I feel this also gave the wrong impression – for instance when I was questioned in interviews – about Government's focus on social care. Together with officials in DHSC, I was spending almost every waking hour working on the social care pandemic response. The lack of data was frustrating, not just because I could not provide full answers to journalists' questions, but more significantly it meant we lacked insights to inform the early response – for example, we had no indication of whether some areas of the country or types of care homes were being affected worse than others.

58. I subsequently received an explanation for this lack of data, which was due to differences between the two sources for deaths data and time lags in reporting. The two sources were the Office of National Statistics (ONS) and CQC. ONS data was based on completion of death certificates, but the time taken for deaths to be certified and registered meant ONS weekly figures were usually published after eleven days. CQC data was based on notifications from providers. However, early in the pandemic this data appeared to undercount COVID-19 deaths. An explanation of this was set out in a joint press statement issued with the ONS and CQC in April 2021 (HW/62 - **INQ000327850** HW/63 - **INQ000327852**). I first received reliable figures for COVID-19 deaths in care homes in early April.

59. Also in March, I read reports of deaths in care homes in Spain where staff had stopped coming into work, apparently leaving residents to die. I was determined to prevent this happening in England. I asked for data on staffing levels in care homes and for home care agencies so we would know if any care provider in England was facing this situation (HW/64 - INQ000327825). This data was also not available at that time. I commissioned work which led to the development of a new data tool for the department which was to prove central to our social care COVID-19 response.

60. As Ministers we discussed the data issues in HMIGs in March 2020 (HW/26 - INQ000055934) (HW/65 - INQ000055942), and I continued to raise this as a priority issue for DHSC in May 2020 (HW/66 – INQ000146701).

61. This led to the development of the adult social care **'Capacity Tracker'**, which became our formal data collection tool for social care pandemic status in June 2020. The original Capacity Tracker was a data collection tool already in use in some areas to give hospitals visibility of vacancies in care homes.[8] Officials identified this as our best option for rapidly improving operational social care data.[9]

62. The Capacity Tracker underwent continual development during the pandemic. Initial additional data fields included suspected COVID-19 deaths and provider staffing information. Over time, it was developed to include data on access to PPE, resident and staff testing rates and results, social care staff movement numbers, staff wellbeing and support measures, vaccination rates, and the financial viability of care providers (HW/67 - INQ000327986; HW/68 - INQ000328122).

63. I also commissioned analysis of capacity tracker data to inform ministerial and stakeholder discussions (HW/69 - INQ000327985; HW/70 - INQ000327993). The Secretary of State would make requests for the latest data on the number of reported cases among care home residents and staff (HW/71 - INQ000327951). I had my own log-in to enable me to check data in between formal meetings.

64. At times the Capacity Tracker acted as an early warning system. When the tracker showed a significant number of positive tests among care home staff, that information was then fed back to COVID-O meetings as an indication of a potential wider outbreak in the local community (HW/72 - INQ000091795).

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[8] Credit is due to the North of England Commissioning Support Unit who had developed the tool.
[9] At the outset of the pandemic the main dataset available to DHSC on social care provision was the Adult Social Care Outcomes Framework (ASCOF), an annual dataset published six months after financial year-end. In addition, CQC published assessments of individual care providers and an annual report on the state of the health and care system in England. Other sources of data include the Skills for Care annual report on the care workforce, surveys by ADASS and periodic reports by select committees and think tanks with an interest in social care. None of this information was "real time".

65. By mid-June 2020 the Director General for Adult Social Care was able to report back in a COVID-S meeting that there had been a *"step change"* in the data available for care homes, with 90 percent of homes providing information, and *"assurance from local authority chief executives, all of whom were carrying out monitoring and reviewing data"* (HWI73 - INQ000088789).

Guidance for Adult Social Care

66. During the pandemic DHSC published guidance on the pandemic response for the social care sector, alongside extensive material from Public Health England, NHS England and the UKHSA about infection prevention and control. Guidance was voluntary rather than statutory, and frequently in response to requests from the sector.

67. Early in the pandemic our understanding of the COVID-19 virus developed almost day by day, together with our capabilities to respond. Consequently, guidance was updated frequently.

68. The pace of the pandemic made normal consultation processes impossible, and the department faced criticism that we had not sufficiently engaged stakeholders, had not considered the differences between provider-types, were publishing guidance too late and updating it too frequently.

69. While I understand these criticisms, I also saw how incredibly hard officials worked to produce guidance in the face of the rapidly changing understanding of COVID-19, time pressure to publish, the trade-off between time for stakeholder engagement and timely publication and the diversity in how social care is provided. From the outset, officials worked with trusted sector representatives to review drafts of guidance. As the pandemic progressed the departments' capacity to develop guidance improved, helped by increased headcount and a more established stakeholder engagement process including the Adult Social Care Taskforce.

70. In May 2020 a new 'Triple Lock' process for guidance was introduced (co-designed between Cabinet Office, the DHSC Guidance Cell and the PHE Guidance Cell). This sought to improve the process for sign off and publication of guidance. The DHSC Guidance Cell assumed responsibility for providing DHSC clearance (including DCMO and, where appropriate, Ministerial clearance) for all COVID-19 guidance published on GOV.UK. In June 2020, these responsibilities transferred to the newly formed COVID-19 Programme Directorate as part of an enlarged Guidance and Knowledge Hub.

(1) Admissions to care homes

71. In the early days of the pandemic, we saw hospitals in other countries overwhelmed, some even forced to turn patients and their families away. In

preparation for the spread of COVID-19 in England, the NHS – with the support of DHSC – sought to free up as many beds as possible to be ready for COVID-19 admissions. I was not involved in the development of the discharge guidance in early March 2020. However, I was aware of the importance of freeing up space in hospitals and that this would involve the discharge of patients (when medically fit for discharge) into social care. At the time it was believed that COVID-19 was limited to a small number of known cases,[10] (HW/74 - INQ000327769) and we believed if you had COVID-19 you would have symptoms, so there was no reason to expect that patients with COVID-19 would be discharged into care homes.

72. On 3 March 2020, DHSC published the *'Coronavirus (COVID-19) Action Plan'* (HW/74A - INQ000057508). This stated that in the "Mitigate" phase: "*health and social care services will work together to support early discharge from hospital, and to look after people in their own homes".* The Prime Minister held meetings with the Secretary of State on 12 March 2020 to discuss the freeing up of 30,000 beds from hospital. This involved the discharge of patients into care homes, which would be accompanied by new funding to NHS Clinical Commissioning groups and local authorities of some £1.3 billion (HW/75 - INQ000279904; HW/76 - INQ000327781; HW/77 - INQ000055933; HW/78 - INQ000106253). I was not involved in these meetings.

73. On 19 March 2020, DHSC published the '*Hospital Discharge Service Requirements'* for all NHS trusts, community interest companies and private care providers in England (HW/79 - INQ000325248). For 95% of patients leaving hospital, the assessment and organisation of ongoing care was intended to take place in their own home, while for the remaining 5% a suitable rehabilitation bed or care home was to be arranged. This was known as "discharge to assess". This approach has the advantage of assessing long term care needs for most people after they have left hospital, which is often a better time to make this assessment rather than in hospital. Hospitals can be a disorientating environment and can exaggerate dependency – potentially leading to a decision for someone to be discharged to residential care when they could in fact continue living in their own home. This approach also reduces length of stay in hospital after a patient has been identified as medically fit for discharge, which is beneficial to patients given the risk of deconditioning in hospital, as well as freeing up hospital beds for those who need them.

Decision on 'Admission and Care of Residents during COVID-19 Incident in a Care Home' guidance issued on 2 April 2020

[10] For example, as at 4 March 2020, the total number of confirmed COVID-19 cases in England was 80, and the total across the UK was 85.

74. PHE and NHSE/I developed guidance for care homes to support them admitting residents, including those coming from hospitals, and to advise them on IPC measures. This followed on from the discharge guidance of 19 March 2020. On 25 March 2020, I received a draft of the guidance for approval (HW/80 - INQ000109205). I was concerned about the proposals to discharge COVID-19 positive patients into care homes and also the apparent intention on the part of the NHS to direct care homes to take patients (HW/81 - **INQ000327794**). My private office sent an email on 28 March 2020 following my review of the guidance. This includes my comment that: *"this is written as if the NHS is going to direct care homes to take patients, while in practice it is at the care homes' discretion"*, and: *"I am concerned about proposals to discharge patients with Covid symptoms into care homes".* I questioned whether: *"we really want to be discharging patients into a care home unless it already has Covid cases?"*, as I was *"concerned that a patient will take Covid into a care home, and even with PPE that surely materially increases the risk to others in the facility"* (HW/82 - **INQ000327795**).

75. On 31 March 2020, I was provided with a final version of the guidance, along with the Secretary of State and his Special Advisors to review in parallel. I was still not happy to approve it, given the risks of spreading infection to other patients and staff in care home facilities. I therefore requested a revised draft before anything was published (HW/83 - **INQ000327800**) (original emphasis in bold):

> *"MSC has reviewed and is currently not content to approve of this guidance (although she felt it was much better).*
> *[...]*
> *Following your response to the particular comments MSC previously raised, MSC has an additional comment to your response:*
> • ***MSC previous comments: In either case, do we really want to be discharging patients with Covid into a care home unless it already has Covid cases? MSC is concerned that a patient will take Covid into a care home, and even with PPE that surely materially increases the risks to others in the facility.***
> ○ ***DHSC team response:*** *Due to capacity concerns, care homes may need to accept patients in these circumstances, but we would expect care homes would do a risk assessment to ensure that appropriate isolation facilities are available. DCMO is content with this advice.*
> ○ ***MSC Additional comment:*** *The use of the word 'need' here suggests there is still a lack of clarity about how directive the process is. The NHS may want care homes to accept them, but I don't envisage care homes will need to […]."*

76. In response, I was told that any patient in hospital with symptoms would be tested, so that *"hospital[s] would provide a clear diagnosis and a clear view on*

how many days isolation are needed", and that asymptomatic patients would not be tested prior to discharge as "*there is not a reason to suspect they have COVID-19*" (HW/84 - **INQ000327801**).

77. I received a revised version of the guidance on 1 April 2020 to review. I was told that No. 10 had reviewed it and it was due to be published on 2 April. I cleared the publication subject to a comment about the length of time required for isolation in care homes – which DCMO and PHE later confirmed would be 14 days (HW/85 - **INQ000327808**). The Secretary of State and Special Advisors also cleared the guidance (HW/86 - **INQ000327807**). We published the '*Admission and Care of Residents during COVID-19 Incident in a Care Home*' guidance ("the Admissions Guidance") later that day (HW/87 - **INQ000327809**) (HW/88 - INQ000233798).

Care home admissions guidance April 2020

78. The next iteration of care home admissions policy was developed for inclusion in our Adult Social Care Action Plan, a plan I commissioned to bring together multiple strands of social care support (across PPE, testing, etc) into one place. As part of this document, I wanted to change the discharge policy to address the concerns I was hearing from care providers about patients being discharged from hospital with COVID-19, which they believed was then spreading among residents despite attempts to quarantine new admissions. I proposed as part of the new guidance that all patients being discharged into social care settings should be quarantined by the NHS before they were transferred to a care home. Around this time we also learnt that tests were effective at picking up Covid asymptomatically.

79. I was sent a version of the plan on 12 April 2020. I provided my response the following day . I stated that: *"Discharge strategy seems to have reverted (in 1.29) to saying discharge of Covid positive patients to care sector without step down is ok if they have the PPE. Please can we see the evidence from PHE that this is keeping care residents safe before including this in the strategy."* (HW/89 - **INQ000327831**). This reflected my concern that quarantining and PPE were not proving effective within residential care services. I also asked that the strategy document address more specifically how COVID-19 positive admissions from the community would be dealt with. My comments were fed back to officials at No.10 (HW/90 - **INQ000327830**). A paper outlining the plan was presented at a COVID-S meeting held with the Cabinet Office and No.10 on 13 April 2020, which the Secretary of State and I also attended (HW/91 - INQ000088629). On admission to care homes, the policy agreed was for all patients to be tested prior to discharge, with responsibility given to local authorities to identify alternative accommodation where care homes were

unable to provide appropriate isolation facilities. The Adult Social Care Action Plan was published on 15 April 2020 (HW/92 - INQ000325315 pg10).

80. On 7 May 2020 I discussed sending a letter to local authorities to draw attention to the discharge and quarantining policy, set out how it would work in practice and ensure compliance. This letter was drafted with input from the NHS, local government and provider stakeholders, and reviewed by MHCLG ministers alongside my review (HW/93 - INQ000106403). I provided comments on the draft letter (HW/94 - INQ000327896). This letter sought – along with the guidance – to reiterate the policy that discharges into social care settings should not put residents at risk of catching COVID-19, and that all those leaving hospital should be tested before admission to any care home (HW/95 - INQ000327900; HW/96 - INQ000327899).

Updates to the Admissions Guidance in May and June 2020

81. On 21 May 2020, I received updated guidance on the admission and care of people in care homes for review and clearance alongside the DCMO (HW/97 - INQ000327909). This guidance clarified that residents being admitted to a care home from hospital, interim care facilities or from the community should be isolated for 14 days within their own room on admission, whether or not they had tested positive for COVID-19. By now it was understood that care home residents may have COVID-19 without symptoms (i.e., asymptomatically). The guidance also highlighted that people with cognitive and intellectual disabilities, and those experiencing serious mental ill health might require additional support to recognise and respond to symptoms quickly, and in some cases were at greater risk of developing serious illness from COVID-19. Therefore, additional guidance was provided to support the isolation and care of these individuals (HW/98 - INQ000327911; HW/99 - INQ000327910; HW/100 - INQ000327857).

82. Following my initial comments, and further discussions with PHE and DCMO, a revised version of the guidance was submitted to me on 29 May. DCMO gave clearance on 3 June. I told my private office on 7 June that I wanted to write directly to the Secretary of State to get the NHS discharge policy updated so it was consistent with the Admissions Guidance (HW/101 - INQ000327919).

83. In the following days I was told a revised version of the NHS discharge policy would be circulated (HW/102 - INQ000327920) – and therefore did not need to write to the Secretary of State. I cleared the admissions guidance on 8 June (HW/103 - INQ000327921). No.10 cleared the guidance on 19 June, and the update was published that day.

Updated Hospital Discharge Guidance

84. As described above, in March 2020, the "*Discharge Service Requirements*" setting out the discharge to assess model was published alongside £1.3 billion funding for discharge. In July 2020, as part of the announcement of a new £3 billion funding package for the NHS, HM Treasury committed to an additional £588 million to cover the immediate costs of care at home for those being discharged from hospital. Following that announcement, DHSC updated the "*Hospital Discharge Service Requirements*", reiterating the use of the discharge to assess model ("the Discharge Guidance") (HW/104 - **INQ000327958**; HW/105 - **INQ000327959**; HW/106 - **INQ000327975**) (HW/107 - **INQ000327976**).

85. I wanted it to be clear in the Discharge Guidance that anyone being admitted to residential care should be tested for COVID-19 and irrespective of the result, they should be quarantined – given the incubation period for the virus. If quarantining was not possible for the care home, then alternative accommodation (with care) needed to be used. I stressed that care homes should not be made to accept admissions if they did not have appropriate quarantining facilities, which I had been told anecdotally had happened (HW/108 - **INQ000327977**).

86. These changes were accepted (HW/109 - **INQ000327978**; HW/110 - **INQ000327980**), and on 14 August a new section on testing of people being admitted from the community into a care home was added. On 19 August Jenny Harries (DCMO) cleared the guidance, after which I also cleared the guidance (HW/111 - **INQ000327982**). It had been agreed that the Secretary of State would not need to provide his review, and that Special Advisors would give their clearance in due course (HW/112 - **INQ000328152**). No.10 provided its clearance on 21 August, and the funding was announced publicly later that day (HW/113 - **INQ000327983**). The guidance was also updated on 21 August.

Development of Designated Settings policy

87. During the summer of 2020 I was determined to make sure that we made every possible preparation to help care homes, home care agencies and carers in the event of a second COVID-19 wave in the forthcoming winter. I am confident officials in DHSC shared this aim. We worked with the Adult Social Care Taskforce chaired by David Pearson to bring together contributions from the care sector.

88. As part of this work, I wanted us to look again at the discharge process from hospitals into residential care. Research indicated that while most COVID-19 infections had been introduced into care homes from the community, it was

highly likely that some outbreaks occurred as a result of patients being discharged from hospital.[11] Some care homes I spoke to also told me how incredibly hard it was to effectively quarantine some of their residents, as a result of a combination of their building design and difficulty restricting movement of some residents with dementia. At this point local authorities were required to provide alternative accommodation with care for quarantining people discharged, if care homes were unable to do so, but I lacked evidence to assure me of the success of this approach.

89. This led to the development of the Designated Settings policy, which would identify and specify residential care locations which had the facilities needed to fully quarantine residents, and where staff could be given enhanced IPC training. These facilities would serve as dedicated units for patients discharged from hospital with COVID-19 or during the potential incubation period. We required every local authority to identify sufficient designated accommodation to meet demand over Winter, and to have access to at least one designated location by the end of October. Each location was assessed and approved by CQC for use as a designated setting.

90. The initial submission on an 'ASC post-discharge designation scheme' was sent to the Secretary of State on 23 September, with a delivery plan submitted on 30 September. I received an update note on the CQC designation scheme and a draft of the letter on 9 October (HW/114 - INQ000327996; HW/115 - INQ000327998; HW/116 - INQ000327997). My office was told that No.10 had advised that this letter and all other operational letters needed to be cleared with No.10 via private offices/officials (HW/117 - INQ000327999). The letter was finally cleared and sent on 13 October 2020.

91. On 10 November 2020, DHSC sent a second letter to directors of adult social care services to thank them for their work to implement the designated settings policy. The letter also provided additional information and clarification. I signed the letter off with minor amendments, as did No.10 on the date of publication.

92. Building on those two letters, we developed guidance on the delivery and use of designated settings. This guidance made it explicit that: *"no one will be discharged into, or back into, a registered care home setting without being tested, and having received their test result"*, and that: *"anyone who has tested positive and is still likely to be infectious with COVID-19 is discharged to a*

[11] While I do not remember the specific source of this research, DHSC commissioned an independent report on the association between the discharge of patients from hospitals and COVID in care homes, published in May 2022, which concluded that: *"Hospital discharge of people to care homes without testing early in the pandemic is highly likely to have caused some outbreaks or been one of the often multiple introductions of infection to care homes which experienced an outbreak. However, it is highly unlikely to have been the dominant driver of all care home outbreaks in wave 1."*

designated care setting to complete a period of isolation before moving to a care home". Existing discharge procedures continued to apply in exceptional circumstances, particularly where designated settings were not yet operational.

93. I received the initial submission with the guidance on 1 December 2020, at which point it had already been reviewed by the DCMO. The Secretary of State and I both cleared the guidance on 9 December. I provided further input prior to final clearance by No.10 on 16 December 2020. We published the *'Designated Settings Guidance'* on 16 December 2020 (HW/118 - INQ000234652).

94. In January 2021, I pushed for the Guidance to be updated as I was concerned about a paragraph which stated that *"as a last resort … COVID-19 positive individuals to be temporarily discharged under existing arrangements to a non-designated care home, with sufficient IPC arrangements, that is willing to receive the individual".* The policy was meant to be clear that individuals should be discharged into designated settings unless there was a very specific health need that could not be met by a designated setting (HW/119 - **INQ000328039**). Following my request, the update was published on 25 January 2021 with agreement from the LGA (HW/120 - **INQ000328049**).

95. There were further updates to the designated settings guidance in February 2021, but these did not require my sign-off and the accompanying clinical assessment updates were signed off by PHE and NHSE.

Decision on updating Admissions guidance

96. In April 2021 we needed to update the *'Admission and Care of Residents in a Care Home during COVID-19'* guidance to reflect recent policy changes in the guidance on designated settings and updated guidance on care home testing. Stakeholders also said the existing guidance was difficult for the sector to use. I received a submission and draft updated guidance on 12 May 2021. This made it clear that people who ordinarily resided in a care home but had been admitted to hospital, and who had then tested positive, should be discharged to a designated setting to complete their recommended 14-day isolation period, before returning to the care home (HW/121 - **INQ000328120** ; HW/122 - **INQ000328121**).

