Witness Name: HELEN WHATELY
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UK COVID-19 INQUIRY

WITNESS STATEMENT OF HELEN WHATELY

I, HELEN WHATELY, Shadow Secretary of State for the Department for Work and Pensions at the House of Commons, London, SW1A 0AA, will say as follows:

INTRODUCTION

1. I make this statement in response to a request from the UK COVID-19 Inquiry (**the Inquiry**) dated 20 September 2024 under Rule 9 of the Inquiry Rules 2006, asking for a draft witness statement for Module 5 of the Inquiry (**the Rule 9 Request**). This is my second statement to the Inquiry as I have already produced a detailed statement for Module 2 of the Inquiry 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.

2. In the Rule 9 Request the Inquiry has specifically asked about my involvement in the procurement and distribution of key healthcare equipment and supplies including PPE, ventilators and oxygen, lateral flow tests and PCR tests for the social care sector in the period from 1 January 2020 to 28 June 2022.

3. This statement is accurate and complete to the best of my knowledge and belief at the time of signing. Notwithstanding this, it is the case that DHSC continues to prepare for their involvement in the Inquiry, including their involvement in Module 5. As part of these preparations, it is possible that additional material will be discovered. In this eventuality the additional material will of course be provided to the Inquiry and a supplementary statement will be made to address the same if that would assist the Inquiry. Given the volume of material I have not been able to review all the documents referred to in this statement.

4. I understand that DHSC are preparing a statement to address the issues raised in Module 5 at a corporate level (**the Corporate Statement**). That statement will address the broader picture and overview of what was happening across DHSC in relation to the procurement and distribution of key healthcare equipment and supplies. My statement should therefore be read alongside the Corporate Statement.

OPENING REMARKS

5. Early in the pandemic doctors, nurses, care workers and many others were reporting PPE shortages at the front line. There were reports of bin bags being used as aprons and that hospitals were within hours of running out of supplies of gloves and masks. The UK was attempting to source PPE at the same time as many other countries around the world, so there was fierce competition for scarce supplies.

6. Many people came forward to help in the effort to source and distribute PPE. Some businesses and volunteers set up production lines to make visors for their local hospitals. Others repurposed their equipment to make hand sanitiser. For me, and for colleagues I spoke to about this at the time, our priority was clear: do what we could to help get PPE to health and care staff to protect them from COVID-19. We did not know how dangerous COVID-19 was and who would be most at risk, but we did know that healthcare workers – like the doctor in Wuhan who raised the alarm – had died from it.

7. Although I was not the minister responsible for PPE, I was the minister responsible for the healthcare workforce and for social care. I therefore wanted to do what I could to ensure that systems and processes were in place so that key healthcare equipment and supplies were distributed and available to the healthcare workforce and the social care sector.

8. There was also pressure to get out guidance to the social care sector on the use of PPE. Given this was early in the pandemic, this guidance was being developed whilst PHE advisors themselves were working out what level of PPE was needed and how it should be used. For instance, at that time we didn't know what types of masks would be effective at protecting people from COVID-19, and how frequently they should be changed.

9. Since the pandemic there has been much criticism of the procurement of PPE, focused on the high prices paid and the poor quality of some shipments. I share the frustrations of critics that Government ended up paying so much and worse still, sometimes paying

high prices for PPE that was not up to the job. One consequence of the fierce competition for PPE was a surge in costs. Some people saw an opportunity to make substantial profits. I would welcome views from the Inquiry on whether there was any way for the UK to avoid paying these inflated prices, in the absence of more supplies in stock and greater UK production capacity.

10. I wasn't involved in any of the procurement processes or negotiations, but I am mindful that I was one of many pressing for PPE to be provided. The civil servants doing the procurement must have been under a huge amount of pressure and I believe they worked night and day to try to get hold of PPE. I would ask the Inquiry to consider this context as you carry out your work on this module.

11. There was similarly a huge demand for COVID-19 tests at the outset of the pandemic. Our pride at being the first to produce an accurate test was quickly overtaken by frustration at the limited number of tests and what felt like a slow ramp up in production. While I was not involved in discussions about test production, I do remember the Health Secretary being adamant that the volume of tests should and could increase at a faster pace. My involvement was particularly to lobby for social care to receive a larger share of tests in the early days when volumes were so limited, and then to press for faster turnarounds on results. As lateral flow tests became available I worked to get these distributed to social care at scale so care staff could be regularly tested, and also visitors, to reduce the risk of COVID-19 being brought into a care home or the home of someone receiving domiciliary care. I look back at the scale of the testing system we set up and take pride in the fact that we managed to do it so fast, and so comprehensively. It involved an extraordinary level of effort on the part of all those involved, including care workers themselves.

