Witness Name: Rt. Hon. Matt Hancock
Statement No: 10
Exhibits: MH10/1 – MH10/234
Dated: 3 June 2025

UK COVID-19 INQUIRY

TENTH WITNESS STATEMENT OF THE
RT. HON. MATT HANCOCK

I, Matt Hancock, will say as follows

Introduction

1. I make this tenth substantive statement in response to a request from the Inquiry dated 27 September 2024 made under Rule 9 of the Inquiry Rules 2006 ("the Request") in relation to Module 6.

2. As this Inquiry works in 'modules', and does not cross-disclose documents between modules, I have transposed paragraphs of my other witness statements into this statement where relevant to the matters under consideration in Module 6 in order that it can be read as a standalone statement, as the Inquiry has requested. Nonetheless, the evidence should not be considered in isolation as the events and decisions considered in each module were concurrent to, and interrelated with, each other.

3. This statement focuses on the period 1 March 2020 and 26 June 2021, when I resigned as Health Secretary, in respect of the impact of the Covid-19 pandemic on the publicly and privately funded Adult Social Care ("ASC") sector which is the focus of Module 6.

4. This statement is to the best of my knowledge and belief accurate and complete at the time of signing. The Department of Health and Social Care ("the Department") continues to work on its involvement in the Inquiry, and should any additional material be discovered I will of

course ensure that this material is provided to the Inquiry and I would be happy to make a supplementary statement if required.

5. This witness statement is set out in the following sections:

    i) Professional background;

    ii) Role and responsibilities as Health Secretary;

    iii) Professional working relationships in respect of ASC;

    iv) Equalities considerations of those with disabilities, from lower socio-economic backgrounds, and ethnic minority communities;

    v) Initial response to the pandemic;

    vi) Asymptomatic transmission;

    vii) Key decisions;

    viii) Personal Protective Equipment;

    ix) Workforce and Funding;

    x) Vaccines and Vaccination as a Condition of Deployment ("VCOD");

    xi) Do Not Attempt Cardiopulmonary Resuscitation ("DNACPR");

    xii) Changes to regulatory inspection regimes within the Care Sector;

    xiii) Deaths related to the infection of Covid-19;

    xiv) Data; and

    xv) Care Act Easements.

Professional Background

6. Prior to entering politics, I worked at a data company, as an economist at the Bank of England, and as Chief of Staff to the Shadow Chancellor of the Exchequer. In May 2010, I was elected Conservative MP for West Suffolk and served in that role until 30 May 2024. From 2010, I served as a backbencher on the Public Accounts Committee and the

Standards & Privileges Committee. In September 2012, I entered government and served in a number of ministerial roles, including for Skills and Business, and as Paymaster General. From July 2016, I served at the Department of Digital, Culture, Media and Sport (DCMS) as Minister of State for Digital. In January 2018, I was appointed Secretary of State for DCMS. In July 2018, I was appointed as Secretary of State for Health and Social Care ("the Health Secretary" or "Secretary of State").

Role and Responsibilities of Health Secretary

Role generally during the pandemic

7. The pandemic created an unprecedented challenge to ordinary decision-making processes. There was no book or report to pull off a shelf to tell us how to handle a pandemic, and there was no-one alive with experience of dealing with a pandemic of this scale. The scientific advice as to what we were facing and the depth of the threat, was exemplary, but changed frequently as new information became available. The logistical requirements were without doubt the most complicated in peacetime history. The reassurances from the World Health Organization ("WHO") that we were one of the best pandemic prepared countries in the world were wrong. We had to build many parts of our response from scratch, including the response in social care.

8. Very early on, we found that instead of fighting an influenza virus, which had been the assumption underpinning the plans, we faced a coronavirus. For quite some time we did not know exactly how it could be transmitted; for example, whether the virus could live on surfaces such as the handrails in public staircases or most importantly whether asymptomatic transmission was possible. We adapted to new information and the changes in scientific advice as we went on and at all times sought as much information as possible.