97. I provided comments to the policy team on 13 May 2021, and requested further information on the following (HW/123 - **INQ000328123**):

- Whether someone could isolate in their own home to avoid isolating in care home upon admission.
- Rationale for avoiding visitors during 14-day isolation period.

- Why all COVID-19 positive people aren't admitted into designated settings.
- Clinical advice on the transmission risk from individuals who cannot be tested, and rationale for not admitting them to designated settings.
- Clinical advice on why admissions should only be 'ideally delayed' if individuals have had close contact with someone who has tested positive for COVID-19 and rationale for not admitting them to designated settings.
- Further clarification on isolation rules following visits out for essential medical appointments.
- Clarification on different treatment of asymptomatic positive and symptomatic positive individuals.
- Clinical advice on advising care workers to avoid sharing a home with someone who is quarantining, e.g. on return from holiday.
- Introducing a new policy of prioritising vaccination for unvaccinated individuals prior to admission into care home.
- Addition to guidance to clarify staff will not suffer income loss when they need to isolate as a result of testing positive for COVID-19 or because they are a contact of someone who has tested positive.

98. In response, the policy team sent draft guidance and clinical advice confirming the following (HW/124 - **INQ000328124**; HW/125 - **INQ000328125**):

- A private home is not the same as a designated centre or similar clinical setting which are staffed by trained staff adhering to best practice in IPC. Private homes are able to have external visitors which may include untested or unvaccinated individuals.
- Allowing visitors to new admissions during their 14-day isolation period increases the risk of transmission as should the new admission be COVID-19 positive, there is a risk that visitors will be exposed and transmit the virus.
- Designated Settings were set up primarily to safely receive people from hospital, not the community – a policy decision for designated settings to include admissions from the community would negate the need for care homes and may be problematic in terms of supporting an individual transition from own home to care home.
- Care homes are vulnerable to outbreaks, and even vaccination cannot fully negate risk of infection. If individuals cannot be tested, a precautionary approach of isolation is appropriate; individuals with an unknown test status should not be sent to facility specifically designed for those with known positives.

99. On 17 May 2021, we published an interim update to the care home admissions guidance to reflect new information about the COVID-19 variant.

100. On 21 May 2021, DHSC Ministers and Special Advisors reviewed the updated guidance document but did not provide clearance to proceed to Triple Lock clearance (HW/126 - INQ000328128). Ministers and Special Advisors requested further clarification on the role of essential care givers during the 14-day isolation period, as well as a policy change regarding whether known COVID-19 positive cases from all settings should have their admission into a care home delayed for 14-days or instead be admitted straight into a designated setting. I received a submission on 26 May advising that positive admissions from the community should not be admitted into designated settings.

101. We published an interim update to the guidance on 4 June 2021 to reflect the change in procedure for reporting COVID-19 cases and the management of outbreaks in care homes.

(2) PPE

102. Prior to the pandemic social care predominantly procured their own PPE from commercial suppliers – for instance, gloves and aprons for personal care. Face masks were not used routinely, though would be used in the event of a flu outbreak. At the outset of the pandemic some providers had spare stocks of PPE (for instance, in case of a flu outbreak). Others operated on a more 'as needed' basis', carrying very little stock and often without material storage space for spare PPE as well.

103. The pandemic required care providers to use face masks and increase the use of other PPE items such as gloves and aprons. This was set out in IPC guidance developed by PHE. PHE updated their guidance on PPE requirements several times during the pandemic, based on clinical evidence and in response to requests for guidance from different social care services and also unpaid carers.

104. In the early weeks of the pandemic there was a surge in demand for PPE which led to many organisations struggling to secure the supplies they needed.

105. DHSC worked with NHSEI Incident Response, NHS Supply Chain (SCCL), the Ministry of Defence and Unipart Logistics to provide social care with emergency stocks of PPE, particularly face masks, at the outset of the pandemic. In March 2020 we put in place the National Supply Distribution Response (NSDR) hotline to respond to care providers who had an urgent need for PPE. From April 2020, PPE was also distributed to local authorities/LRFs so they could supply care

providers who were in urgent need of stock in their local area, as well as supply non-CQC registered care services and personal assistants. After initial frustrations with the performance of the central PPE stock/distribution system, DHSC developed a PPE Portal distribution system which enabled care providers to order and receive PPE free of charge. This was developed in partnership with eBay, Clipper Logistics, Royal Mail, NHS, Volo and Unipart.

106. My primary concerns during the early period of the pandemic were to:

- Make sure providers were able to get the PPE they needed.
- Secure funding for PPE for social care so care providers did not have to bear additional costs and would not face financial pressure to use anything less than the recommended level of PPE.
- Make sure care providers had clear, timely and user-friendly guidance on the PPE they should use to keep staff and residents safe from COVID-19.

107. As the pandemic progressed, I heard about PPE not being used effectively. Therefore, making sure PPE was used properly at all times in social care became an additional objective of PPE policy. The downsides of PPE, and particularly face masks, became increasingly clear as well – for instance, difficulty for people hard-of-hearing to understand what was being said to them, and discomfort for staff wearing face masks for long periods of time. Mitigating these disadvantages and looking at when/where we could safely reduce use of PPE, therefore, also became objectives.

Establishing emergency channels of supply

108. During February 2020, NHS Supply Chain (SCCL) were instructed to purchase additional PPE using existing suppliers and the open market. International demand, however, skyrocketed at this time outstripping global supply.

109. During March 2020 I heard many concerns about the supply of PPE to social care. These included a shortage of PPE in care homes, care providers and local authorities not being able to access PPE, the NHS being given priority to social care by PPE suppliers, and the National Supply Disruption Response (a telephone line set up by DHSC to provide advice) being overwhelmed with calls. I had several conversations and communications with Jonathan Marron and then with Emily Lawson (NHS England Commercial Director) seeking their help to improve supplies of PPE to social care.

110. On 18 March 2020 I approved a letter addressed to providers of Adult Social Care to encourage them to use the NSDR hotline, and to emphasise that wholesalers should not be prioritising the NHS over the care sector (HW/127 -

INQ000327780). On 21 March 2020, we expanded the hotline to a 24-hour service.

111. On 19 March 2020 my private office sent me an update on the supply of PPE in response to my concerns. The update confirmed that there were PPE shortages, DHSC was working with wholesalers to help ensure a longer-term supply of PPE to the care sector and that no wholesaler had been asked to prioritise the NHS over the care sector. The update also confirmed that from 18 March 2020 onwards, each CQC registered care provider would be provided with 300 face masks from the stocks available to the DHSC. This initial distribution of over 7 million face masks to 26,000 care providers was set up to meet the most immediate need – as we heard some care providers had low or no stocks of face masks given these were not used day to day. (HW/128 - INQ000327782).

112. There was a Ministerial Implementation Group which met on 20 March 2020. One of its actions was for DHSC and the NHS to ensure stocks and delivery of PPE consider social care providers (HW/129 - INQ000327783).

113. On 20 March 2020 I flagged to the Adult Social Care team in the Department that small, unregistered providers in my Kent constituency needed PPE but were not receiving it as the national system was only providing PPE to CQC registered providers. On 21 March 2020 I was told that the team had been collating queries from other settings where people may require PPE and flagging this with the supply team, and that local authorities were procuring PPE and distributing it to these settings (HW/130 - INQ000327784).

114. I continued to receive complaints about PPE supply, so on 26 March 2020 I asked for an urgent meeting with the PPE team (HW/131 - INQ000327788). On 27 March 2020 I prepared an update on the COVID-19 response for Social Care and Workforce for the Secretary of State. I stressed that I was concerned that we lacked data about what PPE was being distributed to the sector and I was having to rely upon anecdotal evidence. I reiterated that the ongoing concern of the sector was that the NHS was receiving priority. I confirmed that I would like to see data and reporting from the PPE supplies team (HW/132 - INQ000327789).

115. Ahead of a PPE call with MHCLG on 27 March 2020, I was provided with an agenda/note for the call. The note set out that some health and care settings procured their PPE via the local authority or LRFs rather than the NHS Supply Chain. The director general Ros Roughton informed me on the note that she did not consider it was clear that the supply chain being set up would cover social care as it referred to Community Healthcare partners, however, the

intention was that the supply chain would cover social care (HW/133 - INQ000327792).

116. By this time, DHSC were working on plans to set up a PPE distribution system parallel to the NHS supply chain which would distribute PPE to health and social care organisations, to be run by Clipper Logistics. I was told that organisations would be able to register for an account on an online portal, order their items and the delivery would then be made from the PPE warehouse and undertaken by Royal Mail (HW/133 - INQ000327792).

117. The call took place with MHCLG, and the actions were circulated by Robert Jenrick's assistant private secretary. Two of the actions from the call were for DHSC and PHE to provide guidance for appropriate use of PPE and for DHSC and PHE to provide guidance on prioritising use of PPE between different sectors (HW/134 - INQ000327793).

118. On 31 March 2020 Name Redacted (England Director for the Association for Real Change) sent an email to my private office attaching a list of collated concerns from social care providers (HW/135 - INQ000327798; HW/136 - INQ000327799). This list of concerns included providers being told by suppliers that their stock had been requisitioned for the NHS or the "national supply stock" run by the NHS supply chain, and that the helpline was referring providers back to wholesale suppliers. My private office forwarded the email to those responsible for PPE and I asked if someone could contact a wholesaler to find out who in the government told them that they should ringfence their PPE products for NHS. Emily Lawson (NHS England commercial director and one of the senior individuals overseeing the PPE response) told me that that the NHS was not requisitioning or ring-fencing supply until other sectors could obtain PPE from elsewhere (HW/137 - INQ000327803).

119. On 1 April 2020 I had a meeting with Jonathan Marron (Director General with responsibility for PPE supply). I asked him to investigate the supply of PPE in Sussex and to ensure that a clear message was being sent out to social care providers about PPE (HW/138 - INQ000327804; HW/139 - INQ000327805).

120. On 2 April 2020 I was provided with a "Q&A" document that was due to be published by PHE and the DHSC on the use of PPE. I thought the document did not reflect the guidance we had given to the sector - which was to use their usual suppliers and the named suppliers in the guidance and to only get stock from the National Supply Disruption Centre if those suppliers had been unable to meet their needs. I asked for the document to be made clearer and in line with the recommended approach for social care (HW/140 - INQ000327806).

121. On 4 April 2020 the Secretary of State received a joint submission from DHSC and MHCLG officials regarding an emergency PPE "drop" to all 38 Local Resilience Forums (LRF). The submission confirmed that *"DHSC offered to arrange a one-off drop of PPE to each LRF in England, to help respond to local spikes in need and blockages in the supply chain of PPE to local organisations with a critical need for PPE that cannot be met from local stocks or mutual aid. The additional PPE stocks may be used by LRFs for health and care settings or wider public services where LRFs identify need…"* This was due to be temporary until the national logistics ordering system was set up (HW/141 - **INQ000327811**; HW/142 - **INQ000327812**). This led to distribution of 8 million aprons, 4 million masks and 20 million gloves between 5-8 April 2020 (HW/143 - **INQ000327818**).

122. One of my concerns was that the national PPE supply, which was already struggling, was geared towards the NHS. I raised this with the Secretary of State on 5 April 2020, and he suggested I speak with Jonathan Marron, Director General for Public Health at DHSC. I also asked for someone in the supplies team to be dedicated to overseeing PPE to social care, rather than someone from within Adult Social Care or DHSC (HW/144 - **INQ000327814**).

123. I was asked to comment upon material prepared for a Healthcare MIG to take place on 7 April 2020. One of the questions it asked was *"What is the picture on the supply of PPE v demand and how confident is the system in ensuring that there is sufficient PPE for frontline care providers to operate?"* (HW/145 - **INQ000327813**). I provided my comments on the proposed slides for the meeting on 6 April 2020 (HW/146 - **INQ000327815** HW/147 - **INQ000327816**).

124. On 6 April I attended meetings about supplies and adult social care. I asked officials to work out timings for the launch of the new PPE supply system for social care and said that there should be a lead contact so that care providers would have someone to speak to if needed (HW/148 - **INQ000327817**). On 7 April 2020 I had a meeting with care providers and explained the current PPE situation (HW/149 - **INQ000327833**).

125. On 9 April I asked to be provided with an update by the end of the day covering: the stock levels at the seven wholesale suppliers for social care; their policies for supply; prices on the main items; plans for the national supply service ("Clipper logistics"); and "national supply line" waiting times. Officials responded confirming they were delivering PPE to the suppliers that day; newly sourced PPE stock would be managed by the Clipper supply chain and there were not any plans to ask suppliers to release their stock to Clipper (HW/150 - **INQ000327826**).

126. This same day, my Senior Private Secretary sent an email to the Secretary of State's Private Secretary with my priorities for Adult Social Care. In the email I confirmed the policies I would like to be reconsidered for the care sector, which included the discharge policy; funding; testing; visiting; support at the end of life; guidance issued by PHE; and support for care staff. I stated *"It has been a battle to get PPE stocks to social care. We need a PPE supply chain designed - in partnership with suppliers and stakeholders - for social care. We also need effective reporting so we know what PPE has reached whom"* (HW/151 - **INQ000327827**).

127. We had a further PPE call on 10 April 2020, which identified that PPE had been distributed by local authorities via the LRFS to social care, but that the Clipper Logistics system would not be available to social care that week. The Secretary of State agreed we should continue with the LRF drops until the Clipper logistics system was up and running and asked when the next drop would be (HW/152 - **INQ000327828**).

128. On 13 April 2020, I received further information about LRF drops. The submission confirmed that a further drop of PPE to LRFs was going to be made in that week and it was expected that subsequent drops would be needed over the next four weeks whilst the new online portal (Clipper) was being tested and developed (HW/153 - **INQ000327836**). I agreed with this but expressed concern about the volume of the PPE given to social care, as there was a limit on the amount which did not appear to be related to social care sector need (HW/154 **INQ000327835**).

129. On 14 April 2020 I was provided with an update on the Clipper system. At the point 40 GP practices and 11 social care providers were set up to register and order PPE to test the system. The proposal was to scale up the site to be able to supply 45,000 providers in around three weeks. This was an ambitious ramp up. In response I asked for detail on the test with the 11 selected social care providers and a detailed timeline on the Clipper delivery for social care (HW/155 - **INQ000327839**), which I received on 17 April 2020 (HW/156 - **INQ000327843**).

130. On 16 April 150 additional Adult Social Care providers across three different areas were invited to test the system. It was proposed that 500 more providers would be able to order an appropriate amount of PPE for an organisation of their size from 20 April. Once the system was shown to be working the plan was to begin wave 2 of the rollouts, planning to increase by 1,000 providers every 2 days (HW/157 - **INQ000327844**).

131. On 18 April 2020 a further two submissions were sent to the Secretary of State and copied to Ministers (HW/158 - **INQ000327845**). The first submission

confirmed that demand for PPE from social care, primary care and other non-NHS settings was being met through LRF drops and via wholesalers, but the system was constrained due to low stock. It also warned that the drops represented only a small proportion of the modelled demand in health and social care. Further small drops were due to be made in week commencing 20 April but would only be able to provide supply to the Critical and Critical/High categories of the Prioritisation Framework – which meant hospitals, hospices, adult social care, prison hospitals, ambulance and MOD medical services would be prioritised (HW/159 - **INQ000327846**). The second submission was a proposal for sharing incoming PPE supplies with Devolved Administrations and Crown Dependencies (HW/160 - **INQ000327847**).

132. I provided my comments on 19 April 2020. Whilst I understood that the submission was to seek to update the LRF guidance to ensure the PPE would only be used for health and social care, I provided a caveat that there may be a small number of other areas for which PPE is required and the consequences of a lack of supply are serious such as close contact care of (symptomatic) disabled children and visits by social workers to households where people are symptomatic and family members are at risk of abuse (HW/161 - **INQ000327848**).

133. On 4 May 2020, I sent a message to the Secretary of State notifying him that I was scheduling an introductory conference call with Lord Deighton and PPE wholesalers. I asked if I could *"push harder"* to get PPE supply into care homes, as I was not getting clear answers in the Secretary of State's formal supply meetings. I requested that social care supplies be the focus of one of these future meetings. The Secretary of State agreed that we should address this issue formally. He also explained that his view was that the issue was more one of problems in distribution rather than securing supply (HW/162 - **INQ000327869**).

134. In my call with Lord Deighton on 5 May 2020, we discussed the supply issues and how social care provision of PPE operated. Lord Deighton confirmed that there would likely be a shortage of IIR face masks through to July, with supply dependent on China and uncertainty around deliveries. He also noted that there was a lack of clear information about PPE stocks held by social care providers, what the shortages were and what they were actually using.

135. On 5 May 2020, I asked the Adult Social Care team to gather data on the current shortages among Adult Social Care providers for our Adult Social Care Oversight meeting (HW/163 - **INQ000327870**). The information I requested included:

- how many suppliers had reported serious shortages in the last 48 hours;

- how widespread and serious the shortages of masks were at the frontline; what providers were doing if they did not have 2R masks and other required PPE.
- what our guidance was if providers did not have 2R masks.
- whether providers were still using commercial suppliers.
- what stocks we had left nationally and how they would be distributed; and
- whether Clipper Logistics access would be provided to social care organisations, so that this could be used to order PPE.

136. On 12 May 2020, I hosted a roundtable meeting, alongside the Parliamentary Under Secretary of State Jo Churchill, with the 11 largest wholesalers who supply PPE within Adult Social Care. I was also keen to have an in-depth discussion at the Social Care Deep-Dive meeting, chaired by the Secretary of State, to be clear on what DHSC's view was on these issues before engaging with wholesalers (HW/164 - **INQ000327873**).

137. At the 12 May 2020 meeting, (HW/165 - **INQ000327895**), we agreed to:

> (a) further consider best routes for linking suppliers to the UK and international manufacturers when moving to a longer-term strategy; set up a buying and logistics team session to share experiences between wholesalers and DHSC;
> (b) commission further advice on current stock position and projections for gloves;
> (c) commission further advice on price variations of 10 key PPE items from December 2019 to May 2020; and
> (d) commission advice to the Secretary of State regarding PPE requests from education sector to wholesalers to ensure effective prioritisation and avoid misuse in educational settings.

138. On 22 May 2020, I asked for further information on when the PPE portal would be available across England, who it would be available to, and whether it would be free or a paid-for service (HW/166 - **INQ000327913**). I was told by Rosamond Roughton that all smaller social care providers (residential and domiciliary) and GPs in England would be able to access it by 12 June 2020, and that further groups could be added after this initial phase (i.e. larger providers). A previous meeting chaired by Lord Deighton on 20 May (which I did not attend) had approved plans for the roll out, with PPE free at point of access, but in limited quantities (HW/167 - **INQ000327914**). By early June the PPE portal was available for use by care providers and guidance was published on how they could use it to order PPE (HW/168 - INQ000106462).

Pilot on distribution of ClearMask face masks

139. Once PPE was being distributed and used in care homes, I heard from care homes, families, and service users that people with hearing loss or other communication impairments found it exceptionally difficult to understand what people were saying when wearing facemasks. This was partly because lip reading and facial expression were hidden by masks. I recollect that in around June 2020 it was recognised that those with disabilities could require alternatives to a "standard" face mask. NHSEI had therefore procured 250,000 ClearMask transparent face masks.

140. I wanted to be able to distribute these masks to social care. I received a submission about this on 6 August 2020. The recommendation was to use LRFs[12] for immediate supply to the social care sector, and then provide the ClearMask masks through the PPE portal in the longer term (HW/169 - **INQ000327972**; HW/170 - **INQ000327973**).

141. On 14 August, I asked for there to be a clear method for getting feedback from social care providers on how they found the masks, given that this was a pilot and further procurement depended on its success (HW/171 - **INQ000327981**) The pilot was signed off on 21 August 2020 (HW/172 - INQ000058133).

Decision to supply free PPE to frontline primary and social care services

142. In July 2020 I requested a submission on distributing an increased level of PPE to social care settings to meet their needs for COVID-19. I received a submission on 15 July 2020 which proposed free distribution of PPE to frontline primary and social care services until March 2021 (HW/173 - **INQ000327950**). The submission noted that although we had previously maintained emergency supply of PPE to social and primary care, there was now confidence in our inbound PPE supply. DHSC was authorised by HM Treasury to purchase £14 billion worth of PPE to distribute across the health and social care system (to date the DHSC had distributed around £312m worth of PPE to social and primary care).