12. By the autumn of 2020 the government was providing free PPE and thousands of tests to care providers so they could follow a rigorous testing regime. Even with regular staff testing and plentiful PPE (and strict processes for admissions to care homes), residents in care homes still caught COVID-19. I look forward to seeing the Inquiry's findings on whether there is more we could have done with our testing and PPE regimes to protect people, and particularly whether there are lessons to be learned from other countries.

STRUCTURE OF THIS STATEMENT

13. I have been asked a number of questions in the Rule 9 Request. In order to answer them fully this statement is split into the following sections:

    a) **Overview of Role, Function and Responsibilities:** This section provides an overview of my roles and responsibilities over the period requested by the Inquiry and sets out the key people and departments/bodies I worked with;

    b) **Communication with the Care Sector:** This section explains how DHSC liaised with individuals and stakeholders in the care sector during COVID-19;

    c) **The Structure of the Social Care Sector:** This section gives a brief overview of the structure of the social care sector;

    d) **Data:** This section explains my role in ensuring that relevant data was available to DHSC in relation to PPE within the care sector;

    e) **PPE Procurement and Distribution to the Social Care System:** This section sets out my involvement in the procurement and distribution of PPE to the care sector during COVID-19;

    f) **LFT and PCR Testing Equipment:** This section provides details as to my role in decisions concerning the prioritisation of COVID-19 tests for the social care sector;

    g) **Reflections and Lessons Learned:** This section sets out some reflections and lessons learned, in so far as is relevant to the content of my statement and the scope of Module 5.

Overview of role, function and responsibilities

14. I have been an MP for Faversham and Mid Kent since 2015. The Inquiry has asked me specifically about the positions which I held prior to the pandemic in the period from 1 January 2018 to 31 December 2019:

    a) In January 2018 I was appointed Parliamentary Private Secretary to Brandon Lewis, Conservative Party Chairman;

    b) In July 2018 I became a Vice Chair of the Conservative Party;

    c) On 17 April 2019 I was promoted to Deputy Chair of the Conservative Party;

    d) From September 2019 to February 2020 I was Parliamentary Under-Secretary of State for Art, Heritage and Tourism.

15. From 13 February 2020 to 16 September 2021 I served as Minister of State for Care. 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.

16. From September 2021 to July 2022, I was Exchequer Secretary to the Treasury. During that time, I was not involved in any decisions concerning PPE or other key healthcare supplies which would fall within the scope of the Rule 9 Request.

17. When I was first appointed as Minister of State for Care 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 (the latter until March 2021) (**HW/3 - INQ000327961; HW/4 - INQ000327984; HW/5 - INQ000328115**).

19. As my portfolio included adult social care, during the pandemic I was involved in decisions to ensure that systems and processes were in place so that key healthcare equipment and supplies were distributed and available to the social care sector. I was not involved in direct operational decisions on distribution or on procurement but gave strategic direction on policy, which included liaising with various individuals/bodies on the prioritisation of the social care sector when decisions were made. In doing so, I worked with many people and departments/bodies, including:

a) The Secretary of State
b) Jo Churchill (Parliamentary Under Secretary of State)

c) Lord Bethell (Parliamentary Under Secretary of State)
d) Jonathan Marron (Director General with responsibility for PPE supply)
e) Emily Lawson (NHS England Commercial Director)
f) Ros Roughton (Director, Care and Transformation and later Director General, Adult Social Care)
g) Lord Deighton (leading on the domestic sourcing of PPE)
h) Lisa Lenton (England Director for the Association for Real Change)
i) NHSEI Incident Response
j) NHS Supply Chain (**SCCL**)
k) The Ministry of Defence (**MoD**)
l) The Ministry of Housing, Communities and Local Government (**MHCLG**)
m) Unipart Logistics

20. I worked with these people and departments/bodies in several different forums, including:

a) 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, on 26 May 2020 I attended a meeting led by the Prime Minister focussing on the delivery of IPC training to care home staff, PPE, and testing within care homes (**HW/6 - INQ000327906; HW/7 - INQ000327915**). 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.

b) In March 2020, four Ministerial Implementation Groups (**MIGs**) were established to support COBR, including a healthcare committee (**HMIG**) chaired by the Secretary of State. 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.

c) The MIG system was replaced on 29 May 2020 with two Cabinet Committees, COVID-Operations (**COVID-O**) and COVID-Strategy (**COVID-S**). My diary indicates that I attended 11 COVID-O meetings, usually alongside the Secretary of State.