9. In a crisis of the scale of the pandemic, there are inevitably a vast number of decisions taken at all levels. The approach I took in leading the Department was to set the direction in which we needed to go, based on the best available advice, and encourage and empower all involved to take decisions to the best of their ability. There were thousands of decisions to be taken every day. One of the central tasks of the Department and wider Government was to make decisions at the right level.

10. I went into the pandemic with experience of crisis management both from my time at the Bank of England and in ministerial roles for seven years. However, no one in public service had handled a crisis of this scale since the Second World War. As Health Secretary,

together with the Department's senior official team, we consistently did our very best to manage the huge number and scale of decisions we had to make.

11. I tried to lead the Department using some basic rules of thumb:

    a. Delegate authority on a principle of subsidiarity, and take accountability;

    b. Empower the team at all levels to make decisions without fear of reprisal if it goes wrong;

    c. Demand as much information as possible to make a decision, but no more than is possible;

    d. Work as a team, and protect the team from undue interference and distractions;

    e. When something goes wrong, ask not the question 'who is to blame?' but rather 'how can we fix this?'; and

    f. Concentrate on saving lives, not how it will look afterwards.

Role in relation to ASC

12. I have been asked by the Inquiry regarding my role in respect of operational decision making in respect of ASC. I, along with other Department ministers, was responsible for decision-making on strategy, policy and implementation in the Department. I would receive submissions outlining issues, accompanied by information and recommendations, and I would act on these recommendations. These submissions were usually addressed to both myself and Helen Whately, Minister of State for Care and Mental Health ("MSC"), amongst others.

13. However, social care is delivered largely by private care homes, contracted by local authorities, whose budgets are set locally and with the Department responsible for local government, and so the Department for Health and Social Care in fact has nominal national policy responsibility across England but very few levers in this area. From the start of the pandemic, we were clear that social care settings were as important a consideration as the NHS, and took action on this basis, notwithstanding the complex governance structures.

14. Responsibility for ASC is divided between the Department, the Ministry of Housing, Communities and Local Government ("MHCLG"), and local authorities. In short, the Department is responsible for setting national policy and the legal framework. MHCLG oversees local government funding and the financial framework. Local Authorities are

responsible for contracting and provision of care. Therefore, the Department did not have any direct levers over ASC, through funding, contractual arrangements, data collection, or operational accountability arrangements. I understand that the Department has prepared a corporate statement which explains these relationships in greater detail.

15. Local authorities are responsible for planning and securing adult social care services, and they do this largely through an outsourced market of approximately 18,000 provider organisations. Section 78 of the Care Act 2014, requires local authorities to act under the general guidance of the Secretary of State in carrying out their functions. In this respect, the Department is responsible for the statutory framework for adult social care and sets policy to guide local authorities in discharging their duties.

16. I have been asked to address Paragraph 18 of Schedule 12 of the Coronavirus Act 2020. This provision provided that the Secretary of State could issue guidance about how local authorities were to exercise their functions. It further required local authorities to have regard to, and comply with, any guidance issued under this paragraph.

17. In brief, the CQC is an arms-length body of the Department and works together with the Department to deliver its strategic objectives. The CQC is the independent regulator of health and social care in England, responsible for registering health and adult social care providers, monitoring, inspecting and rating their services on whether they are safe, effective, caring, responsive and well-led, and has legal powers to take action where it identifies poor care.

18. The CQC regulates organisations through a system of registration and inspection, ensuring the quality of adult social care providers. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Care Quality Commission (Registration) Regulations 2009 set out offences and the CQC's powers to prosecute, including cancelling registrations and the fixed penalties and fines payable. Introduced in 2022, as part of the Health and Social Care Act 2022, new duties were introduced for the CQC to assess the performance of local authorities in carrying out their "regulated care functions" under Part 1 of the Care Act 2014. This includes if residents have been able to take part in visits in and/or out of the care home, also the visiting options currently being supported.

Working relationships in respect of ASC

19. I have been asked by the Inquiry to outline my working relationship with the following individuals, bodies and organisations with respect to the Care Sector during the relevant period:

The Minister of State for Care and Mental Health;

20. Helen Whately was the Minister of State for Care and Mental Health during my time as Secretary of State. The Minister of State for Care's responsibilities include adult social care, hospital discharge and end of life and palliative care. We worked closely together to oversee the introduction of policies and guidance concerning the adult social care sector during the pandemic. We had a shared objective of ensuring that these vulnerable members of our society were protected from the high risks Covid-19 posed to them.