143. Initially, I was not happy with the proposal that all PPE should be provided by a single central system, given the difficulties we had experienced with central distribution of PPE to social care. My instinct was to fund providers to cover their additional PPE costs and allow them to source from their usual

[12] Local resilience forums (LRFs) are multi-agency partnerships made up of representatives from local public services, including the emergency services, local authorities, the NHS, the Environment Agency and others. These agencies are known as Category 1 Responders, as defined by the Civil Contingencies Act.

wholesalers. However, the budget had already been used for purchasing PPE centrally.

144. I therefore fed in my views on what I wanted from the Clipper system to meet the needs of social care – for instance, customising the offer to meet the needs of each provider, as we had been previously criticised for standardising our supply of masks, and making sure the PPE Portal could successfully supply the PPE at scale to over 20,000 different providers. I was also concerned on behalf of wholesalers, as they would likely have also procured PPE stock in the expectation of supplying providers over the ensuing months.

145. I wanted providers to give us more assurance on their appropriate use of PPE in return for receiving free stock, as I was concerned that they were using less PPE than they had previously during the peak infection period (HW/174 - **INQ000327956**). The Secretary of State was content with the overall approach (HW/175 - **INQ000327954**) and agreed to the free distribution policy on 20 July 2020.

146. The strategy was due to be published in the second week of September 2020. I received a copy of the strategy on 9 September for sign off and publication, alongside the Secretary of State and Parliamentary Under Secretary. Although the Secretary of State agreed to the policy, I remained concerned about a strategy that involved DHSC committing to meet all PPE needs of social care given the scale and complexity of sector. I raised several queries in relation to how the approach was going to work in practice, and what contingency measures had been put in place. For example, what would occur in the event of a serious issue with supplies, such as the destruction of stock or a large batch of stock not being fit for purpose (HW/176 - **INQ000327987**; HW/177 - **INQ000327988**).

147. In practice I believe the Clipper distribution system, once up and running, worked well for social care. I cannot remember receiving many complaints from providers about the distribution of PPE in the winter of 2020/21, and the capacity tracker showed that most providers had sufficient PPE.

Decision on extending free PPE to health and social care beyond June 2021

148. In January 2021, DHSC committed to providing free PPE to health and social care providers until 30 June 2021, with a review in April 2021 for provision beyond that date. On 18 March 2021, the Secretary of State and I received a submission for approval, which set out a number of options for how to extend provision beyond June 2021. The decision had to be announced in April to give providers enough lead time for any changed beyond June 2021 (HW/178 - **INQ000328084**; HW/179 - **INQ000328085**; HW/180 - INQ000110871). On 24

March 2021, Ministers agreed to extend the provision of free PPE to 31 March 2022 (HW/181 - INQ000328092).

Guidance on PPE for Domiciliary Care Staff and Care Home workers

149. On 5 June 2020, the Secretary of State announced that all staff in hospitals should wear facemasks continually to prevent further spread of the virus, and that this policy would be considered for social care. Subsequently, SAGE considered the policy for care homes and submitted a paper to DHSC on 2 July 2020, which mirrored the recommendations for hospital staff. The SAGE paper, however, did not make recommendations for domiciliary care settings (HW/182 - INQ000327945).

150. Although the SAGE paper did not refer to domiciliary care, PHE provided updated guidance advising care homes and domiciliary care providers what PPE would be needed in different scenarios. Type I and IIR masks were to be worn by all staff in communal areas (both in care homes and domiciliary care), and in domiciliary care head offices, where care and non-care staff could not be separated to prevent transmission, facemasks were to be worn. I was sent the updated guidance from PHE following sign off from the DCMO, prior to it being sent to the Cabinet Office for Triple Lock with No.10 (HW/183 - INQ000327944). I cleared the guidance on 14 July 2020 (HW/184 - INQ000327947).

Supply of PPE to unpaid carers

151. In March 2020, DCMO and PHE advice was that unpaid carers should not use PPE while providing care. They were concerned that unpaid carers would not necessarily use PPE properly and that without direct training and supervision, this could create additional risk and/or a false sense of protection. In addition, as unpaid carers were frequently members of the same 'household contact group', they would share transmission exposures in the same way that a family does, making PPE less effective in such circumstances. Given the uncertainty about PPE supply, environments, and workers where the risk of transmission and the opportunities for mitigation were greatest were prioritised - particularly hospitals and care homes.

152. Subsequently, understanding of how the virus transmitted within the community evolved and DHSC reviewed its position. The Scottish Government also reviewed its advice and recommended the use of facemasks for unpaid carers who were caring for someone who is shielding, or where carers, themselves, were shielding.

153. On 26 May 2020, DHSC asked PHE for updated advice. PHE advised that carers living in the same household as those they cared for should wear PPE if the cared-for person had COVID-19 symptoms; however, if neither the carer nor the cared-for person had symptoms, then PPE was not required.

154. I asked for an update about this in July 2020 as I was receiving information from MPs, the public and local authorities that family and unpaid carers were concerned that PPE was not being provided to them. The submission I received on 29 July stated that although the virus was still formally in general circulation within the population, the likelihood of an individual coming into contact with an infected case had now reduced considerably. As a result, the recommendation was that the current policy should not change, and unpaid carers did not need to wear PPE unless advised to by a healthcare professional. The position was to be reviewed as part of planning for a potential second wave. In the interim, the current explanation in the unpaid carers guidance was to be strengthened to give greater confidence to carers (HW/185 - INQ000051396; HW/186 - INQ000051397; HW/187 - INQ000051398).

155. Although I agreed with the recommendation, I was still concerned that in local situations unpaid carers might be overlooked. I asked to see what the formal protocol was that local authorities would consider in the event of a locally raised COVID-19 rate (HW/188 - **INQ000327970**). The Secretary of State supported my comments. I was told that specific recommendations on what local authorities were to consider in the event of a local outbreak were not within the current remit of the Adult Social Care Winter Plan and would be best dealt with by MHCLG or the Cabinet Office's COVID-19 team (HW/189 - **INQ000327979**).

156. At the start of winter, I again raised concerns about the supply of PPE to unpaid carers. I was provided with information in a submission on 12 November 2020. The submission proposed to trial a free PPE offer for unpaid carers who provide care to someone they do not live with ('extra-resident carers'), in five local authorities, with a view to rolling out across the country by January 2021 (HW/190 - **INQ000328011**; HW/191 - **INQ000328012**; HW/192 - **INQ000328013**). I agreed to all the recommendations in the submission (HW/193 - **INQ000328015**), as did the Secretary of State (HW/194 - **INQ000328016**). The pilot commenced in the second week of December in Leeds City Council, Essex County Council, South Gloucestershire Council, North Yorkshire Country Council and Durham and Darlington. We selected these because they had high prevalence of COVID-19 in the community and provided a mixed sample of predominantly rural/ urban locations with a geographical spread.

157. On 13 January 2021, I received an update and proposal to roll out the pilot of PPE to carers nationally as soon as possible (HW/195 - **INQ000328037**). Local

Authorities found the level of demand for PPE from carers was manageable from their existing stock. Given the increased community prevalence across the country at the time, the national lockdown, and the emergence of a new strain of COVID-19, I wanted the safest possible care for the most vulnerable (HW/196 - INQ000328038). I approved the national roll out offer, as did the Secretary of State (HW/197 - INQ000328040; HW/198 - INQ000328042).

158. I received an update on the progress of the national roll out on 19 May 2021 (HW/199 - INQ000328126). This advised limited take-up across the country, mirroring earlier pilots. Nevertheless, many local authorities who had emphasised the difficulty of identifying unpaid carers in the past, said that this offer had enabled them to identify and register additional resident unpaid carers in their locality even if in relatively small numbers. This enabled local authorities to offer these carers further support, such as signposting to support networks, carers assessments and access to funding (HW/200 - INQ000328127). I asked the policy team to address some of the problems flagged by the roll out to be addressed in our plan for the next phase of the pandemic, in particular that stronger systems were needed to ensure all carers were contacted and supported (HW/201 - INQ000328129).

(3) NHS support

159. In late March/early April many care homes were experiencing outbreaks. I heard in discussions with care homes that many felt they needed greater support from the NHS as they were having to care for very sick residents, with greater needs than they usually experienced. Others told me they were getting fantastic support, for instance from local GPs doing regular virtual 'rounds'. We therefore asked NHS England to develop a package of additional clinical support to include in the April Adult Social Care Strategy. This resulted in an Enhanced Health in Care homes package for care homes from GPs and community health services, as well as an offering of additional training support for infection control for every care home from the NHS.

160. On 9 April 2020 I was presented with a draft of the clinical support package. This included a commitment to collaborate across the health and social care services for the most vulnerable, greater use of GP telephone and video consultations, additional support for social care from district nursing, as well as outreach from the acute sector. Provision of oxygen and improved access to professionals and equipment to support end of life and palliative care was planned to ease the burden on care providers. I wanted to ensure we were robust about the support that social care would be receiving – so I requested more detail to be added to the strategy document (HW/202 - INQ000327829).

161. DHSC presented the strategy to Ministers and NHS leaders at COVID-S meetings on 28 April 2020 and 6 May 2020 (HW/203 - INQ000088641; HW/204 - INQ000088705; HW/66 - INQ000146701). In the latter meeting, chaired by the Deputy Prime Minister (Dominic Raab), DHSC provided an update on the difficulties care homes were having controlling the spread of infection. MHCLG were supportive of clinical support to care homes from local NHS services. Simon Stevens confirmed that, following the request for support in the previous meeting on 28 April, the NHS had offered support to all care homes via Clinical Commissioning Groups. He also confirmed that there would be a named clinical lead for every care home by 15 May 2020, and that an offer had been made for NHS 'super trainers' to support care home staff in IPC training.

162. The Enhanced Health package included a commitment from NHS England to provide the following for care homes:

- a named clinical lead (usually a GP) for every care home to provide better access to clinical advice through weekly check ins to review patients.
- clinical teams to provide remote monitoring (and face-to-face assessments where appropriate) for care home residents with suspected or confirmed COVID-19 cases. This included those who needed monitoring following discharge from either an acute or step-down bed.
- key medical equipment such as pulse oximeters to enable remote monitoring within care homes; and
- returning nurses to be deployed to care homes through the Bringing Back Staff programme, as well as NHS nurses to deliver IPC training to care home staff in every area in England.

163. This model of NHS support for social care continued throughout my time as Minister. In the Adult Social Care Winter Plan of 2020-21, there was a renewed commitment from the NHS to "support care homes and social care through primary care and community services and the rollout of the Enhanced Health in Care Homes model". This included continuing the system of a named clinical lead and weekly multidisciplinary support, and professional leadership and expert advice on IPC in local areas through Directors of Nursing in Clinical Commissioning Groups (CCGs) to support the local authority and directors of public health in discharging their responsibilities (HW/206 - INQ000234495). These commitments continued into the April 2021 'Coronavirus (COVID-19): care home support package' (HW/207 - INQ000110940).

(4) Testing policies

164. The UK was one of the first countries to have an effective COVID-19 test. PHE developed this test and in early March 2020 was able to process about 1,500

tests/day. Initially this test was used for people who were considered at risk of having COVID-19 and for 'surveillance' testing to establish the spread of the virus. By mid-March testing capacity reached about 5,000 tests per day. Demand for tests far exceeded capacity.

165. A prioritisation process was established to determine how the limited supply of tests should be used. This was based on clinical guidance. The volume of tests available and the outcome of this process is set out in the table below.

166. Testing was prioritised as capacity increased:

Date	**Daily testing capacity**	**Groups added to eligibility**
14 March 2020	3,000 (approx.)	Testing of patients requiring critical care for the management of pneumonia, ARDS or influenza like illness (ILI), or an alternative indication of severe illness has been provided. All other patients requiring admission for management of pneumonia, ARDS or ILI. Clusters of disease in residential or care settings e.g. long-term care facility prisons, boarding schools. Where clusters arose, following 5 positive tests, any new symptomatic cases were assumed to be positive without conducting testing.
27 March 2020	10,949	NHS staff with symptoms and their symptomatic families.
12 April 2020	27,947	Testing of all symptomatic care home residents (expansion from first 5 members of a cluster). Testing of all symptomatic staff in care homes and symptomatic members of their household (expansion from first 5 members of a cluster).
15 April 2020	38,766	People being discharged from hospital to a care home, whether or not symptomatic.
24 April 2020	49, 862	Symptomatic essential workers and their symptomatic family members.
27 April 2020	73,400	All emergency admissions to hospital.
28 April 2020	77,365	Asymptomatic staff and residents of CQC registered care homes whose primary demographic is residents over 65 or those with dementia. Anyone symptomatic over 65, as well as

		symptomatic members of their households. Symptomatic workers who were unable to work from home.
18 May 2020	127,697	Anyone symptomatic across the population.
30 May 2020	205,634	Antibody testing launched for health and social care staff in England.
7 June 2020	186,455	Asymptomatic staff and residents of all remaining CQC registered care homes for adults.
10 June 2020	229,704	Asymptomatic people in high contact professions, e.g. taxi drivers.
6 July 2020	349,109	Regular retesting of care home staff (weekly) and residents (monthly)
13 July 2020	339,755	Outbreak testing guidance amended to include rapid response testing.

167. As testing volumes increased, we were able to introduce progressively more testing for social care – building from the mid-March policy of testing care home residents with symptoms until five residents tested positive, to the rolling programme of weekly staff testing and monthly residents testing from July 2020 onwards. This was an important tool for controlling outbreaks within social care, although testing was not able to prevent all outbreaks.

168. As Care Minister, I argued for social care to receive tests, and worked with some brilliant DHSC and MOD staff on: testing policies and guidance for social care, getting tests effectively distributed to social care, getting results provided back to care homes as quickly as possible, getting testing data reported and shared so it could be used to direct support to care providers, and getting the data analysed to better understand the spread of Covid.

Prioritising care home staff and residents for Covid Tests

169. On 7 April 2020, I received a submission on the prioritisation of COVID-19 tests for keyworkers. The submission proposed that during April, while capacity was being scaled up, tests should be prioritised for frontline NHS staff and then social care workers (where spare capacity allowed) (HW/208 - **INQ000327819** HW/209 - **INQ000327820**). I was concerned about the prioritisation of social care in this proposal (HW/210 - **INQ000327822**). The submission read:

"15. In the short-term, while overall capacity remains limited, our overwhelming focus will therefore remain tackling delivery issues for NHS keyworkers and ensuring we maximise the use of available capacity to test NHS staff. Where we have spare capacity, we will look to fill it with other very high priority key-worker groups who can easily dock into the existing delivering infrastructure, starting with social care workers.

16. This means we plan to focus keyworker testing during this period on:

Frontline NHS staff across all settings (including those from the charity, voluntary or private sectors) who are providing vital services) – to support the sustainability of the workforce – latest figures suggest over 116,000 NHS staff are off sick, of which over 77,000 are due to COVID (67%);

Social care workers (where capacity allows) – given the importance of this workforce in supporting the old and vulnerable population as well as in supporting the discharge of patients from the NHS, thereby freeing up valuable bed space; …" (HW/209 - **INQ000327820**)

170. I specifically asked for care workers to be given the same prioritisation as NHS staff, especially as they worked in close proximity with those they were caring for. I also felt the initial prioritisation allocation did not take into account the risk of high levels of staff absences in care homes. I also pushed for all patients being discharged from hospitals to be tested (HW/211 - **INQ000327823**). The Secretary of State agreed and wanted the changes to be taken on as a policy decision (HW/212 - **INQ000327824**), which he later presented in the HMIG on 9 April 2020 (HW/213 - **INQ000327840**; HW/213A - **INQ000327841**). During discussion at the HMIG, we highlighted that social care was facing increasing numbers of staff in isolation, and would therefore need to be tested at the same levels as NHS staff (HW/214 - INQ000083704).

171. On 15 April 2020 the Secretary of State announced that all symptomatic care home residents would be tested for COVID-19, and all patients discharged from hospital were to be tested before going into care homes (HW/215 - **INQ000327838**). Ros Roughton sent an email on 14 April 2020 confirming the intention to test everyone going into a care home from the community as soon as capacity would allow (HW/216 - INQ000292608).

Decision on prioritising testing of asymptomatic staff and residents

172. On 21 April 2020, I attended a virtual meeting with Lord Bethell, Parliamentary Under Secretary of State at DHSC, to discuss testing residents and staff in care homes irrespective of symptoms (HW/217 - INQ000327849). Lord Bethell flagged that as asymptomatic infection was emerging as a high risk, and testing capability and guidance had changed in the last week [until mid-April tests were considered ineffective or unreliable in the absence of symptoms], the consequent scale of demand would be challenging. I requested further information on what would enable more staff testing, and whether current constraints were due to narrow testing windows or other problems such as a lack of awareness or willingness to be tested (HW/218 - INQ000327851).

173. On 23 April 2020, I received a ministerial submission, along with the Secretary of State and Parliamentary Under Secretary, which recommended prioritising the testing of asymptomatic staff and residents in care homes where an outbreak had been recorded within 14 days. The recommendation estimated that this would result in 60,000 tests being carried out across 2000 care homes in the following 10 days (HW/219 - INQ000327855 HW/220 - INQ000327856.

174. On 24 April 2020, the Parliamentary Under Secretary's office emailed me and the Secretary of State stating that he had agreed with the recommendations (HW/221 - INQ000327859).

175. On 26 April 2020, I received an email from the Secretary of State confirming that Ministers had reviewed the advice and were content to agree to the recommendations in the submission as follows (HW/222 - INQ000327860):

> *"• Prioritise testing of asymptomatic staff and residents in care homes where an outbreak has been recorded within the past 14 days.*
>
> *• Public Health England work with Directors of Adult Social Services and Local Resilience Forums to identify additional high-risk care homes for testing.*
>
> *• More detailed testing and observational studies to be carried out in a sample of 500 care homes (including some where no cases have been reported to date) to ensure robust evidence is collected to inform ongoing outbreak management advice.*
>
> *• Officials approaching domiciliary care providers to offer to test asymptomatic workers and recipients of care as and when additional home testing capacity comes on line."*

176. As can be seen from the table above, testing increased after April 2020 so that by July 2020, care home staff were being tested weekly. There was discussion at this stage about daily testing of care home staff, but my memory is that those working in the sector felt that daily testing would be too intrusive and difficult to implement with the existing PCR tests which required throat and nasal swabbing.

177. We piloted regular asymptomatic testing of staff in high-risk 'extra care' and supported living settings from August 2020.

178. In November 2020, lateral flow tests were piloted in care homes. Regular asymptomatic testing of staff using PCR tests in domiciliary care was introduced on 23 November 2020. This was extended to supported living settings and extra care settings from 9 December 2020. From 23 December 2020, testing was introduced for all visitors to residential care settings.

(5) Care Act Easements

179. The Coronavirus Act 2020 provided for a set of "easements" to local authorities, so that if absolutely necessary (and for as short a time as possible) they would not have to meet some of their legislative obligations under the Care Act 2014. I was advised to approve the easements to make sure that where local authorities did not have enough staff to carry out their usual workload (due to COVID-19 related absences) they would be able to prioritise staff time on activities which were most important to minimise harm.

180. The Coronavirus Act 2020 was reviewed every two months, and this included a review of the use of the Care Act easements. The Care Act easements provision in the Coronavirus Act expired on 16 July 2021.

181. On 27 March 2020 I received a submission advising me about the oversight of the easements and how to handle publication of the guidance with the sector (HW/223 - INQ000327790). This showed that there had been extensive stakeholder involvement. However, user/carer groups were still concerned about the easements. The oversight proposals advised that local authorities should notify the Department when they 'turned on' the easements, explaining why the decision has been taken and briefly providing any relevant detail (HW/224 - INQ000327791). I indicated my agreement and provided comments on the proposed guidance (HW/225 - INQ000327796 HW/226 -

INQ000327797 The guidance was published on 1 April 2020 (HW/227 - INQ000327802

182. I kept track of the use of the Care Act easements through oversight meetings. For example, on 23 April 2020, I asked CQC to publish a heat map in partnership with the Think Local Act Personal (TLAP) national partnership, to show which local authorities were no longer doing assessments and reviews, and flag where people's needs were not being met and for the Chief social workers to feed back to me after they had engaged with Directors of Adult Social Services and principal social workers (HW/228 - INQ000327853). At that stage, only six councils had enacted Care Act easement and it was important that the local authorities were involving/informing providers in their decision-making processes (HW/229 - INQ000327854 .