d) At the outset of the pandemic, the Secretary of State organised daily morning meetings involving the CMO, Public Health England (**PHE**) and ministers to provide updates on the situation and preparedness: see for example (**HW/8 - INQ000233747**). I attended these where appropriate.

e) 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/9 - INQ000327868; HW/10 - INQ000327867; HW/11 - INQ000327927; HW/12 - INQ000327928**).

f) Between June 2020 and May 2021, I usually attended regular JCB 'Gold meetings': see for example (**HW/13 - INQ000327995; HW/14 - INQ000328061; HW/15 - INQ000328069**). These meetings were chaired by the Secretary of State to review data and inform decisions on 'tiering' and the consequent non-pharmaceutical interventions (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.

g) 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/16 - INQ000327810; HW/17 - INQ000327842**).

h) A number of different forums and meetings held with the Adult Social Care Sector, which are detailed below in the section headed **"Communications with the Care Sector".**

21. Throughout the pandemic I was provided with advice and support from PHE and the Office of the CMO, as well as from NHS England. Most of the guidance about Infection Prevention and Control (**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. This advice covered a wide range of COVID-19 related issues and informed a number of decisions, including those taken in relation to PPE and healthcare equipment and supplies to the social care sector. Further, 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.

22. I have set out in more detail my specific involvement, how I worked with other individuals and bodies, and the decisions I was involved in under the section headed "**PPE Procurement and Distribution to the Social Care System**".

23. The Inquiry has asked specifically about my involvement with the PPE Programme/Cell and NHS Test and Trace and with the Devolved Administrations. So far as I can recall:

    a) I was not included in meetings discussing PPE distribution in general (such as meetings that talked about distribution of PPE to NHS facilities as well as the social care sector) other than when PPE was an agenda item in a general COVID-19 departmental or cross-government meeting;
    b) A senior civil servant attended the Test and Trace meetings to represent the social care sector;
    c) I discussed, through my private office and the Secretary of State's office, setting up communications with the Devolved Administrations' ministers about social care. The decision was taken that those conversations would be held by the Secretary of State and between officials, rather than by junior ministers. I am aware that the Corporate Statement sets out in more detail the coordination between the Four Nations on the issues relevant to the scope of Module 5.

24. The Inquiry has also asked about my role in the distribution and procurement of LFT and PCR testing for the social care sector. I had no role in procurement of tests and no direct role in organising their distribution. I did establish some oversight of the distribution of tests to social care and I have explained the nature of that oversight, and also set out my involvement in decisions on the prioritisation of tests, in the section below entitled "**LFT and PCR Testing Equipment**". Whilst the Inquiry has not asked specifically about the prioritisation decisions, I hope that the brief explanation assists the Inquiry, as decisions about prioritisation of testing had an impact on decisions made by those directly involved in the operational distribution of tests.

Communications with the Care Sector

25. 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.

26. 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.

27. 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/18 - INQ000279924**) and (ii) the May Support Policy for care homes (**HW/19 - 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.

28. The Taskforce was chaired by Sir David Pearson, former President of ADASS, who reported to me as Minister. Eight advisory groups were established to explore specific areas of social care. 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.

29. At this time DHSC received a large volume of correspondence from stakeholders, MPs and members of the public. In March 2020 alone DHSC received 8382 pieces of correspondence compared to 2488 in March 2019. This resulted in significant delays in

correspondence being read and answered. I did not generally see these letters/emails until many months later. Later on we established a process to prioritise correspondence which would need a particularly prompt response, but it took some time for the correspondence unit to work through the backlog.

30. Both during the pandemic and in normal times, as Minister I made sure I had stakeholder 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, including in relation to PPE and other healthcare supplies, and feed that into decision making. I held monthly roundtables with care providers and representative organisations, monthly roundtables with those representing people living in retirement communities and Government supported living and monthly meetings with a group of care user representatives. I held several roundtables with representatives of the social care workforce. In normal times I would visit care providers in-person to hear directly from front-line staff, care home residents and carers. Public health advice prevented me doing this in-person during the pandemic, so instead I did 'virtual visits' and talked to staff, residents and carers over Zoom or Microsoft Teams. I attended roundtables with local authorities jointly with my ministerial counterpart from MHCLG and held multiple discussions with Directors of Adult Social Care and Directors of Public Health.

31. 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, and TLAP. 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. I also had a number of ad-hoc meetings with care organisations and providers.

32. All of these different meetings and forums were a chance for providers and stakeholders to raise any concerns regarding the supply of PPE and/or key healthcare supplies. I also communicated with the adult social care sector by letter and received emails from

representatives. I have set out the key communications I received in relation to PPE and other key healthcare equipment and supplies in the care sector in the section below headed "**PPE Procurement and Distribution to the Social Care System**".

Structure of the Social Care System

33. 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 MHCLG (now 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.

34. 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.

35. Prior to the pandemic social care providers generally 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. One challenge mentioned by some providers during the pandemic is that they lack storage space for spare PPE.

Data

36. I identified early on in the pandemic, in March 2020, that there was a stark lack of data from the social care sector to inform our pandemic response, particularly a lack of timely data on COVID-19 cases and deaths, access to PPE and availability of staff. 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".

37. The Department did not have a register of social care providers at the start of the pandemic. As I was not in post prior to the pandemic, I do not know whether there had been earlier discussions about setting up a DHSC register of care providers. However, given the non-operational role of the Department in social care, I am not surprised at the lack of a register. DHSC does not commission or regulate care; those activities are carried out by local authorities and the CQC. I recollect that DHSC officials expected local authorities to know the care providers in their local area and be able to communicate with them. The CQC had a list of all registered providers and contact details. This was used by the Department at the start of the pandemic both as a data source and for communications with providers. It was harder to identify and communicate with unregistered providers of social care as CQC does not hold the details of these organisations. The Department worked with local authorities to reach unregistered providers and distribute PPE to them if required.

38. I was extremely concerned about this lack of data. I wanted to have reliable and up-to-date information about the situation on the ground in care providers to inform the pandemic response. I commissioned work which led to the development of a new data tool for DHSC which was to prove central to our social care COVID-19 response.

39. Ministers discussed the data issues in HMIGs in March 2020 (**HW/20 - INQ000055934**; **HW/21 - INQ000055942**), and I continued to raise this as a priority issue for DHSC in May 2020 (**HW/22 – INQ000146701**).

40. 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. Officials identified this as our best option for rapidly improving operational social care data. Credit is due to the North of England Commissioning Support Unit who had developed the tool.

41. 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/23 - INQ000327986; HW/24 - INQ000328122**) and therefore became the tool which we used to gather data from the care sector about the quantities and type of PPE which were required during the pandemic.

42. From recollection I believe that care providers were required to provide weekly updates to the Capacity Tracker to communicate the number of COVID-19 cases and any PPE and/or staff shortages but I understand that more detail is given addressing this issue in the Corporate Statement. The Inquiry has specifically asked me how this data was integrated into DHSC's PPE cell; I cannot answer this. The question may be better directed to someone within the PPE cell team.

43. Initially, when provision of PPE was first introduced to the Capacity Tracker, social care providers would input information on their PPE supplies by categorising themselves as Green, Amber or Red. Later on, in August 2020, a Blue Category was added. The different categories reflected a defined period of PPE stock level:

    a) Blue: At least 1 month supply of PPE **and** are confident of ongoing supply
    b) Green: Up to 1 month supply of PPE available **or** are confident of ongoing supply
    c) Amber: Up to 7 days supply of PPE available
    d) Red: No PPE supplies or less than 48 hours supply of PPE available.

44. The Capacity Tracker therefore allowed those distributing PPE to see where it was most needed within the social care sector. I used the Capacity Tracker to check PPE status across providers, especially in the early days, and I recall that it was used to inform discussions in meetings.

PPE Procurement and Distribution to the Social Care System

45. 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.

46. 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. 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.

47. The Inquiry has asked me to address the principal means by which social care providers obtained access to PPE between January and June 2020. As I have explained, before the pandemic social care providers sourced their own PPE from commercial suppliers and I understand that that continued during the pandemic. During the pandemic the Department also made their own distributions of PPE to providers, such as the distribution of facemasks detailed in paragraph 54 below. DHSC worked with NHSEI Incident Response, SCCL, the MoD and Unipart Logistics to provide social care with emergency stocks of PPE, particularly face masks, at the outset of the pandemic.

48. In March 2020 DHSC put in place the National Supply Distribution Response (**NSDR**) hotline to respond to care providers who had an urgent need for PPE and my understanding is that supplies were distributed to providers where possible if they contacted this PPE hotline. From April 2020, PPE was also distributed to local authorities/Local Resilience Forums (**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.

49. 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.