183. I also discussed easements with those representing individuals with disabilities who received services. On 6 May 2020, I had a call with the Chief Executive of Mencap, Edel Harris, where we discussed the Care Act easements and Edel confirmed that she would feedback to me on specific examples of lack of transparency on use of the easements as she became aware of them (HW/230 - INQ000327872).

184. I held a further oversight meeting on 7 May 2020, in advance of a meeting on 11 May 2020 with care users (HW/231 - INQ000327874 HW/232 - INQ000327875).

185. On 19 May 2020 I received a note I had requested covering the impact of the Care Act easements, the powers of enforcement for DHSC, how easements were being monitored; and the criteria for turning off the easements. The submission confirmed six (6) Local Authorities were making use of the powers at that time. A further two (2) had used them but since stopped. I was advised that the Chief Social Workers had been in contact with the Principal Social Workers in these local authorities to understand their use of the easements. The advice indicated that Local Authorities operating under the easements had followed the guidance (HW/233 - INQ000327904).

186. On 26 May 2020, I responded to this asking for information about the conversations between the Chief Social Worker and those in local authorities and asked for an outline of a monitoring process or approach. I also asked for

an independent source of information by, for example, feedback from a sample of care users (HW/234 - INQ000327916).

187. On 25 June 2020, I received a submission about oversight of the Care Act easements. This submission confirmed that since the easements commenced on 31 March 2020, eight local authorities had notified the Department that they were operating under easements and as of 24 June 2020 only one local authority was still operating under easements. The submission recommended taking a proportionate approach to monitoring through Chief Social Worker and Principal Social Worker conversations and developing a Chief Social Worker-led review process using information already available to the Department (HW/235 - INQ000327933). I responded to the submission on 3 July 2020 confirming that I agreed with all of the recommendations, in particular with the review process (HW/236 - INQ000327935).

(6) Supporting the Workforce, increasing staffing capacity and limiting staff movement

188. The social care workforce and unpaid carers did extraordinary things during the pandemic looking after people who had few defences against the virulence of the COVID-19 virus. As well as suffering the loss of people they cared for, care workers themselves tragically lost their lives to COVID-19. As Care Minister, I worked to support and protect care workers and unpaid carers from the earliest days of my involvement in our pandemic response.

189. Before becoming a Minister, I spoke several times in Parliament about the NHS workforce and the need for staff to be valued and supported, drawing on my experience working in healthcare. This is a concern I brought with me into social care, a sector with historically high vacancy and staff turnover rates, staff who described feeling undervalued, often paid the minimum wage and employed on zero-hour contracts without the predictability of guaranteed hours.

190. As the pandemic hit us in the UK, I recognised we would be asking the social care workforce to look after people in incredibly difficult circumstances. While many people could switch to working from home, care workers would still have to go to work. Their job would likely involve them caring for people with COVID-19, and even with PPE I knew care workers would understandably be worried about their own exposure to the virus.

191. Some people who receive care at home will not live for long if no care worker turns up. Early in the pandemic we saw news stories from other countries about

care home residents dying because staff did not go in to work. I was determined to avoid that in England. Thankfully we never saw a care home abandoned by staff; throughout the pandemic I worked extremely hard as a Minister to support those working in social care.

192. I was briefed early in the pandemic about a small number of care homes which reached critical staffing situations and the response mechanisms worked with local authority and NHS staff providing support. I believe the incidents where care workers were asked (or told) to work while COVID-19 positive due to staff shortages were exceptional, and swiftly rectified. The call out to furloughed staff from other sectors to join social care helped fill gaps and boosted the care workforce during some of the most difficult months of the pandemic. The extra funding we provided for the workforce also made a material difference, increasing capacity and giving staff extra support.

193. Another risk I was warned about was that lack of sick pay could lead to staff working despite being Covid positive or suffering potential Covid symptoms. I therefore wanted to make sure staff received their normal wages from day one of isolation, coupled with clear guidance on when to isolate. This was implemented in early June 2020 (HW/237 - **INQ000328141**).

194. As tests became available, I pushed for social care staff to be prioritised. This would enable staff who were COVID-19 negative to go back to work. Once we understood the extent of asymptomatic carriers and learnt that tests could identify infections in these cases, I argued for tests so we could detect COVID-19 early among care workers and avoid care workers unknowingly taking the virus into their workplace. As we learnt more about the virus PHE and DCMO updated their advice which fed into updated guidance to the social care sector and workforce.

Covid-19 guidance for people supporting those needing care and support

195. Guidance from PHE /UKSHA was also produced for unpaid carers on use of PPE on 8 April 2020, which was regularly updated (HW/238 - **INQ000327821**). DHSC guidance for unpaid carers looking after adults with learning disabilities and autism was issued first on 24 April 2020, and then updated several times including in August 2020, and January, February, March, July and August 2021 (HW239 – **INQ000328149**). DHSC also issued general guidance for unpaid carers. This was issued on 8 April 2020 and withdrawn on 1 April 2022; it was amended numerous times throughout this timeframe (HW/238 - **INQ000327821**).

196. Alongside this, the Social Care Institute for Excellence produced resources for carers of adults with learning disabilities and autism, to provide them with help and support not just about PPE, but about the emotional and social consequences of isolation on these individuals. The guidance for those who were clinically extremely vulnerable to coronavirus was also published and updated regularly (HW/240 - INQ000328154). DHSC also produced and supported the production of guidance in accessible formats for people with disabilities.

197. Throughout the pandemic I wanted to hear directly from the care workforce, about what they needed from Government. I also wanted a channel of communication to give care workers direct updates on new guidance and support available to them. Finding ways to communicate directly with care workers required creative thinking because most care workers are 'unregistered', relatively few are members of unions and there are far more employers to reach out to in order to get a message passed onto staff.

198. Personal assistants and unpaid carers were harder still to reach and support, given the lack of registers and formal channels of communication. Our main channels of communication were nationally published guidance (on gov.uk) and through stakeholder groups.

199. To support our communications with the workforce, I created a care worker app to serve as a channel of communication (and a peer-to-peer forum) for care staff and established a newsletter to the sector. These achieved a moderate level of uptake but never at the scale needed to reach the majority of the care workforce.

200. As part of my efforts to raise the profile of the sector, I pushed for social care to be mentioned in press conferences by the Prime Minister and sent a message asking her late Majesty the Queen to speak about care workers in her Christmas message. When she did so, recognising health and social care workers in the same breath in her speech to the nation at Christmas 2020, it felt like a landmark in the recognition of the care workforce. We also gave care workers keyworker status, reached out to supermarkets to advise their staff to recognise the ID care workers would have (e.g., letters from their employer), and distributed the Care Badge as a mark of recognition for care workers.

201. I also engaged directly with workers on the frontline. I carried out virtual visits and calls with care worker and carer groups to hear first-hand about their experiences. Union representatives provided a valuable perspective as did Skills for Care, who invited me to join their group calls with registered managers, which took place regularly.

Increasing workforce supply - Skills for Care rapid training scheme

202. One of our aims in the early stages of the pandemic was increase the supply of social care staff because not only was there high vacancy rates but staff absences due to Covid would make safe staffing difficult for care providers. We therefore worked to rapidly to ramp up recruitment and training to provide extra care workers ready to be deployed rapidly into social care.

203. On 24 March 2020, I had a meeting with the CEO of Skills for Care (SfC) about a rapid induction training scheme for volunteers and new/returning staff to be delivered by their endorsed national learning providers with the aim of making recruitment faster and more streamlined. The scheme would be managed by SfC and funded through their Workforce Development Fund, which is funded through an annual core grant that the Department allocates to SfC (HW/241 - **INQ000327785**).

204. A couple of days later, I confirmed to the CEO of SfC that I was happy to proceed and scale up delivery as quickly as possible subject to agreeing the content of the training and delivery model (HW/242 - **INQ000327786** ; HW/243 - **INQ000327787**).

205. I received further advice on 24 April 2020 with information as to how this scheme would work in practice. In particular I wanted to understand how the training packages would be delivered and funded (HW/244 - INQ000050177). I responded on 11 May 2020 with questions about how the training being offered fitted across existing online platforms. I also wanted to review how training support packages were working in combination, especially the number of people being trained, the feedback from care workers/employers, the costs, and how to make the most of the investment to maximise the benefits for providers and the care workforce (HW/245 - **INQ000327879**).

206. Following further work involving CQC, a new online platform was launched to fast-track recruitment into social care supported by £3m of funding from the Workforce Development Fund (HW/246 - **INQ000327858** . This recruitment platform allowed people looking for jobs in social care to record an interview and access free training supported by SfC before starting employment. It also helped social care employers to recruit more quickly as they were able to search for candidates in their local area, view their video interviews before starting DBS checks and make jobs offers. The online platform was included in April's Social Care Action Plan and launched following month alongside a new national social care recruitment campaign. Within a week of the platform going live approximately 220 people had started the induction training (HW/247 - **INQ000327924**).

Risks for ethnic minority staff working in health and social care

207. As the pandemic spread, we learnt that COVID-19 was more dangerous for people with impaired immunity, underlying health conditions, learning disabilities and disabilities, and individuals from black Caribbean, African Pakistani, Bangladeshi and other minority ethnic communities. Ensuring care workers had effective PPE was extremely important to me especially as the workers from ethnic groups as measured by Skills for Care make up approximately 22% of the social care workforce.

208. I had a meeting with officials from NHS England and NHS Improvement in May 2020 where I was provided with the latest iteration of the NHS risk framework and guidance from NHSEI (HW/248 - **INQ000327887** HW/249 - **INQ000327884**; HW/250 **INQ000327885** HW/251 - **INQ000327886**).

209. When a survey published by the Royal College of Physicians June 2020 found that only 24% of healthcare workers had been formally risk assessed despite advice that all healthcare workers should be risk assessed for COVID-19, I sent a WhatsApp message to the Secretary of State as I was concerned about wider systemic issues affecting staff in the NHS stating that *"One more thing on 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 NHSBT[13]. Now could be a good moment to kick off a proper piece of work to investigate and tackle it."* (HW/252 - **INQ000328119**; HW/253 - **INQ000327923**).

210. At my request, I received an update from DHSC officials on why the proportion of staff who had received a COVID-19 risk assessment was so low as I was advised that the 24% survey figure did not reflect what NHSEI was hearing from employers. I held discussions with Prerana Issar (Chief People Officer) to ensure NHS organisations improved its support on COVID-19 to staff.

211. When the NHS People Plan was published in July 2020 (HW/254 - INQ000292624). Some of the measures it set out included:

- Recognising the disproportionate impact of COVID-19 on BAME communities and colleagues.
- All NHS organisations to complete risk assessments for vulnerable staff, including BAME colleagues and anyone who needed additional support, and take action where needed.

[13] This refers to an NHS Blood and Transplant (NHSBT) independent report which found that there was systemic racism at its site in Colindale, London.

- Changes to recruitment and promotion practices to reflect the diversity of the community, and regional and national labour markets - including creating accountability for outcomes, agreeing diversity targets, and addressing bias in systems and processes, supported by training and leadership about why this was a priority for staff and patients.

212. In Question 26 in the Rule 9 letter, I am asked to clarify a reference I made to there being a "a gap in approach" between the NHS and some levels of Government on racism and inequalities. On 5 June 2021, the Secretary of State had sent me a page from the NHS webpage containing a glossary on equality and diversity and asked me whether I had any thoughts (HW/255 - **INQ000327923**). I had not seen the NHS page before, but I told the Secretary of state that I sensed that there was a gap between the NHS approach on tackling racism and inequalities, and the stance from No. 10 and the Equalities Minister, Kemi Badenoch (HW/256 - **INQ000328132**).

213. To provide context to this comment, in the summer of 2020, Prime Minister Boris Johnson appointed the Commission on Race and Ethnic Disparities to review the causes of race inequality in the UK. Its remit was *"not just to identify disparities as with previous reviews, but to undertake the foundational work to understand why these disparities existed and understand what has been happening over time in order to target solutions effectively at root causes and not on symptoms, assumptions or perceptions"* (HW/257 - **INQ000328106**).

214. In response to the Commission's report, the Government set out actions including reducing pay disparity in NHS England, requiring CQC to measure workforce diversity and inclusion in inspections and tackling health disparities – with the launch of a new body, the Office for Health Improvement and Disparities (OHID) to do so (HW/258 - **INQ000328153**). Following the publication of the Public Health England report 'Disparities in the risk and outcomes of COVID-19' in June 2020, the Equalities Minister also led work to address its findings.

Protection of ethnic minority members of the social care workforce

215. As work progressed on the NHS risk reduction framework, I also wanted to take steps to increase protection for ethnic minority staff at greater risk from Covid in social care. On 3 June 2020 I received a submission on the risk reduction framework for the social care workforce (HW/259 - **INQ000327918**). I responded on 8 June 2020 asking about further potential measures for staff from ethnic groups and ethnic minorities to reduce the Covid risk; for instance,

what extra level of testing would PHE advise, or enhanced PPE (HW/260 - INQ000327922). I cleared the framework on 11 June 2020 (HW/261 - INQ000327925). Special Advisors provided their approval on 12 June (HW/262 - INQ000327929. The risk reduction framework was published on 19 June 2020 (HW/263 - INQ000303267).

Decision to introduce a Chief Nurse for Adult Social Care in DHSC

216. In June 2020, I had discussions with the Director General of Social Care about creating a clinical nurse leader post within the Adult Social Care group in DHSC (HW/264 - INQ000327930). I asked for advice on the scope of a Chief Nurse for Social Care role and the process for recruitment (HW/265 - INQ000327968 HW/266 - INQ000327969).

217. The advice recommended a Chief Nurse formally sitting with DHSC and reporting to the Director-General of Adult Social Care. The Chief Nurse would also have a professional line to the Chief Nursing Officer, to establish a clear professional link to NHSEI. The Chief Nurse would provide expert clinical and professional advice in relation to nursing across the social care sector and would support DHSC's social care policy more generally. Professor Deborah Sturdy was appointed as Chief Nurse for Adult Social Care on 7 December 2020 (HW/267 - INQ000328023).

218. I consider the creation of the Chief Nurse position as an important step to increase the voice of social care both within and outside Government, improve recognition of social care nurses and build professional leadership within Adult Social Care.

Decisions on limiting staff movement

219. In April 2020, PHE research to understand the spread of COVID-19 in care homes identified that a significant source of transmission to residents was from staff. This was backed up by a paper I received in the same month which demonstrated a connection between staff movement and COVID infection rates (HW/268 - INQ000327837).

220. I also recall seeing evidence – for example, from the US – that movement of staff between care settings (both across care homes and between health and social care) was increasing the likelihood of COVID outbreaks.

221. Staff movement was also considered by the Prime Minister and the Cabinet Secretary. I was sent slides on 27 April 2020 to be discussed at the COVID-19 strategy meeting on 28 April which set out proposals to restrict staff movement,

together with the challenges to implementation (HW/269 - INQ000327863; HW/270 - INQ000327864).

222. The action following the COVID-19 strategy meeting required DHSC to work with MHCLG to develop a plan and timeline to restrict movement of staff (HW/271 - INQ000327865). In May 2020, the Care Home Support package was published which set out actions for care home providers should consider taking to restrict staff movement and minimise workforce transmission. These actions included ensuring that staff work in only one care home wherever possible and extending these restrictions to agency staff.

223. The Care Home Support package also provided new funding (through the Infection Control Fund) to help reduce staff movement, such as paying for care homes to recruit additional staff to enable staff to work in only one care home and providing accommodation for staff who proactively choose to stay separately from their families in order to limit social interaction outside work. The infection control fund also supported care homes to ensure that staff who are isolating in line with government guidance receive their normal wages while doing so (HW/95 - INQ000327900)

Further measures to limit staff movement

224. In June 2020, we received a report from the first phase of a PHE-commissioned study into Covid-19 in care homes, known as the 'Vivaldi Study'. The first tranche of that research demonstrated that regular use of 'bank' staff (i.e., staff likely to work in more than one setting) was an important risk factor for infections in care homes (HW/272 - INQ000106159). On the basis of this evidence, I asked DHSC to look again at how we could stop or substantially restrict staff movement between sites.

225. On 23 July 2020 I had a meeting with David Pearson and the adult social care taskforce where I raised staff movement as a priority (along with isolation and testing) and asked for a briefing as to how staff movement could be restricted (HW/273 - INQ000327960).

226. A submission was produced in response on 29 July 2020 following two workshops with the care sector (HW/274 - INQ000327965; HW/275 - INQ000327966; HW/276 - INQ000327967). The submission advised me; *"National and international research has demonstrated that a significant risk factor in outbreaks of Covid-19 in care homes is staff movement".* It made recommendations on limiting staff movement but advised against legislating to stop staff movement (HW/275 - INQ000327966). In response (on 4 August 2020) I asked for further advice on practical actions to reduce staff movement

such as requiring care homes to have staff dedicated to a single site except in emergency situations (HW/277 - INQ000327971).

227. A paper outlining the adult social care winter plan was discussed at COVID-O on 15 September 2020. This included a proposal to legislate to stop staff movement (HW/278 - INQ000090190). This was taken forwards as an action for DHSC from the meeting (HW/279 - INQ000090012).

228. The Secretary of State and I received a submission on 18 September 2018 setting out two potential legal routes to stop staff movement by amending CQC regulations (HW/280 - INQ000109760). I agreed with the recommendation and the Secretary of State signed this off (HW/281 - INQ000109792). At this time, we were using the capacity tracker to monitor staff movement. For instance, the 18 September submission mentions that capacity tracker data showed that 91% of care homes were confident that staff were not moving between sites.

229. A number of risks and issues were set out in the advice which I followed up on, including the risk that that restrictions would be more likely to impact those working part-time or on zero hours contracts. This concerned me as the majority of the workforce are women, working for often low levels of pay. I wanted to see staff given a guarantee of minimum hours in return for the commitment to only work in one place (HW/281 - INQ000109792_pg3).

230. I requested further advice from DHSC officials about how the staff movement regulations would be enforced. I received this on 24 September 2020 (HW/282 - INQ000109793). I also received advice on how we could prevent financial hardship for care workers if this policy was introduced. Given the implementation challenges, I specifically requested for the policy to be developed with the sector (HW/281 - INQ000109792_pg1).

231. A short public consultation on the draft regulations on restricting staff movement was proposed. I received advice on 30 October on the draft consultation document and accompanying documents (including a code of practice and compensation guidance) for my approval (HW/283 - INQ000328002). Upon reading the advice, I was concerned that the consultation was not ready for publication. I requested further work, including the addition of consultation questions which would get the perspective of residents and their families (HW/284 INQ000328004 I was sent an updated submission on 5 November and promptly provided my comments (HW/285 - INQ000110017; HW/286 - INQ000110023; HW/287 - INQ000328005).

232. On 12 November 2020, the Secretary of State and I signed off on the consultation document, as did No 10 (HW/288 - INQ000328009 HW/289 -

INQ000328010). The consultation on these proposals was held between 13 and 23 November (HW/290 - INQ000328144; HW/290A - INQ000328145).

233. The consultation proposed to amend regulations to:

233.1. Create a temporary requirement that CQC registered care home providers do not deploy staff to provide personal or nursing care if they are, or have in the previous 14 days, been carrying out a regulated activity in another health or social care setting (further details on which groups are excluded is set out in this document).

233.2. Provide a limited temporary exception to the requirement in order that care home providers can continue to ensure enough staff are available to care for service users safely. This would allow providers to use people who are also being deployed in another health or social care setting, but only for a reasonable period of time to allow the provider to make other arrangements to enable them to comply with the requirement.

234. During this period up to the end of the year, I held a series of telephone conferences with social care stakeholders including local authorities and care providers to discuss their current concerns and issues on a weekly basis (HW/291 - INQ000328018 pg2). In some of these meetings care sector representatives told me that limiting staff movement via legislation would be likely to lead to understaffing (HW/292 - INQ000328020; HW/293 - INQ000328019; HW/294 - INQ000328021).

235. A submission sent to me on 3 December 2020 advised that the staff movement consultation responses were 86% against introducing the regulations. Themes in the responses included:

- Concerns about the inclusion of settings for working age adults, particularly those with challenging behaviours, and the impact that changes in care could have on their well-being;
- The impact on staff well-being and the risk of burnout, particularly if the regulation led to staffing shortages, and whether staff would leave the workforce for higher paid jobs; and
- Insufficient funding to compensate staff hours, which would lead to financial hardship for care workers. (HW/295 - INQ000328025)

236. I argued that the staff movement restrictions should be accompanied by furlough payments for staff and/or financial support to compensate for lost earnings. This would require HM Treasury approval (HW/296 - INQ000328024).

237. On 18 December 2020 HM Treasury rejected the proposals to compensate staff through the furlough scheme but said that they would consider extending the Infection Control Fund – or creating a new compensation scheme – to support the regulations. The submission from officials advised me to continue with the regulations – with an exemption for care homes where there was full vaccination of staff (HW/297 - **INQ000328026**). I responded the next day saying I did not want to go ahead without furlough payments being made (HW/298 - **INQ000328027**).

238. The regulations were then discussed at a COVID-O meeting on 22 December 2020, where I made a presentation. An action from that meeting was for further work to identify a way to compensate care staff which would not amount to a furlough payment – with a view to implementing the policy from 4 January 2021 (HW/299 - INQ000091096).

239. The proposed compensation scheme involved a ringfenced fund for care homes providers, to be administered by local authorities. It would pay 100% of the salary of care workers who had to stop work to comply with the proposed regulations (HW/300 - **INQ000328028**). This did not get HMT approval – and instead the HMT steer was to make an alternative proposal which would increase the supply of care workers (HW/301 - **INQ000328029**).

240. On 5 January 2021 I received a submission recommending that I agree not to pursue the staff movement regulations given the following context (HW/301 - **INQ000328029**):

> *"Staff capacity problems now appear acute and widespread as increasing numbers of social care workers self isolate.*
>
> *Against this backdrop, even stakeholders who should support the regulation (like ADASS) are concerned that the exception will have to be used so widely, it won't be effective, or will be disruptive*
>
> *HMT ministers have yesterday decided not to fund a compensation scheme, saying it is the wrong mechanism but that they are open to options to support increased staff supply."*

241. On 7 January 2021, I indicated that I agreed with the submission (with reluctance) and on the same day the proposal was dropped (HW/302 - **INQ000328031**; HW/303 - **INQ000328032**).

Workforce Capacity Fund

242. I received a submission on 6 January recommending a bid to HM Treasury to fund a £120 million ringfenced grant to local authorities (HW/304 - INQ000328030). This was in line with the HMT steer to bid for funding to increase supply of staff rather than for compensation for the impact of staff movement restrictions. This was later known as the Workforce Capacity Fund.

243. On 16 January 2021, DHSC announced the £120 million Workforce Capacity Fund. This funding was introduced to help maintain the provision of safe care in response to staff shortages and to address Adult Social Care workforce capacity pressures. Local authorities could use the funding to deliver measures to help all providers of Adult Social Care in their geographical area, or to pass funding directly to providers.

244. On 20 January 2021, I received a submission setting out the final grant design for the fund and asking for ministerial clearance of the guidance and grant documents. Funding would be paid out as a grant ring-fenced exclusively for actions which enable local authorities to supplement and strengthen Adult Social Care staff capacity. This included both increasing the use of the existing workforce and increasing the size of the workforce in care homes and domiciliary care (HW/305 - INQ000110419; HW/306 - INQ000110421). This was a new grant, separate to the second Infection Control Fund (ICF2) and Rapid Testing Fund, and would be paid directly to local authorities in England. Funding had to be spent by 31 March 2021.

245. I was asked to respond by the following day as there was a need to publish the grant guidance and grant documents so that local authorities could receive payment and begin to deliver additional staffing capacity as soon as possible, and final approval had to be secured from MHCLG, HM Treasury and No.10 (HW/305 - INQ000110419).

246. In my review of the grant guidance I highlighted that I wanted it to be clear that the purpose of the grant was for two main reasons: (i) to make sure that continuity of (safe) care was achieved, in the face of workforce shortages that put this at risk; and (ii) to make sure there was capacity for discharges (and also new admissions from the community to care homes / new recipients of domiciliary care). This was the underlying purpose for boosting workforce supply. My other concern was the lack of reporting to provide insights into the extent to which the grant was being used to achieve (i) and (ii) above. I wanted regular reporting at local authority level on care capacity, workforce supply, and how the funding is being used (HW/307 - INQ000328043).

247. On 21 January 2021, the Secretary of State stated that he was happy for me to clear the guidance (HW/308 - INQ000328045).

248. Following a conversation at the Prime Minister's dashboard meeting on 25 January 2021, I proposed using the £120m to reduce staff movement as far as possible and updating the grant letter and conditions to reflect this. My priority, however, was to get the guidance out as soon as possible. I therefore agreed to publish this first and then supplement the conditions at a later date (HW/309 - **INQ000328052**). On 26 January 2021, I gave my formal approval to clear the guidance and grant determination letter (HW/310 - **INQ000328053**).

249. As part of the funding conditions we asked local authorities to complete returns setting out how this money was being used, and what impact they expected on the availability of care provision and on staffing capacity. The returns from local authorities showed that 39,000 new staff had been recruited into the sector from the funding. It was also estimated that an additional 7.3 million hours of care were provided through the fund (HW/311 - **INQ000328150**).

Strengthened guidance on restricting staff movement

250. Following the decision not to legislate on staff movement, we decided to further strengthen guidance on this to make clear the importance of restricting staff movement as part of infection prevention and control.

251. The aim of the updated guidance was to:

- reinforce the continued importance of restricting routine staff movement to care home providers;
- confirm that staff sourced through agencies, staff banks and other temporary sources should, wherever possible, also be subject to efforts to reduce staff movement between settings; and
- set out those exceptional circumstances in which staff movement could still take place and gives advice on the use of LFT testing to manage the associated risks.

252. I cleared the staff movement guidance on 20 January 2021 (HW/312 - **INQ000328041**). Further amendments were made incorporating my feedback to make clear that where a care provider had exceptionally high levels of staff absence, such as a COVID-19 outbreak with a large number of staff testing positive, they might need to use mutual aid from their local care system which could involve staff who had recently worked at another regulated setting. I thought it was important to emphasise that this was the only exception and ensure this was understood by stakeholders (HW/313 - **INQ000328044** HW/314 - INQ000110431).

253. On 21 Jan 2021, the Secretary of State agreed to these changes (HW/315 - INQ000328046). The guidance was sent for triple lock procedure on 22 January 2021 (HW/316 - INQ000110456).

254. The *'Restricting workforce movement between care homes and other care settings'* guidance for care home providers was formally published on 1 March 2021 following approval by the Cabinet Office, PHE and No.10.

PM dashboard meeting in January 2021

255. On 24 January 2021 ahead of the PM dashboard meeting on 25 January 2021 the Cabinet Office sent an email confirming the agenda would cover care homes and the dashboard update on the latest vaccination data for care home residents and care home staff (HW/317 - INQ000328048).

256. At the meeting on 25 January, it was recorded that *"The Health Secretary committed to update the PM on all the non-legislative levers being used to reduce staff movement to a minimal level, and the ways in which the £120m fund and testing of agency staff would be used to help achieve this. DHSC and TF to provide a note on this by COP Thursday, including an update on the latest data."* (HW/318 - INQ000325304).

257. After the meeting with the Prime Minister, the Secretary of State and I met and discussed the outcomes from the meeting, together with mandating vaccination for social care staff and vaccinations for people with learning disabilities and autism. The Secretary of State asked that I write a note to the Prime Minister explaining the challenges of restricting staff movement (HW/319 - INQ000328050).

258. Following the discussions at the PM dashboard, I asked my office to commission DHSC officials to prepare a short note send to the PM setting out what non-legislative levers were being used to reduce staff movement, including ways in which the £120m Workforce Capacity fund and testing of agency staff would help limit staff movement (HW/320 - INQ000328051). I reviewed the note on 27 January 2021 (HW/321 - INQ000328054 HW/322 - INQ000328055, and it was sent to No.10 on 29 January following clearance from the Secretary of State.

259. On 4 March 2021, I received a submission providing further detail on the monitoring and assurance of staff movement, along with a draft of the consultation response. I was asked for approval to commission the Cabinet Office Field Work Team to conduct research on ongoing staff movement noted

in the capacity tracker (HW/323 - INQ000328078). I agreed to both recommendations on 11 March 2021 (HW/324 - INQ000328077). The Secretary of State approved the publishing of the consultation response to publish and the monitoring plans on 17 March 2021 (HW/325 - INQ000328081).

IPC Enforcement

260. During winter 2020/21 I heard of an incident involving staff continuing to work in a care home after testing positive for Covid. My recollection is that this was reported by our DHSC Social Care Regional Assurance Team. I was extremely concerned and asked for further information, and also for the regional team and CQC to investigate to see whether this was a one-off or happening more widely.

261. On 10 February 2021 the Secretary of State and I received advice on steps to address Covid-positive staff working in care settings (HW/326 - INQ000328062. The submission set out how CQC were responding, where they had identified instances of Covid positive staff working in care settings, and advised on additional potential actions including police investigation of potential offences (HW/327 - INQ000328063).

262. My private office sent an email to the Secretary of State's private office on 15 February 2021 agreeing with the recommendations other than the advice not to involve police. I commented that working when COVID-19 positive was a very serious matter and *"an extraordinary thing for anyone in a public health team or local authority to have agreed to, where systems are involved"* (HW/328 INQ000328065). Secretary of State's private office responded, highlighting that he had given a clear steer on his attitude to police involvement, so officials would need to explain consequences/alternatives if advising against this (HW/329 - INQ000328066).

263. After receiving further advice, my private office emailed the Secretary of State's private office on 8 March 2021 to say that I wanted cases of COVID-19 positive staff working in care settings to be passed to the police (HW/330 - INQ000328076).

264. On 14 April 2021, I received a further submission on this issue which recommended that I write to the CQC to ask them to take overall responsibility for ensuring cases are referred to the police, but that local authorities should have the opportunity to work through their own safeguarding processes in the first instance (HW/331 - INQ000328114).

265. On 22 April 2021, my private office emailed the Secretary of State's private office confirming that I had cleared the submission on police involvement and agreed to the recommendations: (i) to write to CQC asking them to take overall

responsibility; (ii) that CQC give LAs the opportunity to work through their own safeguarding process; and (iii) to write to LAs to outline the process and DHSC's view that COVID-19 positive working meets the bar for local authorities to conduct their own safeguarding enquiries (HW/332 - INQ000328116). The Secretary of State's office confirmed that I should feed this back to the policy team (HW/333 - INQ000328117). On 27 April 2021, I signed off a letter to the CQC setting out the policy proposal (HW/334 - INQ000328118).

266. CQC responded expressing concern that this policy would set a precedent for Government intervention and potentially risk the CQC's independence. I then wrote to Peter Wyman, CQC chair, asking CQC to ensure that local authorities had referred any substantiated cases of COVID-19 positive working to the police; and, where the police had not been involved, that CQC referred these cases back to DHSC to pass onto the police. In his response, Peter Wyman reiterated that CQC could not undertake such a role as it had no responsibilities under legislation to monitor local authority safeguarding processes. He also said changes would need to be made to provider fees to allow this scheme to be administered, which would take until early 2022 to be implemented (HW/335 - INQ000328135; HW/336 - INQ000328136).

267. I met CQC on 8 July 2021 and confirmed that I understood CQC's position and was content not to pursue the matter further.

268. On 22 July 2021, I received a further submission on this topic, advising that the police did not have sufficient resources to investigate all cases of Covid-positive working and that CQC had written to confirm that they would not follow up on cases – but that local authorities would continue to consider cases through safeguarding processes. The recommendation was that I agree to no further action with CQC, and that I consider whether: (i) to write local authorities reiterating that they should refer substantiated cases to the police via safeguarding processes; or (ii) make it clear in the forthcoming Winter Plan that COVID-19 positive staff must self-isolate and that local authorities are responsible for investigating individual breaches (HW/337 - INQ000328147).

269. I responded to the submission on 28 July 2021, agreeing to set clear expectations and guidance in the Winter Plan (HW/338 - INQ000328148). The winter plan contained a set of actions for care providers on IPC including that they should ensure all care staff have ongoing training on IPC, and ensure staff do not work if they have Covid-19 symptoms, or a member of their household has symptoms or a recent positive test, or if they have been told to isolate by NHS Test and Trace (HW/339 - INQ000328148.

(6) Visiting policies

270. Visits matter more than words can say for care home residents and their families. Some residents are visited daily by a relative or friend. Some frequent visitors play an important part in the care of the resident. For instance, helping at mealtimes, providing vital stimulation, or a connection to life outside the care home. They may be the one to notice when the resident isn't quite themselves. We often talk about this group of visitors as 'essential care givers' or 'care partners'. Visitors who come less often can still make a significant difference to the wellbeing of residents.

271. Visits matter to the visitor too. I have spoken to the husband of a nursing home resident with advanced dementia. His wife no longer recognises him but – until the pandemic – he had always visited her every day. He found the visiting restrictions heartbreaking. It filled him with worry and guilt. I have lost count of the number of stories like this I have heard.

272. Staff told me about the challenges for them supporting residents who couldn't understand or remember why they weren't seeing loved ones. I know staff went to extraordinary lengths in many care homes to keep up the morale of the people they cared for.

273. Visits out are important too, for residents who can do so. For instance, for an autistic young adult who usually spends the weekend with their family, the visiting-out restrictions were enormously distressing.

274. Decisions about visiting restrictions were debated within Government as we sought to strike the right balance between minimising the risk to care home residents and staff from COVID and maintaining the broader wellbeing of residents. The families and friends of care home residents also had strong but divergent views. Some families were adamant that there should be no visiting to protect their loved ones, while others wanted visiting to be allowed but for instance with the stipulation that all visitors should "shield" in between visits.

275. I recall Ros Roughton talking about the importance of visiting and discussing in the early days of the pandemic (in March and April 2020) whether we could establish the model of 'essential visitors' who would care for their loved one on a daily basis, supplementing care home staff. I believe this model was used in some care homes in Australia. However, this approach was not supported by the clinical advice, which was clear about the importance of minimising footfall into care homes and therefore stopping visiting.

276. During the pandemic I became increasingly concerned about the impact of visiting restrictions. I commissioned research into the wellbeing of care home residents to provide an evidence base. I thought not allowing people to visit during end of life was particularly hard for relatives, depriving them of the chance to say goodbye. This is why I asked for public health advice on visiting to be refreshed multiple times during the pandemic to reflect reduced levels of COVID-19 in communities, easing of lockdowns, innovations like visitor pods, access to testing and the vaccination roll-out. This led to the series of updates to guidance, including specific exemptions to restrictions for end-of-life visits, the introduction of 'COVID-secure' visiting and the 'essential visitor' policy later in the pandemic. I also endeavored to publish guidance that worked for different types of accommodation and visiting-out guidance to allow residents to spend time with their families outside the confines of the care setting.

277. Guidance covering care homes was issued by PHE on 25 February and 13 March 2020. Neither version restricted visits.

278. Alongside this, PHE published guidance on staying at home for those with confirmed or possible COVID-19 infection. On 16 March 2020, general guidance was issued for several sectors identifying the need for social distancing and guidance on large gatherings, called Guidance on Social Distancing for everyone in the UK. This guidance was aimed at those living in their own homes but included those who received care within their own home. All those over 70, or those under 70 with co-morbid conditions were particularly urged to follow the guidance stringently. The guidance said: (i) gatherings with friends and family should be avoided; (ii) the provision of care within the home should continue as normal; and (iii) social visitors from friends and family should be avoided, unless they are providing essential care, such as personal care or meal preparation.

279. That said, that many care homes and extra care settings stopped visitors on a voluntary basis by mid-March 2020, having seen the scenes in Italy and the United States and not wanting to expose their residents to a virus.

280. Guidance on shielding was issued on 21 March 2020. The Coronavirus Act was passed on 25 March 2020 with the Coronavirus restrictions coming into force (SI 2020/350) on 26 March 2020. Regulation 4 of those regulations prevented individuals from leaving their home unless various exemptions applied. That did not include visiting relatives, although it did include providing care and assistance, including personal care to someone else in another home. This allowed unpaid carers to continue to provide care.

281. On 2 April 2020 DHSC, PHE and the CQC published joint guidance on admission and care of people in care homes. It advised that families and friends should not visit individuals in care homes, save in exceptional circumstances (such as end of life) and that visits should be facilitated and held remotely where at all possible (whether through a window, by telephone, video or technology).

282. I was concerned that his could lead to social isolation and affect the mental health of residents, as well as their carers. I commissioned research into this area and asked for more information on supporting the wellbeing of care home residents to be included in the guidance (HW/340 - INQ000327905 HW/341 - INQ000327903 HW/342 - INQ000327917).

283. In June 2020, the government eased restrictions and altered the coronavirus act and regulations to provide various exemptions from the need to remain at home (the Coronavirus (Amendment No 3) (England) Regulations 2020) from 1 June 2020. What they did not do, however, was to create an exemption in those regulations if individuals were visiting people in residential care settings and so in effect made it illegal to visit a care home. I cannot remember seeing these regulations before they were implemented - and searches do not reveal that I was copied into sight of them. I wanted the Regulations to be amended and I spoke to the Secretary of State to that end a few days after they were implemented. I wanted a provision to allow visits to care homes, particularly for end-of-life.

284. No.10 agreed to amending the Regulations to allow visits provided that it was followed up with updated guidance – an approach I accepted (HW/344 - INQ000327926. The Regulations were amended and came into force at midnight on 12 June – twelve days after the previous regulations. The Health Protection (Coronavirus Restrictions) (England) (Amendment No 4) Regulations 2020 allowed someone to visit a person receiving treatment in hospital (or staying in a hospice or care home) where they were a member of their household, close family member or a friend. However, "care home" was defined for these purposes as that under s3 of the Care Standards Act 2000. That did not include supported living or shared lives placements, but the general relaxations meant that visits should be able to take place at the very least outdoors in those settings.

285. As levels of COVID-19 in the community fell during the summer of 2020, and lockdown restrictions lifted, I knew families wanted to be able to visit loved ones in care homes. Providers also asked me for updated guidance on visiting (HW/345 - INQ000327931).

286. On 24 June 2020 I received a submission which recommended moving towards a 'dynamic risk-based approach' on visiting, which would take into account the local situation of each care home, with an increased role for local public health teams (HW/346 - **INQ000327932**). The risks and benefits of the proposal as set out included:

286.1. The largest potential risk was that increasing visitors to care homes increased the risk of introduction of infection from the community as well as increasing the risk on wider community levels of infection. At the current time, however, the evidence provided no indication of care homes 'seeding' infection in the community.

286.2. The primary benefit was to patient and family wellbeing, including a reduction in anxiety, loneliness and isolation, and additional support for end-of-life cases. Alongside this it was the view that an increase in social interaction for residents could lead to calmer behaviour for people with dementia and learning disabilities, a reduction in depression, and reduction in agitation making it easier to apply social distancing and disease transmission mitigations. The submission recognised that the lack of contact with relatives could plausibly link to a reduction in life expectancy.

286.3. As part of this process, I wanted to see what other countries were doing about care home visiting. I received advice which told me that several other countries had begun reviewing their visiting policies. Germany was using a similar model to the one we were proposing, and several Canadian provinces had also relaxed restrictions.

287. The advice emphasised that the proposed approach maximised the control of local professionals, who would have the greatest awareness of community transmission in the care home area, whilst giving due regard to the needs of individual residents. It was expected that all care homes would only relax visiting arrangements for specific individual needs and continue to take the health protection of the whole care home population as the priority objective.