50. The Inquiry has asked specifically about how I worked with the Secretary of State and how the Secretary of State contributed to key decisions in relation to the procurement and distribution of PPE and other key healthcare equipment and supplies for the social care sector. I have therefore explicitly set out when the Secretary of State was involved in any of the key decisions explained in this section of my statement and have set out the extent of that involvement.

Establishing emergency channels of supply

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

52. During March 2020 I heard many concerns about the supply of PPE to social care. These included reports of PPE shortages in care homes and for homecare staff, care providers and local authorities not being able to get hold of PPE, concerns that the NHS was being given priority over social care by PPE suppliers, and the NSDR being overwhelmed with calls. I had several conversations and communications with Jonathan Marron and then with Emily Lawson seeking their help to improve supplies of PPE to social care.

53. 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/25 - INQ000327780**). On 21 March 2020, we expanded the hotline to a 24-hour service.

54. 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/26 - INQ000327782**).

55. There was a MIG 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/27 - INQ000327783**).

56. On 20 March 2020 I flagged to the Adult Social Care team in DHSC 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/28 - INQ000327784**).

57. I continued to receive complaints about PPE supply, so on 26 March 2020 I asked for an urgent meeting with the PPE team (**HW/29 - 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/30- INQ000327789**).

58. 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/31 - INQ000327792**).

59. 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/31 - INQ000327792**).

60. The call took place with MHCLG on 27 March 2020, 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/32 - INQ000327793**).

61. On 31 March 2020 Lisa Lenton (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/33 - INQ000327798; HW/34 - 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 ring-fence their PPE products for NHS. Emily Lawson told me that that the NHS was not requisitioning or ring-fencing supply until other sectors could obtain PPE from elsewhere (**HW/35 - INQ000327803**).

62. On 1 April 2020 I had a meeting with Jonathan Marron. I asked him to follow up on a number of matters, including to contact local authorities on PPE arrangements in unregistered care providers, to ensure that a clear message was being sent out to social care providers about PPE and to follow up about issues that had been raised with me regarding the supply of PPE in Sussex and Hove (**HW/36 - INQ000327804; HW/37 - INQ000327805**).

63. 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/38 - INQ000327806**).

64. 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 LRFs. 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/39 - INQ000327811; HW/40 - INQ000327812**). This led to distribution of 8 million aprons, 4 million masks and 20 million gloves between 5-8 April 2020 (**HW/41 - INQ000327818**).

65. 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 (**HW/42 - INQ000327814**). I was concerned that we needed someone who would focus on social care within the PPE team.

66. 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/43 - INQ000327813**). I provided my comments on the proposed slides for the meeting on 6 April 2020 (**HW/44 - INQ000327815; HW/45 - INQ000327816**).

67. 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/46 - INQ000327817**). On 7 April 2020 I had a meeting with care providers and explained the current PPE situation (**HW/47 - INQ000327833**).

68. 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/48 - INQ000327826**).

69. 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/49 - INQ000327827**).

70. 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/50 - INQ000327828**).

71. 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/51 - 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/52 - INQ000327835**).

72. On 14 April 2020 I was provided with an update on the Clipper system. At that 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/53 - INQ000327839**), which I received on 17 April 2020 (**HW/54 - INQ000327843**).

73. 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/55 - INQ000327844**).

74. On 18 April 2020 a further two submissions were sent to the Secretary of State and copied to ministers (**HW/56 - 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/57 - INQ000327846**). The second submission was a proposal for sharing incoming PPE supplies with Devolved Administrations and Crown Dependencies (**HW/58 - INQ000327847**).

75. 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/59 - INQ000327848**).

76. 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/60 - INQ000327869**).

77. 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.

78. 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/61 - 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.

79. 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/62 - INQ000327873**).

80. At the 12 May 2020 meeting, (**HW/63 - 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;

(b) set up a buying and logistics team session to share experiences between wholesalers and DHSC;
(c) commission further advice on current stock position and projections for gloves;
(d) commission further advice on price variations of 10 key PPE items from December 2019 to May 2020; and
(e) 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.

81. 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/64 - 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/65 - 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/66 - INQ000106462**).

Pilot on distribution of ClearMask face masks

82. 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.

83. 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 for immediate supply to the social care sector, and then provide the ClearMask masks through the PPE Portal in the longer term (**HW/67 - INQ000327972; HW/68 - INQ000327973**).

84. 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/69 - INQ000327981**). The pilot was signed off on 21 August 2020 (**HW/70 - INQ000058133**).

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

85. In July 2020 I requested a submission on how to distribute an increased level of PPE to social care settings to meet their needs for COVID-19 as I wanted a more sustainable approach to distribution. 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/71 - 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).