288. My comments during the development of the guidance indicate that I felt that I needed to make the case for the importance of visiting – flagging not only the detrimental impact of visiting restrictions on residents and their families, but also the increased risk that abuse or neglect might not be identified. I also push for the next version of the guidance to address home visits and 'visits out' especially for care home residents of working age, and say I want, at the very least, parity with the NHS, where it was permitted to accompany a relative with dementia in hospital (HW/346A - **INQ000327936**

289. I pressed for the guidance to be published as soon as possible, given both the benefits it would bring to resident quality of life and because some care settings had already started relaxing their visiting policies. There were delays, however, in getting the final guidance approved by the Secretary of State and No.10 (HW/347 - INQ000327934) (HW/346A - INQ000327936). On 9 July 2020, the Secretary of State informed me that he had already announced that new guidance would be published *"in the next few days"* (HW/348 - INQ000327937). My private secretary sent a Departmental email that day stating that the Secretary of State had committed to publishing new visitor guidance imminently and that I was very keen to have the guidance published as soon as possible. I then informed the Secretary of State that I was due a new draft the following day, but understood that it needed sign off from No.10 (HW/348 - INQ000327937).

290. That evening I was provided with a copy of the amended guidance, and accompanying advice on the changes, and advice sent to No.10 for me to clear. The guidance was informed by advice from SAGE, and proposed enabling visits on the basis of a risk assessment by the local Director of Public Health (DPH), and included recommended precautions such as face coverings. It confirmed that the CMO was happy in principle and DCMOs were content with the oversight and mitigation (HW/349 - INQ000327938; HW/350 - INQ000327939; HW/351 - INQ000327940; HW/352 - INQ000327941)

291. I received an updated draft of the guidance the following day on 10 July 2020 (HW/353 - INQ000327942). Having reviewed it, I was content to clear the guidance and for police to seek No.10's agreement; however, I flagged the following points (HW/354 - INQ000327943):

- The policy could be clearer on the process;
- I asked for all DPHs to be given advance notice so that they were ready to advise regarding visiting in their area when the change was made public. I stressed that I did not want DPHs to be taken by surprise and that they needed time to decide what their local policies would be.
- The policy had to include guidance on residents leaving the care home – e.g. family members of working age adults with learning disabilities are often taken home overnight or for weekends, or on trips.

292. An updated draft was circulated later that day, which I made further edits to, and was then sent to the Secretary of State (HW/355 - INQ000327946).

293. On 13 July 2020, I met with Martin Green, the Chief Executive of Care England, and other providers, where we discussed the need to make sure there was advance sight of the guidance by providers (HW/356 - INQ000327948).

294. On 14 July 2020, I received an email from the Secretary of State confirming that Ministers were content to publish the guidance and for it to be sent to No.10. The Secretary of State also asked that we ensure that when a locality goes into "supported" status at GOLD meetings (an explanation for which is set out above that we consider rescinding care home visitor guidance and become stricter on visits (HW/357 - INQ000327949). I received an email on 20 July 2020 from No.10 informing me that the guidance was going through the "triple lock" process (HW/358 - INQ000327957).

295. On 22 July 2020, DHSC published the *'Visiting arrangements in care homes'* guidance (HW/359 - INQ000325285). Care providers were advised to develop a policy for limited visits from a single constant visitor per resident where community transmission rates were low. The guidance further stipulated that where there was an outbreak, care homes could impose visiting restrictions but were required to consider alternative options to maintain social contact for residents and their families.

Decision on visiting policy in Winter Plan

296. In September 2020, following the rise in confirmed COVID-19 cases in care homes, the Prime Minister asked for advice on strengthening guidance for visits to care homes. Separately, on 12 September 2020, I sent a text message to the Prime Minister to update him on the latest situation in care homes, including the threefold spike in infections since August. Although I told the Prime Minister that there was no evidence it was from visitors, and that DCMO was not recommending any change to visiting policy, the Prime Minister gave his clear view that visiting needed to be stopped immediately (HW/360 - INQ000328156; HW/360A INQ000328155).

297. Following meetings with officials to discuss options, the Prime Minister agreed to a policy of continuing to allow visits but tightening restrictions to ensure stronger infection prevention and control measures, as well as restricting visits in areas of high prevalence (HW/361 - INQ000327990). The Winter Plan was due to be published on 18 September 2020 which would set out any changes to visiting policy.

298. On 17 September 2020, the Secretary of State and I decided upon a form of wording to go into the Winter Plan following on from the Prime Minister's decision (HW/362 - INQ000327989). I wanted to clarify that the number of visitors would be limited to a single constant visitor per resident wherever possible, with an absolute maximum of two constant visitors per resident to limit the risk (HW/363 - INQ000327991). Those amendments were taken forward

and the Secretary of State also approved the wording of 17 September 2020 (HW/364 - INQ000327992). The Winter Plan was published on 18 September 2020 (HW/206 - INQ000234495).

299. In line with the changing guidance set out in the Winter Plan, on 15 October 2020, the visiting guidance was updated, to reflect the change in policy which was:

- The Director of Public Health should provide advice on visiting in local areas:
- Set out tightened infection, prevention and control measures, including enhanced PPE, testing and social distancing.
- Introduced limits on visiting to 2 constant visitors per resident.
- Stated where there was an outbreak or evidence of community hotspots or local lockdown, visiting restrictions should be imposed, subject to exceptional circumstances only such as end of life.

300. When lockdown was announced on 5 November 2020, the guidance was updated to reflect the national restrictions. It was updated again on 1 December 2020, and included guidance on "visiting out". This guidance reflected my continuing view that there should be visiting where possible, and reiterated the need for all local authorities to support visiting save where there was good evidence that it should not take place. It was at this stage (as identified above) that testing was introduced for visitors to care homes. The guidance was then altered regularly in line with changes to restrictions (on an almost monthly basis in early 2021).

Decision on visiting section of the 'COVID-19 Supported Living' guidance

301. In March 2021, DHSC intended to publish a revised visiting section of the *'COVID-19 Supported Living'* guidance. The main COVID-19 supported living guidance was published on 6 August 2020, and had thereafter been updated to reference the latest information on local and national restrictions and required isolation periods. DHSC sought to publish a more comprehensive update to the visiting section with input from relevant teams across DHSC, PHE, MHCLG and CQC, as well as feedback from external stakeholders.

302. The updated visiting section clarified what visits were currently permitted and the responsibility for providers to enable and facilitate those visits. It also covered the role of Lateral Flow Testing (LFT) and the use of PPE to further mitigate the risk of visits. The goal was to publish the revised guidance ahead of LFT capacity being made available to providers to support visits from 25 March 2021 in settings that were eligible for staff testing.

303. On 18 March 2021, PHE, DCMO and I received a submission summarising the guidance as well as a legal assessment of duties. As this is an addition to existing guidance and a clarification of current policy, I was advised that the changes did not require triple lock (HW/365 - INQ000328082; HW/366 - INQ000328083). I responded on 22 March 2021 with a few comments to provide clarity, particularly in setting out what the advice is for people in shared supported settings. I also wanted to understand why the visiting policy was inconsistent with the policy in schools, where tests could be conducted at home (HW/367 - INQ000328088).

304. On 24 March 2021, the Secretary of State stated that he was content with the revision, provided I was also content and my comments had been addressed (HW/368 - INQ000328091). Ministers cleared the revised guidance on 29 March 2021 (HW/369 - INQ000328101).

Decision on care home visiting at Stage 2 of the Roadmap

305. On 22 February 2021, the Government announced a four-step national roadmap which would see restrictions gradually lifted and the eventual return to normal life, beginning with Stage 1 on 8 March 2021. Stage 2, which would not commence earlier than 12 April, involved the opening of non-essential retail; personal care premises (e.g. beauty parlours); indoor leisure facilities and public buildings.

306. DHSC were asked to provide the proposal on the policy in respect of care homes and other support living placements and visitors. This was due to be decided at a meeting chaired by the Prime Minister on 5 April 2021. The intention was to publish updated guidance on care home visiting as soon as possible following the Prime Ministerial announcement of moving to Step 2 of the national roadmap.

307. On 29 March 2021, I received a submission noting the outcome of a COVID-O (officials) meeting earlier that day. Officials had agreed for proposed changes to take effect on 12 April, and that we should indicate what further steps may be needed in the future, and text for that will be agreed in the coming days leading up to the announcement on 5 April 2021 (HW/370 - INQ000328105).

308. I provided my response on 30 March 2021, noting that I agreed with the proposition for the changes to take effect from 12 April. I had comments on the language of the visiting "in" guidance and asked to see an updated version the following day before clearing it. I felt it should reflect that there should be three named visitors if they were providing essential care. I indicated that I would

want a change in the advice for visiting out when we reached Stage 3 of the roadmap, but that this could be addressed in future (HW/371 - INQ000328107).

309. I approved the final draft on 31 March 2021 (HW/372 - INQ000328108 ; HW/373 - INQ000328109), and this was shared with the Secretary of State, the Cabinet Office and No.10 on 6 April 2021 (HW/374 - INQ000328110). No.10 provided its approval that same day (HW/375 - INQ000328111). Stage 2 of the Roadmap was introduced on 12 April, with the easing of restrictions for care home residents announced via a press release.

310. On 8 June 2021, the Secretary of State and I received a submission setting out options for care home visiting and admission into care homes once "Step 4" of the COVID-19 pathway had been met (HW/376 - INQ000328134). Option 1 involved a minimal change approach: existing freedoms would remain, but the limit on nominated visitors would be removed and guidance would be amended so as to encourage a more permissive approach to the nomination of essential care givers who could visit. Option 2, which was recommended by the Policy team behind the submission, involved moderate changes so that residents' freedoms would be largely in line with the rest of society. The key changes in Option 2 included removing the requirement to isolate following admission to a care home from the community, and removing the 14-day isolation requirement on return from a visit out. The Secretary of State agreed to Option 2 other than the removal of the requirement to isolate following admission to a care home from the community. Subsequently the removal of the requirement to isolate following admission was accepted, following clinical advice from PHE on what requirements and testing criteria were needed to facilitate this. On 11 June 2021, PHE provided advice on a proposed testing regime for patients being admitted, which included being fully vaccinated, having had the vaccine at least 3 weeks ago and no known contact with a COVID-19 positive person (HW/377 - INQ000328137 ; HW/378 - INQ000328138 ; HW/379 - INQ000328139 ; HW/380 - INQ000328140).

311. The guidance entered the Triple Lock process on 15 June 2021. I approved the guidance on 17 June, the same day as Triple Lock clearance was provided. The guidance was published the following day.

312. As identified in the corporate statement on adult social care (Part 5), there were regular changes to visiting guidance from May – August 2021 to reflect changes to the roadmap. This involved relaxation of the number of visitors permitted to visit care homes, and on 19 July 2021 there was removal on restrictions in visitor numbers. Throughout this period, I continually sought (within the advice I was given by public health) to ease restrictions where possible. While the frequent changes of guidance caused criticism among providers, the purpose was to adapt restrictions to reflect the level of COVID-19 risk, recognising the

downside of restrictions to residents and families. Vaccination and LFT tests made it possible to safely allow significant relaxation of visiting rules in 2021. We also monitored the level of visiting care homes were supporting through the Capacity Tracker.

(7) Vaccination prioritisation for adult social care staff, care home residents and carers

313. Vaccination was the game-changer for social care. I will never forget the video calls I did with care home residents who had just been vaccinated, in tears with relief. However, much PPE and however many tests we distributed it seemed impossible to stop COVID-19; the vaccine changed that. I feel a real sense of pride in the vaccination programme, and particularly in how the DHSC, the NHS, local authorities and social care providers all worked together with the common aim of getting the COVID-19 jab to as many care home residents and staff as quickly as possible.

314. Early in November 2020 I heard that the first vaccine against COVID -19 (Pfizer-BioNTech) was nearly ready for use. Recollecting the experience with securing tests for social care, I wanted the vaccine to reach social care from day one. On 10 November 2020, I asked my private office to confirm that care home residents and social care workers were on JCVI's priority groups for vaccinations (HW/381 - **INQ000328006**). I was informed that a COVID-O meeting was being held later that week and that the following cohorts had been prioritised (HW/382 - **INQ000328007**):

314.1. Adults over the age of 65 in care homes and care home staff as a top priority;

314.2. All individuals working in care settings where care is delivered, regardless of employer. Social care workers were therefore at the same level of priority as health care workers.

314.3. All those between 18 and 64 years of age who had a condition which makes them clinically extremely vulnerable. This cohort was prioritised below those over the age of 65.

315. I had several concerns with the prioritisation list. I felt that working age adults in residential care (including those with learning disabilities) should be a very high priority, rather than in the sixth group to be vaccinated. Mencap and other care organisations had spoken to me about the higher death rates amongst this group. Pre-existing physical conditions alongside learning disabilities made many working-age adults in residential care more susceptible to severe illness from COVID-19 than the wider population. I also wanted hospices to be clearly included in the health care category and suggested that unpaid carers should

be before the general population. I wanted regular visitors to care homes to be considered alongside staff and suggested that when vaccinating care home staff, a "keyworker visitor" could also be vaccinated (HW/383 - **INQ000328008**).

316. My private office received an email from the JCVI on 16 November 2020. This email emphasised that *"the evidence strongly indicates that the risk of serious disease and death increases exponentially with age and is also increased in those with a number of underlying health conditions. Modelling indicates that as long as an available vaccine is both safe and effective in older adults, they should be a high priority for vaccination".* The email confirmed that those under 65 with specific health conditions would be listed at 6 and 7 in the priority list, above those in the 50-65 year risk group and the rest of the general population (HW/384 - **INQ000328014**).

317. On 23 November, I asked for an internal update on vaccine deployment to adult social care. The Secretary of State had also separately asked for a dedicated meeting on care home deployment and operational readiness, so the two meetings were combined (HW/385 - **INQ000328017**). A COVID-19 and Flu Vaccination Deployment Board meeting was held on 1 December. The Secretary of State, the Minister for Vaccine Deployment, the Permanent Secretary and I all attended alongside DHSC colleagues to discuss vaccine deployment plans. The Secretary of State and I both highlighted that we wanted to vaccinate care home workers on day 1. Operational colleagues explained that the booking system for care home staff would not be ready in time, but they agreed to use a workaround to vaccinate as many care home workers as possible (HW/386 - **INQ000328022**).

Vaccine roll-out and vaccination as a condition of deployment

318. I worked closely with colleagues in DHSC, including Nadhim Zahawi (Vaccines Deployment Minister), NHS England and local authority representatives to make sure care home residents and care workers were vaccinated as fast as supplies of the vaccine allowed. The roll-out involved successful collaboration between local authorities, care providers and local NHS teams. We monitored progress closely at the centre and used vaccination data (in capacity tracker) to identify and intervene where the roll-out appeared to be going more slowly. We drew lessons from flu vaccination programmes, for instance to make it easy for staff to get vaccinated to improve uptake. We therefore set the system up to vaccinate as many staff as possible at work alongside residents.

319. As the roll-out progressed we saw high vaccination rates among residents but lower levels among staff, with significant variation between care homes (HW/387 - INQ000059877). In the light of this, together with the Minister for Vaccine Deployment, I asked for a submission on options for increasing

vaccination rates. I was particularly concerned about the slowing rate of uptake among social care staff and the fact that there were often lower rates of vaccination in areas where the rates of COVID-19 were particularly high. On 22 January 2021, I received a submission on increasing vaccine uptake amongst social care workers, which identified (a) what work was ongoing (b) communications to the sector (c) good local practice and (d) that there was a Task and Finish group within the DHSC to address vaccine hesitancy (HW/388 - INQ000328047). The submission set out options to make vaccination mandatory but advised that an approach based upon persuasion and incentivisation should be pursued. I was also concerned that the vaccination rate amongst ethnic minorities was relatively low, that a significant proportion of social care staff were from ethnic minority backgrounds, and of the increased risk of serious complications from Covid for people from some ethnic minorities.

320. The Secretary of state asked for more detailed advice. On 4 February 2021, the Secretary of State, Minister for Vaccine Deployment (Nadhim Zahawi) and I received a submission on options for making the COVID-19 vaccination a condition of work for people in the adult social care workforce. The submission identified that the need for vaccination as a condition of deployment was primarily to protect the residents of care homes. The submission identified that 59% of the workforce in care homes for residents over 65 were vaccinated. The advice at this stage from PHE and SAGE was that at least 75% vaccine coverage of care homes was needed (staff and residents), but "possibly higher 80-90%". The submission identified four potential options for "mandating" the vaccine. The submission recommended that the most effective option would be by making it a condition of CQC registration that all staff were vaccinated (HW/389 - INQ000328056; HW/390 - INQ000328057; HW/391 - INQ000328058).

321. The Secretary of State's office responded on 10 February 2021 by email stating that Ministers agreed with the CQC condition as the leading option and wanted to progress this at pace in order to save the lives of care home residents and people most vulnerable to COVID-19. This acknowledged the risks of this option. Ministers were also of the view that all actions should be taken to encourage take up of the vaccine through other routes. The Secretary of State requested two commissions, which were (HW/392 - INQ000328059):

321.1. Follow up advice for Ministers setting out he delivery timeline and plan, communications plan, and legal advice; and

321.2. A note to the Prime Minister from me setting out all the things to be undertaken to drive take up, an understanding of the date by which all care home staff will have had many opportunities to be vaccinated, confirmation that the route to condition of deployment is by amending CQC conditions (via legislation), with the legislative process and

timescale, an explanation of whether compulsion should be extended to the healthcare sector and some information on the legal risks, and those to the workforce by the introduction of such. The Secretary of State's email explained that this request had come out of a dashboard meeting earlier that morning where the Prime Minister repeated his interest in vaccination as a condition of employment. Ministers therefore wished to offer reassurance that the work was progressing quickly.

322. I received a private WhatsApp message shortly after this email, from the Secretary of State, informing me that the Prime Minister had asked for a roadmap to requiring vaccines in social care and that the Secretary of State had told him I would be writing to him (HW/393 - **INQ000328060**).

323. I was sent further detail from the Secretary of State's office suggesting what No. 10 were after for the Prime Minister's note. This was as follows (HW/394 - **INQ000328064**):

"Hi all,

For the PM note, No10 shared more detail suggesting what they are after.

Given SoS's preference to lean into the vaccination as a condition of employment and to keep advice to the PM short and clear, I would continue to use the structure set out in the original commission I sent this morning. However, if you are able to include more of the detail No10 have suggested, then great if it can be worked in - but it may be best to annex some of it, to keep the note to the point.

It would be helpful if DHSC could work with NHSEI to provide a short note to update the Prime Minister on your plans to promote take-up of the vaccine in the adult social care sector. It would be helpful if this could cover:

Improving the current approach:

1. What are you planning to say publicly about meeting the 15 February ambition for adult social care? What milestones and timescales are you working to for each group (staff and residents, care homes, domiciliary care and other settings such as supported living)?

2. Focusing on staff working in older age residential care, what is your objective (informed by clinical evidence) for take-up and when do you expect to reach this?

3. What robust evidence (or plans to gather it) does the programme have on what is driving low-take up by region / segmentation of staff groups working in these settings (older age residential care)?

4. What specific policy and communications measures are being put in place to address low take-up amongst this group (including issues with vaccine hesitancy), what timescales are you working to and what metrics are you tracking to measure success?

In relation to making vaccines mandatory:

5. Your preferred option for making vaccination a condition of employment for staff working in older age residential care once other routes have been exhausted, including how this could be implemented and the pros and cons;

6. Your initial assessment of the potential impact of this policy, including on behaviour and the potential equalities impact;

7. What the legal implications of these options are, and how you propose to deal with issues around parity with other sectors (e.g. the NHS)?

8. Your assessment of what impact this might have on workforce pressures in the sector?

The Secretary of State and PM obviously discussed the final four points in the meeting this morning."

324. On 16 February 2021, the Secretary of State and I received another submission setting out further detail on requiring care homes to only deploy staff who are vaccinated (HW/394A). This included preliminary advice from PHE and the SAGE social care working group that "high vaccine uptake is require do protect against the risk of outbreaks", with an estimate of 75% coverage required within each care home setting. It also flagged 85% as the more usual guide for considering a population has protective vaccination coverage.

INQ0003281 13

325. I received a further steer from the Secretary of State on 23 February 2021. I was told that there were now plans for an externally led review of vaccine certification, and that Ministers wanted to frame decisions on vaccination as a condition of employment for Adult Social Care and NHS staff within this wider and feed in developed policy and implementation plans to the review. The Secretary of State therefore asked if I could update the draft letter: it should continue to lead and stress all efforts to increase uptake and should then frame further decisions on vaccines as a condition of work in line with the wider review rather than explicit reference to a one-month deadline.