86. 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 up to that point. My instinct was to fund care providers to cover their additional Covid-PPE costs and allow them to source from their usual wholesalers. However, the budget had already been used for purchasing PPE centrally.

87. 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.

88. 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/72 - INQ000327956**). The Secretary of State was content with the overall approach (**HW/73 - INQ000327954**) and agreed to the free distribution policy on 20 July 2020.

89. 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 provide all social care's Covid-PPE 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/74 - INQ000327987**; **HW/75 - INQ000327988**).

90. 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

91. 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 options for extending 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/76 - INQ000328084; HW/77 - INQ000328085; HW/78 - INQ000110871**). On 24 March 2021, ministers agreed to extend the provision of free PPE to 31 March 2022 **(HW/79 - INQ000328092**).

Supply of PPE to unpaid carers

92. 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.

93. 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.

94. 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.

95. 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/80 - INQ000051396; HW/81 - INQ000051397; HW/82 - INQ000051398**).

96. 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/83 - 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/84 - INQ000327979**).

97. 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/85 - INQ000328011; HW/86 - INQ000328012; HW/87 - INQ000328013**). I agreed to all the recommendations in the submission (**HW/88 - INQ000328015**), as did the Secretary of State (**HW/89 - 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.

98. 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/90 - 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/91 - INQ000328038**). I approved the national roll out offer, as did the Secretary of State (**HW/92 - INQ000328040; HW/93 - INQ000328042**).

99. I received an update on the progress of the national roll out on 19 May 2021 (**HW/94 - 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/95 - 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/96 - INQ000328129**).

Award of Contracts

100. I have been asked specifically by the Inquiry about the approval of contracts for PPE and any other key healthcare equipment and supplies. I was not involved in the approval of contracts but understand that the process is addressed in the Corporate Statement.

101. I was not a direct or indirect beneficiary of any businesses awarded contracts during the pandemic, nor am I aware of anyone or any company receiving preferential treatment as a result of their status as a donor of, or with a connection to, the Conservative Party.

102. I have been asked about conversations with individuals or companies about government business relating to the procurement of key healthcare equipment and supplies on my private devices. There were some potential suppliers who sent emails to my personal email address instead of my government email address which I forwarded to the relevant official mailbox so that they could be dealt with by the correct individuals responsible for PPE procurement. I also received messages from a social care PPE supplier to my phone as I had a single phone for ministerial and personal use, in compliance with guidance from DHSC IT at the time. I advised the supplier to contact me through official channels (which I believe they did then subsequently do) and informed my private office about these communications. I did not have any conversations with individuals or companies about contracts or procurement terms for key healthcare equipment supplies on my private devices.

103. I was not involved in liaising with or organising for any small and medium sized enterprises or local suppliers or manufacturers to produce PPE for the care sector.

The Voluntary Sector

104. The Inquiry has asked me how the voluntary sector assisted in the distribution of PPE and other key healthcare equipment to the care sector. I was aware, through reports in meetings and in the press, that volunteers came forward to help with the sourcing and distribution of PPE and healthcare supplies but cannot comment any further or give any further detail as it was not something I was directly involved in.

LFT and PCR Testing Equipment

105. As I have explained above, I was not involved in the procurement of LFT and PCR tests but was involved in arguing for prioritisation of the care sector when decisions were made as to allocation of tests. The distribution of tests was discussed at a strategic level in a number of meetings which I attended.

General oversight of the distribution of tests

106. While I was not responsible for the distribution of tests, I did establish a level of oversight of test distribution through updates in meetings and testing data. I was not involved in the direct operational decisions. Test distribution was often discussed in meetings so I am unable to set out each and every meeting in which we may have covered this topic. I wanted tests to get to all care homes on time for their regular testing regime and for them to get quick turnaround on results. I used the Capacity Tracker to monitor whether care homes appeared to be following the testing regime. If the Capacity Tracker showed that the care home had no test results, I would ask the team to investigate why this was the case – for instance, whether the care home hadn't received tests.

107. To give a specific example of how I exercised my general oversight of test distribution, as part of my preparation for this module I have read the minutes of "weekly testing meetings" which took place over May and June 2020 (**HW/97 - INQ000533611; HW/98 - INQ000533612; HW-99 - INQ000533613; HW/100 - INQ000050804; HW/101 - INQ000533614; HW/102 - INQ000533615; HW/103 - INQ000533616; HW-104 - INQ000533617**). These meetings were established at my request so that I could understand the number of care staff and residents that had been tested and be updated more generally on any issues that needed to be addressed or escalated. We discussed matters such as the need to start testing individuals within the Learning Disabilities and Autism programme, the need to obtain further advice from SAGE/PHE on certain issues, and the need to ensure that eligible care homes registered on the portal.

108. I can see that in a meeting on 19 May 2020 I asked for officials to consider options for ramping up the number of daily tests that were being distributed and I also wanted to understand how Directors of Public Health were experiencing prioritisation at a local level. These were the kinds of conversations that I was having at a strategic level about the distribution of LFT and PCR testing equipment, which I understand fall outside the scope of this module and the Rule 9 Request. However, should the Inquiry want further information about general oversight of the distribution process then I can endeavour to provide further details.

Prioritisation process for tests

109. 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.

110. 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.

111. 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.

112. 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.

113. 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-19. I recall that MoD were involved in the logistics for testing and were excellent; they did a lot of the operational work on the ground for distributing tests. They also dealt with a lot of practical issues for distribution such as making sure that tests were delivered to care homes when someone was there to take delivery, which was an issue particularly for smaller providers.

Prioritising care home staff and residents for COVID-19 tests

114. 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/105 - INQ000327819; HW/106 - INQ000327820**). I was concerned about the prioritisation of social care in this proposal (**HW/107 - 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/106 - INQ000327820**).

115. 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/108 - INQ000327823**). The Secretary of State agreed and wanted the changes to be taken on as a policy decision (**HW/109 - INQ000327824**), which he later presented in the HMIG on 9 April 2020 (**HW/110 - INQ000327840; HW/111 - 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/112 - INQ000083704**).

116. 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/113 - 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/114 - INQ000292608**).

Decision on prioritising testing of asymptomatic staff and residents

117. 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/115 - 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/116 - INQ000327851**).

118. 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/117 - NQ000327855**; **HW/118 - INQ000327856**).

119. 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/119 - INQ000327859**).

120. 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/120 - 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."*

121. 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.

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

123. 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.

Reflections and Lessons Learned

124. As I reflect on what we can learn from the pandemic I have at the forefront of my mind the lives lost and especially the suffering of loved ones. I think of residents in care homes who were so vulnerable to COVID-19, and care workers and NHS workers who were on the front line. They knew they were risking their lives yet all the same, every day and night, thousands of care workers and NHS workers came to work and cared for people. Some tragically lost their lives leaving behind devasted family and friends. Others caught COVID-19 and may still live with Long COVID-19. Care workers and NHS staff looked to PPE to protect them from COVID-19 but in the early days when we faced shortages – like so many other countries – the PPE they needed wasn't always there to protect them.

125. During the pandemic everyone I worked with did their utmost to stop COVID-19 from taking people's lives, as did I. Every day was a day to do battle with that cruel and unforgiving virus which attacked the most vulnerable. I recognise that this Inquiry is trying to provide answers for those who lost loved ones or who disagree with the decisions that were made and hope that my evidence explains why and how I contributed to the decisions that were made.

126. I have set out below my own reflections and lessons that I believe can and should be learned from the pandemic. The Inquiry has asked me to reflect on preparedness and particular issues such as information on the requirements of the social care sector during the pandemic, stockpiles and distribution networks. As I was not involved in direct operational decisions of distribution or on procurement I am not able to address these issues in detail but I have done my best to reflect on my role and explain what lessons

can be learned from my experience in the decision-making process at the more strategic level.

127. The matters I address in this section are: (a) pandemic preparedness and our system's capability to respond; (b) effective use of PPE; (c) data; (d) distribution of tests; and (e) cross-Whitehall resources for organising distribution.

Pandemic preparedness and our system's capability to respond

128. Adult social care is a devolved and diverse sector in England - as 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-19 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 DHSC have direct relationships with individual care providers. Interactions with care providers were usually through representative organisations, local authorities, and CQC.

129. 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 DHSC/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.

130. 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. But I don't believe local authorities in general checked those plans, nor did I identify any PHE process for assuring themselves of the pandemic preparedness of care providers.

131. There did not appear to be a plan in place to make sure care providers would be able to supply their staff with PPE in the event of a pandemic. My recollection is that care providers were expected to have their own stocks of PPE available. In parallel, the national PPE supply was officially for NHS and social care – but I don't believe material work had been done to work out how to distribute PPE to social care providers from that stock in the event of a pandemic, hence the logistics of distribution were one of the bottlenecks even when there was sufficient stock.