326. I reviewed a version of the letter on 24 February 2021, which I cleared and sent to the Secretary of State (HW/395 - INQ000328071). The letter highlighted (HW/396 - INQ000328072):

- As of 23 February 72% of care home staff who can be vaccinated had been (and 70% in total). This compared to 94% of eligible care home residents (90% in total). The evidence suggested 6-8% of staff had refused.
- We estimated that around 5% of staff would not have the vaccine because of pregnancy or clinical reasons. This suggested we had to achieve a minimum of 80% of care home staff being vaccinated while working towards much more than this (but recognising we would not be able to get to 100%).
- We needed to make it easy for care workers to be vaccinated, recognising many worked long hours on low pay and rely on public transport. The best way to do this was to return to care homes and offer staff vaccinations at work.
- Some staff were not offered the vaccine during the first visit due to limited supply or shift patterns. NHSEI were working on a programme of follow-up visits to care homes, with each care home due to have a minimum schedule of four visits (two to administer the first dose and two to administer the second dose). We were asking all NHS CCGs and Primary Care Networks to ensure that all care homes, with staff or residents still to be vaccinated had a second visit by the end of March.
- In parallel, we were urging employers to get their workers to book in for vaccination via the national booking service, which opened up to care home staff on 11 February, or their local GP. We have emailed all care homes with clear guidance on this, and had sent follow-up emails to those with the lowest staff vaccination rates. COVID-funding could be used by care homes to cover costs of staff getting vaccinated.
- An extensive programme of work was underway to address fears about vaccination. This included webinars for the care sector, educational materials sent to providers and the broader work to build trust amongst hesitant communities. We had shared blogs and videos of social care workers from BAME communities receiving the vaccine, explaining how they have overcome their own vaccine hesitancy and why they would encourage their colleagues to be vaccinated.
- DCMO has warned that making vaccination a condition of work could undermine trust and confidence in the vaccine programme, not just within the care sector but more broadly especially in BAME communities. There is a risk of backlash from the sector and its workforce, many of whom are from BAME groups, who may feel singled-out and stigmatised.

327. On 2 March 2021, the Secretary of State circulated an email stating that Ministers were concerned by vaccination uptake statistics in London and the Northwest, as well as in domiciliary care and non-registered social care provision. The Secretary of State wanted to discuss this at the daily vaccine meeting the following day, and asked to set out how this work could be extended to the wider Adult Social Care workforce beyond older adult care homes given Ministers' concerns (HW/397 - **INQ000328074**). On 9 March 2021, I received a submission in line with the Secretary of State's request (HW/398 - INQ000110831; HW/399 - INQ000110832).

328. Recognising the difficulties this policy would pose I thought we should limit it to care home staff, provided domiciliary care stakeholders would support this approach. Staff beyond care homes should logically be vaccinated in line with NHS staff, as they were in the same JCVI cohort thanks to similar risks. I wanted this requirement for care home staff to go hand-in-hand with support for the workforce – for example sick pay and access to training and funding to complete qualifications. My preference was to pursue primary legislation. If secondary legislation had to be pursued, then I had no issue with limiting the scope of the policy to CQC regulated providers (HW/400 - **INQ000328079**).

329. On 17 March, the Secretary of State shared DHSC's proposal to make vaccination a condition of deployment for staff in older-age care homes and this was discussed at a COVID-O meeting on 17 March 2021 (HW/401 - INQ000092064; HW/402 - INQ000092400; HW/403 - **INQ000328080**).

330. I accepted the proposal. The minutes confirm that that the meeting discussed hesitancy among ethnic groups and ethnic minorities and the importance of having trusted voices in the sector involved, drawing on lessons learned during the vaccine roll-out to date. COVID-O agreed that there should be a consultation on the condition of deployment proposal. There was a clinical imperative to drive uptake rates as quickly as possible and a clear steer from the Prime Minister to put in place these measures as expeditiously as possible (HW/401 - INQ000092064).

331. On 25 March 2021, I received a further submission setting out the plan to ensure that an announcement could be made by 5 April, and to draft and put the regulations in place by the time that Parliament went into recess in the summer of 2021, following COVID-O's decision on vaccination as a condition for deployment (HW/404 - **INQ000328093**; HW/405 - **INQ000328094**).

332. The Secretary of State provided his comments on the submission on 26 March 2021. He wanted the consultation document to be published on 5 April and agreed to running the consultation until 21 May. On the scope of the

consultation document, he agreed to the preferred policy position that regulations would apply to older age homes, all staff who worked on site, and all without a medical exemption. In order to move as fast as possible, he suggested a mid-June deadline (HW/406 - INQ000328096).

333. I also provided my comments on 26 March. I agreed with the scope of the consultation but thought there needed to be a caveat around access so that vaccine supply did not cause workforce issues. I also wanted some consideration of boosters, requiring staff to have winter jabs or new variants if necessary. I also did not think that two doses was practical for newly recruited staff, as it would significantly delay how long an unvaccinated person could start working. I suggested a requirement for a window in which staff had to receive two doses, but that they could start working after the first dose. Nadhim Zahawi provided his comments later that day (HW/407 - INQ000328095).

334. A further draft consultation document was shared on 26 March 2021 along with a draft Write Round letter (HW/408 - INQ000328097; HW/409 - INQ000328098; HW/410 - INQ000328099). A "write round" is a mechanism for one department to ask the other departments of central government to provide comments and/or to be informed of legislation or policy which will impact them and ask them for comments or views.

335. On 27 March 2021, the Secretary of State was content to clear the consultation document, subject to strengthening the language around the evidence of reduced transmission (HW/411 - INQ000328100). I reviewed the documents on 28 March and asked for some of the language in the draft Write Round letter to be toned down (HW/412 - INQ000110917). A redrafted version was circulated on 29 March 2021 (HW/413 - INQ000328102; HW/414 - INQ000328103; HW/415 - INQ000328104).

336. On 7 April 2021, I received an email from the Secretary of State's office informing me that over the course of the weekend the Secretary of State, in agreement with the Prime Minister, decided to shift the launch of the consultation to early the following week to better align with other vaccines communications (HW/416 - INQ000328112).

337. On 14 April, the Government informed the House of Commons of our intention to consult on a proposal to amend regulations to require care home providers, with at least one resident over the age of 65, to deploy only those workers who have received both doses of their COVID-19 vaccination (or have a legitimate medical exemption from vaccination).

338. A consultation took place on the nature of the regulations and the policy which ran from 14 April to 26 May (HW/417 - INQ000256957; HW/418 -

INQ000325334). Following this, a submission was sent to Ministers asking for a decision to determine whether and how to proceed with the policy (HW/419 - INQ000328130 ; HW/420 - INQ000328133).

339. I presented the results of the consultation to COVID-O on 15 June 2021, I highlighted that the consultation had received a mixed response, but having reviewed the responses, the Government had proposed to make vaccination a condition of deployment for all CQC registered care homes (HW/421 - INQ000092238). The papers for the meeting included (HW/422 - INQ000328142) which set out the latest guidance from SAGE as follows: The social care working group of SAGE has advised that 80% of staff and 90% of residents in a care home need a first vaccination dose to provide a minimum level of protection against outbreaks of COVID-19, recognising that current or emergent variants may require even higher levels of coverage and/or new vaccines to sustain levels of protection. As of 9 June, only 64% of older adult homes in England are currently meeting this dual threshold for the first dose, and the proportion is worst in London with only 44% reaching the dual threshold. And – while the SAGE working group advice is specifically about first doses – it should be noted that, for second doses, only 39% of homes are reaching this 80/90% level of coverage, with London the region with furthest to travel, on 21% of care homes reaching the dual threshold.

340. During the meeting, we discussed the need to provide exemptions for people who could not be vaccinated for clinical reasons, including pregnant women. I also presented a second paper considering launching a further consultation on extending the vaccination requirement to the wider adult social care sector and also to health staff. There was a desire from No.10 to expedite the policy to ensure readiness by winter 2021/2022. For both policy proposals, we discussed the impact on women and minority ethnic staff. The meeting also discussed the possibility that 3-7% of the workforce might leave because of VCOD and the ways of mitigating this. It was agreed that these regulations should come into place (HW/421 - INQ000092238; HW/423 - INQ000328143).

341. DHSC published a consultation response on the proposals on 22 June 2021 alongside an Equality Duty Impact Assessment (EqIA) statement on 16 June 2021 (HW/424 - INQ000325335). The Health and Social Care (Regulated Activities) (Amendment) (Coronavirus) Regulations 2021 were placed before Parliament on 22 June 2021. A preliminary Impact Statement was published on 19 July 2021, and the full impact statement was published on 11 November 2021 at the same time as the Regulations were brought into force (HW/425 - INQ000328146 ; HW/426 - INQ000292594). The EqIA statement was also updated on 9 November 2021 (HW/427 - INQ000328151).

342. Regulations introducing vaccination as a condition of deployment in care homes came into effect on 11 November 2021, with the planned extension to the wider sector due to come into force on 1 April 2022. The regulations were revoked on 15 March 2022 following further public consultation and the extension to the wider health and care sector did not take place.

(8) Funding for local authorities and social care

343. The Government announced significant funding packages to help local authorities with the costs of the pandemic. On 19 March 2020, the Government announced £1.6 billion of funding, and this was further boosted by funding of £1.59 billion on 18 April 2020. In addition, on 15 May 2020, the first £600 million Infection Control Fund (ICF) was launched alongside the Care Home Support Package.

Bid for the first ICF

344. Following the March 2020 budget, we wanted to secure an additional £300 million a month per month, for two months, ring-fenced to local authorities in order support measures designed to reduce infection transmission in care homes. This consisted of £90m a month to cover the extra costs that flow from preventing both substantive and agency staff working in more than one care home setting wherever possible; and £210m a month to pay the wages of care staff, irrespective of whether they work in care homes or domiciliary care, who were self-isolating, either with symptoms of the virus or because they have tested positive despite being asymptomatic. An added hope was that this funding would also help secure a commitment from local authorities on future data flows from the front line (HW/428 - **INQ000327881**).

345. On 11 May 2020, I met with the Secretary of State and DHSC colleagues ahead of requesting the funding from HM Treasury. The approach was that the Secretary of State would discuss the funding plan with the Chancellor, while Special Advisors and I would each engage our respective counterparts in parallel to lobby for our funding plan (HW/429 - **INQ000327880**). If HM Treasury signed off the funding, then DHSC would aim to announce the wider care plan package the following day, including a letter from me to local authorities explaining the plan and funding arrangements (HW/430 - **INQ000327882**). It was later decided that the Secretary of State and Michael Gove, would send a joint letter to the Chancellor requesting the £300 million funding. HM Treasury asked DHSC to provide a breakdown and explanation of the costs associated with the fund to support the bid (HW/431 - **INQ000327883**).

346. I remember there being some issues with providing this breakdown of costs. I was very keen to see the maths behind the figures to explain clearly how we

had got to £300 million. I highlighted to Ros Roughton that I expected to see clear assumptions, as well as figures on how much we paid agency staff, how much of the workforce was comprised of agency workers, and what percentage of those we would need to compensate. Ros explained that as a department we did not have all the figures, so we had to rely on several assumptions. She stressed that we did not have all the relevant data in social care compared to the NHS because historically it is a private market run by private businesses (HW/432 - **INQ000327892**).

347. Although the Secretary of State and I cleared the draft joint letter, I was adamant that we needed to provide evidence and sufficient costings to make the strongest case possible for the bid (HW/433 - **INQ000327888**; HW/434 - **INQ000327889**). We therefore decided to submit the letter to the Chancellor without the financial breakdown and submit the latter in due course once we had the necessary information (HW/435 - **INQ000327890**). I received a response to most of my questions the following day, and an amended financial breakdown was sent to the Chancellor (HW/436 - **INQ000327891**; HW/437 - **INQ000327893**). The Foreign Secretary's office also emailed DHSC Ministers and HM Treasury later that day to endorse the funding recommendation (HW/438 - **INQ000327894**).

348. My aim was to get the majority of the money to providers as soon as possible, while making sure there was sufficient leverage to ensure it was spent on the measures we had specified in the letter to Local Authorities. I therefore asked the policy team to explore options on using a formula to help local authorities pass the funding onto care providers without delay. I received a proposal on 14 May that suggested creating an expectation with councils that 75% of the funding would be passed on to care home providers on a per bed basis. The benefit of this approach was that it was quick, and all providers would receive a significant lump sum payment to allow them to take action to reduce risks of infection, and local authorities would have some discretion with the remaining 25%, including whether to allocate to domiciliary care. The disadvantage was that local authorities would lose much of their leverage to ensure the money was spent by providers on the things we thought make the biggest difference. In any event, a condition of would be that Local Authorities had to submit a satisfactory Infection Control Plan by the end of May, and that they only give money to providers who were completing the Capacity Tracker (HW/439 - **INQ000327901**).

349. I gave policy colleagues a clear steer that local authorities should pay 75% of the funding directly to providers with a clear expectation that the funding would be spent on IPC measures, paid on a per bed basis. The remaining 25% would be allocated based on need and on being satisfied it was being spent on IPC (HW/440 - **INQ000327902**). I was also provided with advice on the PSED

impact of the policy, which I considered and confirmed that I was satisfied with the allocation based on beds (HW/441 - INQ000327897).

350. On 21 May 2020 I received an updated submission on the ICF and a new grant determination letter (HW/442 - INQ000327907 ; HW/443 - INQ000327908). The Secretary of State and I agreed proceed with an option whereby 75% of the funding had to be used as specified, while the remaining 25% could be used for other measures. Local authorities also had to allocate that 75% on the basis of CQC registered beds in their area (HW/444 - INQ000327912).

Decision on second phase of the ICF

351. On 17 July 2020, I received a submission requesting that I provide an early steer on my preference for a second phase of the ICF. The second £300 million of the £600 million fund was set to be distributed. 75% of the funding had to be used according to fairly tight conditions, although local authorities had more autonomy over the remaining 25%. The first phase appeared to have reached providers relatively quickly and made a positive impact (HW/445 - INQ000327952 ; HW/446 - INQ000327953).

352. My view was that the rollover fund should run for the remainder of the financial year so that providers had more certainty and knew they could pay staff consistently for sick leave during this time. Moreover, I felt that the amount a provider could use on equipment and facilities for visiting should be capped, to enable some expenditure on this but prevent extravagance. I also wanted to consider whether the fund should be used to incentivise staff getting Flu vaccinations. As winter planning was taking place, I also wanted the Taskforce to include how the ICF could help in that regard. I was keen to get the policy approved by early August, to give providers confidence on the funding situation ready for September. I therefore proposed a commission for input from the Taskforce on lessons learned/proposals for the second phase of the ICF (HW/447 - INQ000327955).

Bids to extend ICF and Rapid Testing Fund

353. On 18 February 2021 the Secretary of State and I received a submission on a proposal to bid to HM Treasury for to bid for post-March funding once the ICF and Rapid Testing Fund (RTF) came to an end. The new costings estimate was that full take-up of all relevant ICF measures would cost £232 million per month – significantly higher than the £91 million per month which was already being provided through the ICF. The advice also recommended asking for a full six months' worth of funding: as well as providing longer-term certainty and protection, it would ensure providers were able to react to possible future waves as restrictions are lifted. I had previously emphasised the need to consider

additional support to staff and for staffing measures, such as continuation of the Workforce Capacity Fund and staff wellbeing funding. The submission acknowledged these considerations, but recommended we did not yet have a robust enough case for immediate funding as we were still at an early stage in understanding how the Workforce Capacity Fund was being used (HW/448 - INQ000328067; HW/449 - INQ000328068).

354. I cleared the submission on 23 February 2021 so that the bid could be put to HM Treasury and discussions could commence imminently. I did, however, request further information on the plan for Workforce Capacity funding from the end of March onwards and whether we could realistically hope to get anything for April if we did not bid for it in the upcoming budget (HW/450 - INQ000328070). The Secretary of State cleared the submission on 25 February (HW/451 INQ000328073).

355. Separately, I received a submission on the Workforce Capacity Fund on 3 March 2021, recommending that I agree not to bid to extend the fund past its end date on 31 March. The basis of this advice was that any new funding for the Workforce Capacity Fund to support providers with critical staffing levels would be hard to make based on the current evidence: the national lockdown had reduced the pressure on staff in care homes, and there had been a decline in staff testing positive for COVID-19 following the national lockdown (HW/452 - INQ000110814; HW/453 - INQ000110815). I agreed with the recommendation and decided not to pursue additional Workforce Capacity funding at that time (HW/454 - INQ000328075).

356. On 12 March 2021, I received advice on the latest position of our bids to extend the ICF and RTF as well as a brief update on NHS negotiations. The note set out the pros and cons of alignment between announcements of new funding for the NHS and social care.

357. Lord Bethell provided his comments on 18 March 2021, which were:

> *"I strongly support the intentions of the Sub. I do not have a strong view on the split on LA allocations.*
>
> *But I do think we need strong LA reporting on the use of the money: I do not like the idea of this money disappearing into a black hole as sometimes the Covid funds have done. So I would lean to keeping the reporting levels from LAs v strong."*

358. Lord Bethell's office also requested that my team follow this up with a very strong steer to the Adult Social Care testing team that where submissions have

testing implications, Lord Bethell should be directly sighted (HW/455 - INQ000328086).

359. On 18 March 2021, the Secretary of State, Lord Bethell and I received a submission on the final design of the extended ICF and RTF for approval. As well as making decisions on the design of the grant, the submission asked us to confirm we were content for £138.7 million to be used for the extension of the RTF, and that Lord Bethell was the responsible Minister for confirming agreement (HW/456 - INQ000110858; HW/457 - INQ000110860).

360. I cleared submission on 19 March 2021, agreeing to all the recommendations. I commented that I particularly liked the recommendation for "*changing the basis of the allocation to local authorities for community care (for ICF) and for Extra Care and Supported Living (for RTF), to use Capacity Tracker community care user data",* as it promoted the proper completion of the capacity tracker. I did, however, ask if we could review which questions could be removed from the capacity tracker to reduce the burden associated with the existing reporting structure. In addition I asked if the team could spend time considering if the fund could be used to support the vaccine roll-out, for example to cover (i) sick pay in the event that someone needs time off after the vaccination; (ii) costs of recruiting staff to replace those who refuse vaccination (other than for clinical reasons); and (iii) funding for care agencies to support their staff getting vaccinated (HW/458 - INQ000328087).The Secretary of State agreed with my view and asked me to lead on the detail (HW/459 - INQ000328089).

361. As part of the conditions of the funding provided, and as part of the rules governing section 31 grants, these were to be shared with HM Treasury and MHCLG – both of whom needed to approve the final proposal before publication (HW/460 - INQ000328090).

362. In July 2021, a fourth round of funding was provided, which amounted to £251 million pounds. This was £142.5 million for infection control and £108.7 million for testing, to be made available via local authorities to social care providers to support COVID-19 pressures between July – September 2021.

EXCHEQUER SECRETARY TO THE TREASURY

363. I was Exchequer Secretary to the Treasury ("Secretary") between 16 September 2021 and 8 July 2022, serving under Chancellor Rishi Sunak and then, briefly, Nadhim Zahawi.

364. HM Treasury, as the Government's economics and finance ministry, is responsible for maintaining control over public spending, setting the direction

of the UK's economic policy, and working to achieve strong and sustainable economic growth.

365. My responsibilities as Exchequer Secretary were:

- Growth and productivity. This included skills, migration, infrastructure (physical and digital), digital economy, cloud computing, economic and business regulation, competition, umbrella companies, off-payroll working, corporate governance, foreign direct investment, and steel.
- Energy, environment and climate policy and taxes.[14]
- Indirect taxes such as excise duties (alcohol, tobacco, gambling, and the soft drinks industry levy).
- Charities, the voluntary sector, and gift aid.
- Acting as Departmental Minister for HM Treasury Group (including responsibility for the Darlington campus).
- The Crown Estate and the Royal Household.
- Tax Free Childcare

366. I did not make decisions relating to COVID-19 as Exchequer Secretary. I recall signing-off letters responding to colleagues on COVID-19 support packages, which explained earlier policy decisions made by my predecessor or other Treasury Ministers.

LESSONS LEARNED

367. My thoughts are first and foremost with all those who lost loved ones in the pandemic. I often think about care workers and NHS staff who contracted COVID-19 at work and tragically lost their lives, and others who still live with Long COVID-19. And I think about people who died while living in care homes. Some who died had lived long lives and some who died were young, with many years ahead cruelly cut short by COVID-19. I know that nothing will give people this time back or heal the grief, but I sincerely hope that this inquiry will provide people with the answers they seek.