132. In order to be prepared for a future pandemic there needs to be clarity about where responsibility lies for social care providers' 'pandemic stock' of PPE, whether that responsibility lies with the providers, local authorities, DHSC or another organisation. Providers will also need to know whether they should keep pandemic stocks on site. It should be borne in mind that many providers have limited storage space on site and it is also challenging to distribute PPE to many thousands of providers at pace – but not impossible given that we did manage to do this during the pandemic. In addition, there needs to be some level of oversight of PPE preparedness, for instance by local authorities, CQC or DHSC.

133. I would also expect PHE to provide guidance on what that pandemic stock of PPE should be, setting out whether a supply of masks, aprons and gloves would be sufficient, or whether additional items should be included in the pandemic stock for social care. The guidance should also confirm what scale of pandemic stock should be maintained to protect lives in any future pandemic, whilst also bearing in mind that PPE goes out of date and that maintaining stock is costly.

134. To the extent that the solution is a Government or NHS-controlled stock of PPE for the NHS and social care, those involved in maintaining that stock and then distributing it, in the event of a pandemic, need to be familiar with social care as a sector. They also need to be able to communicate with the social care sector effectively and would need to provide transparency about how decisions are being taken on allocation of stock and for operational communications with providers.

135. It is well known that the UK Government, alongside many other countries, struggled to procure PPE at fair prices, or at all. A lack of UK capacity to produce many items of PPE was raised at the time as one of the problems. Further planning in relation to the PPE stock will be valuable to make us better prepared for pandemics in the future.

Effective use of PPE

136. Early in the pandemic care providers flagged the high cost of PPE to us as one of the problems they faced. That's why I argued for PPE-funding for social care from the Treasury. I did not want to see staff or people receiving care put at risk because their employer could not afford PPE or was worried about the cost of it. The Adult Social Care Infection Control Fund was first introduced in May 2020. It was extended in October 2020 and, by March 2021 had provided over £1.1 billion of ring-fenced funding to support adult social care providers in England for infection prevention and control. The Treasury decision to provide extra funding to social care and then to fully-fund PPE (and tests) meant the cost of PPE was not an ongoing concern for care providers and there was no financial reason to prevent effective use of PPE.

137. At times I heard that care workers were not always using PPE correctly. I asked for this to be investigated. One of the challenges was that some staff had not received training in effective use of PPE. I therefore introduced systems to make sure staff received training. I also worked with CQC to get them to update their inspections to look at compliance with Infection Prevention and Control (IPC) measures including use of PPE and testing.

138. One of the social care reforms I drove forwards as Care Minister in 2023/4 was the introduction of an online register for care workers to be able to record their qualifications. I urge the new Government to continue this reform. One of the benefits is that staff would be able to record whether they have completed IPC training. In the event of another pandemic this register could enable DHSC to see who has versus hasn't had relevant training and use this information, for instance, to encourage or require those without necessary training to receive it.

Data

139. 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.

140. Prior to the pandemic, DHSC had no comprehensive national source of data from providers on capacity, workforce status, or numbers of people receiving care. We also had no data on care providers' PPE stock levels. Once we had developed the Care Provider Capacity Tracker we were able to use that to have visibility of PPE supplies and

shortages. Until then we relied on informal communications through stakeholders and from providers themselves.

141. In July 2022, we put data collection from providers 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.

142. As we moved from pandemic to post-pandemic we stopped requiring care providers to report on PPE, given that every data requirement imposed an administrative burden (and cost) on a provider. However, I would urge the new Government to maintain the ability to collect this data at a provider level (and the option to require reporting on it) in the event of a future pandemic.

Distribution of Tests

143. As for PPE, distribution of tests to social care providers had to take into account the range of types and sizes of providers. For instance, some smaller providers didn't have someone available to take receipt of tests if they were delivered out-of-hours. My recollection is that the front-line team developed pragmatic approaches to these kinds of problems at pace, after some initial challenges. Financial support for extra costs of testing was also crucial – not just the cost of the tests themselves but also covering the additional staff time needed for testing and the associated administration.

Cross-Whitehall resources for organising distribution

144. As I have highlighted in this statement, I worked with some highly capable people from the Ministry of Defence on the distribution of tests to the social care sector. Whilst the Social Care team in DHSC was extremely knowledgeable the focus of the department pre-pandemic was policy rather than operations. Utilising the resources and experience of the MoD was invaluable and they were particularly helpful dealing with the very practical issues involved in distribution of tests. For example, they were very good at picking up the phone and would spend time talking to providers to find out what was happening on the ground if, for example, we became aware that they weren't completing tests which had been delivered to them.

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.

Signed: PD

Dated: 24/01/2025