368. As my statement demonstrates, DHSC was constantly learning throughout the pandemic. Not only were we learning about COVID-19 as a virus – the symptoms, who was at risk, how it spread and so on, but also how we could most effectively protect people. Improving that protection for people who are

[14] Although I was recused from decisions on carbon (including Carbon Pricing Support, the Emissions Trading Scheme and the Climate Change Levy, and Carbon Borden Adjusting Mechanisms), biomass, and renewable transport fuel.

supported by social care and carers involved improving data, communications, distribution of PPE, tests and vaccinations; building up the support from the NHS; building IPC capability and capacity (like designated settings); building up our team in DHSC and developing stronger relationships with local authorities. As we prepared for the second wave we drew on the experiences of the first wave, commissioned research using our own data and also looked internationally for lessons. Though sadly many lives were still lost in social care in the second wave, the ramping up of the response centrally and the work done by care homes themselves meant care home residents were much better protected. While the second wave was still incredibly hard – and despite regular testing and plentiful PPE many care homes still had COVID-19 outbreaks and sadly lost residents – care providers told me they felt significantly better supported.

369. This module of the Inquiry is about decision making during the pandemic; therefore, I will focus my reflections on that question – which to me is about whether decisions were well made – drawing on the right information, involving the right people, and following a robust decision-making process. Clearly the context is one where information was limited, uncertain and constantly changing; Government faced constant time-pressure to act, officials and ministers were working all hours, and the pace of the pandemic meant normal decision-making processes and statutory consultations to refine policy proposals (which usually take 8-12 weeks) could not be carried out.

370. The more fundamental question is whether the right decisions were taken, to achieve the best outcomes for the UK. What you consider right will depend on your priorities. As Care Minister my priorities were the lives and wellbeing of people who depend on care, together with the wellbeing of the care workforce and carers. As Minister for NHS workforce my priority was to support that workforce through the pandemic. While this submission should provide insights into how we reached those decisions, I have not included objective data on the consequences of those decisions – such as infection rates, deaths or measures of wellbeing for instance – and how these compared between England, other parts of the UK and other countries with similar demographics and exposure to COVID-19. I have intentionally not sought to pre-empt the judgement the Inquiry will no doubt make by drawing on that sort of information on the outcomes of our approach to the pandemic as a Government and as a society.

Residential Care Visiting and Essential Carers

371. The consequences of pandemic visiting restrictions often weigh on my mind. The restrictions were put in place with the best of intentions to protect people living in care homes from COVID-19, but meant family and friends were unable to see those they loved for many months. Although end of life visiting in care

homes was allowed and supported in guidance, I know some people did not get the chance to say goodbye. For others, the person they knew slipped away, with dementia stealing their memories and much of who they were. And perhaps most painful was knowing a loved one's confusion and grief at not being visited.

372. Visiting was understandably a challenging area for policy making. The Government had to balance clinical advice, which emphasised a cautious and restrictive approach to personal contact, against the negative impact restrictions could have on residents' wellbeing, their families, and quality of life. The joint guidance published by DHSC, PHE and the CQC in April 2020 reflected that caution, advising that families and friends should be advised not to visit individuals in care homes, save in exceptional circumstances, such as end of life, and that visits should be facilitated and held remotely where at all possible.

373. I saw restrictions on visiting as a short-term intervention while we rapidly built up our national testing capability and PPE supplies. I was always clear that end of life visits should be allowed and encouraged. As I have described above, I don't believe I was shown in advance the Regulations in June 2020 which didn't allow any care home visitors – but when I raised this issue the regulations were rapidly updated to allow end of life visits. Early in the pandemic I thought we should recognise 'essential care givers' in guidance so this category of visitor could visit in all circumstances provided they followed the same testing and PPE regime staff. However, this took much longer to put into practice.

374. Looking back, I have reflected on why it felt so hard to argue for visiting during the pandemic, given that I found the arguments for allowing visiting – so far as it could be done safely - so compelling. Firstly, I think it was a question of the information and data available. I recognise that for the Prime Minister and Secretary of State, the information they were being provided with was heavily focussed on infection rates and deaths. Clinical advice emphasised the importance of minimising footfall into care homes to minimise the risk of transmission. While I was hearing from families who were distraught about the isolation of loved ones in care homes, together with stories of how the wellbeing of care home residents was being affected, these were anecdotal accounts rather than hard data. There was no objective way in the moment to assess the impact of visiting restrictions on wellbeing against the risk of transmission. This was why I commissioned research to build the evidence base, but this unavoidably took time to report back and meanwhile decisions on visiting restrictions still had to be made. This points towards the need to build the evidence base in 'peacetime' of what contributes to the wellbeing and quality of life for people in residential care.

375. At the time, the voices of people criticising the government about deaths in care homes were probably much louder than the voices of residents and families concerned about visiting restrictions. I welcome the emergence during and since the pandemic of groups specifically representing care home residents and their families – like Rights for Residents (now Care Rights UK) – who helped raise awareness of the importance of visiting. They have added to the voice of existing organisations, like Age UK, Alzheimer's Society and Carers UK who speak up for care users and their families.

376. I have also reflected on 'who was in the room' to contribute to decisions and the level of experience decision makers outside DHSC had of social care. I know some people in no 10 for instance did have personal connections with social care. When there's a judgement call to be made, the incoming perspective of the people involved in the decision clearly plays a big part. Making sure you have a mix of people with a mix of perspectives is important.

377. While I know there is no getting back the time that families lost, I hope that people affected by visiting restrictions find some solace in the progress made during the pandemic and since. We now have a much stronger consensus, at least in Government, about the importance of visitors and care supporters in care homes and in hospitals. With the support of colleagues including my fellow Health Minister, Will Quince, we have consulted on secondary legislation to make visiting a fundamental standard of care across CQC-registered settings in social care and healthcare. I expect this to become law in the coming months.

Admissions to care homes

378. The discharge of patients from hospitals and the spread of COVID-19 in care homes has been the source of much debate and scrutiny. PHE conducted a thorough study in this area which concluded that most outbreaks were closely associated with community sources of COVID-19 rather than a result of admissions from hospitals.

379. That said, the record shows that I had concerns about the discharge of patients from hospital into care homes, that I wanted to see patients destined for care homes tested for COVID-19 and that I was concerned about the ability of all care homes to effectively isolate and quarantine new admissions. Very early on I suggested that the NHS should identify quarantine locations – which subsequently became an expectation on local authorities.

380. I recognise that the testing I wanted to see was initially not included in the discharge policy because of the shortage of tests. The prevailing understanding (and PHE advice to me in mid-April) was also that tests were not reliable in the absence of COVID-19 symptoms and could give false reassurance.

381. Given the scenes in other countries, it is understandable that the NHS priority was freeing up space in hospitals. However, there were times when I felt social care providers were seen as being there to do what the NHS needed, rather than being recognised for their primary role caring for their own residents and clients. This was reflected in some documents like discharge and admissions guidance.

382. Very practically, to be ready for future pandemics, I think work should be done to ascertain the need and capability to quarantine residents in social care – and to plan for meeting that need. During the pandemic it became clear that quarantining was not possible in some care homes. This led to the 'designated settings' policy where specific facilities were identified and assessed by CQC to be used for patients being discharged from hospital. These took some time to set up and roll out. This shows how we learned and responded during the pandemic itself. With the knowledge we have now of how care homes coped in COVID-19, we can plan better for potential future pandemics.

Vaccination in social care

383. The ability to vaccinate against COVID-19 dramatically improved our ability to protect people who receive care, especially care home residents and staff. This provided those who were most vulnerable to Covid-19 with real protection against the virus. The way in which the Department worked together with the NHS and local authorities to coordinate the vaccine roll out, and also with community groups to support those who were vaccine hesitant should serve as positive examples of how a similar programme can be administered in future. Residents in care homes were seen as priority for vaccination from day one, reflecting the understanding of their vulnerability to Covid and the value of their lives, even if some may not have many years or even months of life ahead.

384. Unlike many pandemic decisions that had to be taken under extreme time pressure the decision on vaccination as a condition of deployment in social care was considered over a longer period – albeit still at pace especially considering the differing views and strength of feeling on this subject. I was uncomfortable with mandating vaccination, and this is reflected in the letter I wrote to the Prime Minister in February 2021. That said, I recognised that others had different views; clinicians highlighted that doctors must be vaccinated against certain diseases, and some families felt strongly that people caring for their relatives should always be vaccinated. Clinical advice indicated that we had not achieved a sufficient level of vaccination among staff, which led to the decision to proceed with mandating vaccination. A future pandemic may well encounter the same dilemma. While I expect the decision would need to be taken based on the specifics of the disease and the vaccination, I can see benefits from considering

in advance how this question would be approached and from further discussion as a society about the circumstances in which mandating a vaccination is the right thing to do.

Ethnic groups and ethnic minorities

385. The protection of health and social care staff at greater risk from COVID-19, including some staff from ethnic groups and ethnic minorities, was an important area of work during the pandemic as the evidence of these greater risks emerged. I had several meetings with the NHS Chief People Officer on how to better support and protect these communities and staff from being disproportionately impacted by COVID-19 (HW/461 - **INQ000327871** ; HW/462 - INQ000050906). We developed and issued the Adult Social Care Risk Reduction Framework to be used in all social care settings or social care interventions. This framework provided guidance for employers on how they should support workers who were more vulnerable to infection or adverse outcomes from COVID-19, including risks by ethnicity. Since PHE's Report on '*Disparities in the risks and outcomes of COVID-19'*, DHSC and the Adult Social Care Group has continued to explore ways of strengthening the position of Adult Social Care in reducing these inequalities (HW/463 - **INQ000327974** ; HW/464 - **INQ000327964** ; HW/465 - **INQ000327994** ; HW/466 - **INQ000328001**).

386. I was also concerned about uptake of the COVID-19 vaccination among staff ethnic groups and ethnic communities and care home residents, recognising greater vaccine hesitancy among some communities. That would mean those staff and residents who might be at greater risk from COVID-19 would also be less likely to have the protection of the vaccine. We undertook an extensive programme to support staff vaccination. For instance, we shared blogs, videos of social care workers from ethnic groups and ethnic minorities receiving the vaccine, and educational materials with relevant groups. These explained how others had overcome vaccine hesitancy, and why those who had already been vaccinated would encourage their colleagues to do the same. I spoke to staff about their experiences getting vaccinated and asked what made a difference. Being supported to get vaccinated by someone you trusted and talking it through with a respected colleague were examples I heard. When considering making vaccination a condition of work, we recognised the range of views among the sector and its workforce, particularly as many are from ethnic groups and ethnic minorities, who we understood might be particularly unhappy if vaccination were mandated. Ultimately the clinical case for mandating as a means of raising vaccination rates led to the decision to proceed with that policy, but further support for vaccine hesitant staff was an important mitigation.

The care workforce and carers

387. Social care staffing often involves staff working across more than one site, or for different employers. For instance, some care workers combine care work and NHS work, others may do a mix of home care and care home shifts. During the pandemic we learnt that staff working in multiple settings increased the risk of transmission. This provided a strong case for implementing a 'no staff movement' policy. However, I was warned that this would lead to greater problems of understaffing and potentially unsafe care. The Taskforce provided valuable input to work on this policy, feeding in the views of the sector about the difficulty implementing the policy. Over time restrictions were introduced. These were phased in and supported by work to boost the care workforce and extra funding. A future pandemic could similarly see risk of infection increased when staff work across sites and settings, therefore future pandemic plans should consider how to achieve a rapid shift to single-site/service working by care staff. This will be easier to achieve if the employment model moves away from reliance on agency staff.

388. Social care is known for high levels of staff turnover, reflecting staff moving between employers in the sector but also leaving care to work in other parts of the economy. Research by *Skills for Care* shows that staff turnover is lower where staff are paid above the minimum wage, are not on zero-hours contracts, can work full time, are able to access training and have a relevant qualification. High turnover means staff move on rather than building up their skills and reduces the likelihood of continuity of care for individuals. Vacancies in social care also mean some care providers rely on care workers from agencies, who often work in multiple locations. Social care would be in a stronger position in the event of a future pandemic if a greater proportion of staff were in secure, long-term employment in the sector, and pursuing a career path with training to develop skills. That is why as Care Minister I have been pushing forwards policies to support and develop the social care workforce, improve access to qualifications, establish career paths and career progression, raise pay and improve terms and conditions for staff.

389. The provision of sick pay is an ongoing concern for social care. Early in the pandemic I sought sick pay for staff from their first day of isolation. This avoided staff facing a financial penalty for doing the right thing by the people they cared for. COVID-specific sick pay has now been ended as we have moved on from the pandemic, with the development of more effective treatments as well as the vaccination. However, the principle that unwell staff should not go to work to look after people with weakened immune systems applies for other infectious illnesses as well, like flu. Some staff in social care receive sick pay from day one, but others do not. This can put staff with low incomes in a difficult position if they have an infectious illness.

390. During the pandemic care workers felt they were not appreciated in the same way as NHS staff, despite going through incredibly difficult experiences at work and taking care of people with COVID-19. For instance, people put posters in their windows thanking the NHS – but not generally thanking care workers. Some care workers were challenged on their keyworker status because they didn't have well recognised ID like NHS staff. I worked across Government to increase the recognition for the care workforce, for instance, calling on supermarkets to give care workers preferential access, arguing for care workers to have key worker status so their children could stay in school, getting agreement and funding to distribute the 'CARE' badge (credit is due to Care England for their partnership on that), and asking Her late Majesty Queen Elizabeth to acknowledge care workers in her Christmas address. This job is not yet done; care workers still deserve more recognition for the work they do.

391. Unpaid carers – for instance family members looking after relatives with disabilities – felt they did not receive enough support during the pandemic and continue to feel this. Being a carer is often incredibly hard in normal times, and it was harder still in the pandemic. Many carers were looking after someone likely at great risk from Covid, without any back-up or respite that might normally be in place. Because of this, unpaid carers were considered frequently in Government during the pandemic. For instance, in communications with local authorities I specifically asked them to make sure they were contacting unpaid carers to offer them support. I commissioned advice on PPE for unpaid carers and made sure they were considered in prioritisation for tests and vaccinations. The starting point for the pandemic was that many carers were not known to local authorities as carers. In fact, many carers don't recognise themselves as such. One outcome of the pandemic is some additional carers were identified, as they declared themselves to GPs as part of the vaccination programme. We continue to work across Government to increase the recognition and support for unpaid carers. Having more comprehensive registers about who is caring in any community and having routes to contact them would provide a better starting point in any event. Any future pandemic plan should specifically consider how carers will be contacted and supported.

Pandemic preparedness and our system's capability to respond

392. Adult social care is a devolved and diverse sector in England - and in many other countries. This provided a difficult starting point for a pandemic that needed a rapid and coordinated response to make the most of limited resources (like covid tests or PPE). While the NHS has NHS England and a substantial team at DHSC to develop, implement and monitor policy and activity, at the start of the pandemic the Adult Social Care team within DHSC was a small

group of officials primarily working on strategic policies like charging reform. DHSC did not carry out operational oversight of the sector, nor did the department have direct relationships with individual care providers. Interactions with care providers were usually through representative organisations, local authorities, and CQC.

393. In the early weeks DHSC had to devote significant resources and time into creating communication channels at scale and obtaining data to be able to target support to where it was needed, together with re-deploying and recruiting people to build up our team. As the pandemic response in DHSC became more established we benefitted from some tremendously capable and dedicated people, some deployed from other areas of social care work, some joining the team from other parts of the department/government and externally. Both the social care Director Generals provided extraordinary leadership during that difficult time. We also benefitted from the willingness of people with many years of experience joining the effort, like Sir David Pearson and Professor Jane Cummings. We also recruited a team of regional representatives with experience in social care, for instance former Directors of Adult Social Services, who helped build relationships and were able to work directly with local authorities and providers in their areas.

394. As set out above, the responsibility for pandemic planning for Adult Social Care was seen to lie with local authorities. The small number of plans I saw showed that they in turn looked to care providers to have their own plans. Despite the complexity of the social care system, there could have been plans for how government and local authorities would communicate with care providers, how government would gather data on the situation at the front line, and how extra funding would be distributed. Had plans been created in advance there would have been opportunities to consult more thoroughly with providers, residents, and unpaid carers. This could have identified what residents and families would have wanted, for example in terms of restricting care home visits. We have now established a significant amount of this infrastructure, particularly data collection and communication channels; we're investing in social care digital infrastructure to improve data further; and we have legislated to be able to distribute funding directly to care providers should this be needed. Future governments may look to make savings by cutting back these initiatives and the capabilities in DHSC we have built up for social care; before doing so I would want to see serious consideration of the implications for our capability to respond in the event of another pandemic.

395. Responsibility and accountability for self-funded care is worth further consideration. One of the challenges we faced during the pandemic was that while local authorities generally knew many of the care providers in their areas through commissioning relationships, some lacked equivalent relationships

with providers caring for self-funded clients. I think this is why I heard that some of the self-funded portion of the care sector had not heard from local authorities as part of local authority outreach efforts. It was helpful that providers caring for self-funded individuals were registered with CQC, therefore included in CQC datasets and could be identified for PPE and Covid test distribution.

Data

396. The pandemic exposed that we lacked quality and timely social care data to manage outbreaks and monitor ongoing risks at both a local and national level. Prior to the pandemic, DHSC had no comprehensive national source of data from providers on capacity, workforce status, or numbers of people receiving care. The Care Home Capacity Tracker now provides visibility of all care providers in the country. Since July 2022, data collection from providers has been put on a statutory footing. Following the introduction of the Health and Care Act 2022, all CQC regulated Adult Social Care providers have a statutory duty to provide mandatory information to the Capacity Tracker on: (i) care home bed vacancies, (ii) workforce resourcing and absences, (iii) vaccination statuses of staff and residents, and (iv) visiting options being supported. New enforcement regulations also enable the Secretary of State to impose financial penalties on providers who do not comply with this duty. We are building on the Capacity Tracker with significant investment in the development of social care records and data, to improve the quality and quantity of information about the care system while reducing the administrative burdens of care providers. As these systems develop, we should consider how they will provide information that would help in the event of another pandemic as well as supporting day to day provision of care.

Social care in our system

397. At the outset of the pandemic the NHS had greater resources within Government than social care. There is a much higher level of public spending on healthcare – at the time around £159bn on the NHS compared to £22.9bn on social care, much of which is raised through council tax and almost all of which goes to social care via local authorities. Public awareness of the NHS is much greater than for social care, which many people only experience if they or a member of their family has disabilities, is elderly, or both. I worked to get social care's voice louder within Government. This was one reason why I argued (successfully) for a Director General specifically for social care, and then a Chief Nurse for Social Care (alongside the existing Chief Social Worker). The need for social care to 'be in the room' goes wider than central government. Integrated Care Systems have been set up to join up health and social care; where social care is given a seat at the table. This should be not just local authorities as commissioners but also care providers. With integrated care

systems the prospects of effective joining up, with a greater appreciation of what social care does, are much stronger.

398. The two factors which I saw have the biggest influence on COVID-19 infection rates for social care were community infection rates and the vaccination. The focus from early in the pandemic to develop a vaccine, the preparations to distribute it and then the prioritisation of care home residents and staff for vaccination likely saved thousands of lives. Throughout the pandemic we saw COVID-19 infection rates in care homes were closely correlated with community infection rates. Therefore, the steps Government took to control the level of COVID-19 in communities and break chains of transmission, such as lockdowns, are likely to have helped protect care homes. If we could have kept the level of COVID-19 in the wider community down to a minimal level until the vaccination was available that would have protected care homes further still.

Final reflections

399. I understand that this Inquiry is the primary means through which the Government will examine the UK's response to the COVID-19 pandemic and learn lessons for the future. The evidence provided by decision makers, care home staff, residents and family members will deepen our understanding of what occurred and give a voice to individuals who need to be heard. Evidence from quantitative research into social care responses and outcomes within England, across the UK and internationally should also provide crucial insights and provide us with valuable lessons. I look forward to seeing the Inquiry's conclusions.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Sig Personal Data

Dated: _____30/10/2023_____