21. Helen took on the role of day to day management of the Department's response to the particular challenges the pandemic posed for adult social care. This included liaising with stakeholders inside and outside of government, including service users and their families, organisations representing service users, and care providers.

22. Helen was a highly effective Junior Minister and I had complete confidence in her ability to make considered and effective decisions in respect of adult social care.

23. In accordance with the principle of delegation described above, given the range of issues the Department was confronting at any one time in the pandemic, ranging from test and trace, to procurement, to vaccinations, to non-Covid-19 related health concerns, it was important that a minister was looking at all of these issues from a 'social care' perspective. By myself, I did not have the capacity to do so. Helen was able to give social care specific energy and focus and I am immensely grateful for her tenacity and support.

The Secretary of State for Housing, Communities and Local Government;

24. Robert Jenrick was the Secretary of State for Housing, Communities and Local Government during my time as Secretary of State. We had a good working relationship and collaborated closely, particularly on the shielding programme and in respect of ASC.

Chief Medical Officer for England ("CMO");

25. Throughout the pandemic, I worked closely with and was guided by the science as presented to me by the CMO. The CMO and I worked in close proximity to one another and

I would often seek his advice and guidance, both formally and informally. His advice extended to issues facing adult social care.

Chief Nursing Officer for England ("CNO");

26. Dame Ruth May was the CNO from January 2019 to July 2024. I engaged with Dame Ruth during the pandemic.

27. For example, on 28 March 2020 I consulted Dame Ruth in relation to guidance relating to PPE and how this affected staff doing home visits as she was leading on this area.

Chief Social Work Officer for England ("CSWO");

28. The CSWO provides expert advice to Ministers and senior officials on social work and also more broadly on adult social care. The CSWO had a direct working relationship with Helen Whately.

Public Health England ("PHE" now "UKHSA");

29. From 2013 to 2021, PHE was an executive agency of the Department. PHE was a distinct delivery organisation with operational autonomy that existed to protect and improve the nation's health and wellbeing, reduce inequalities and prepare for public health emergencies. On 1 April 2021, UKHSA was established as a new executive agency of the Department, with the majority of PHE's responsibilities moved across on this date. However, it became operational from 1 October 2021.

Sir Simon Stevens (Chief Executive Officers of NHS England);

30. I worked with Sir Simon Stevens on several policies concerning the care sector. One such policy – which I will discuss later – was the discharge policy. As mentioned at paragraph 270 of my second statement, Sir Simon Stevens stressed the importance of maximising bed capacity in hospitals. This would entail postponing non-urgent operations and discharging elderly patients who did not need urgent treatment either to care homes or their home.

The Association of Directors of Adult Social Services ("ADASS");

31. Sir David Pearson, former President of ADASS, was recruited into the Department as part of its pandemic response from Spring 2020 and was present on calls which I attended.

32. I met with the ADASS and Helen Whately on 23 March 2021 (**MH10/1 - INQ000609970**). I spoke to the ADASS Spring Conference on 30 April 2021.

33. I understand that ADASS had regular contact with departmental officials and Helen Whately. The Vice-President of ADASS co-chaired the National Adult Social Care Covid-19 Group with the Department's Director General of Adult Social Care. Their engagement will undoubtedly have informed advice I received from Helen Whately and officials.

The Local Government Association ("LGA");

34. I understand that the Department worked with the Local Government Association (LGA) during the pandemic and shared draft versions of guidance documents with them. I had a good relationship with James Jamieson, the Chair of the LGA. For example, I had a call with James Jamieson and Councillor Ian Hudspeth, Chairperson of the LGA Community and Wellbeing Board on 25 March 2020 (**MH10/2 - INQ000609942**). In my role I would have regular catchups with James and Ian. Ian had further engagement with James Jamieson in March 2021 to discuss ASC reform, the Health and Care Bill, and vaccine uptake in the ASC workforce (**MH10/3 - INQ000609972**; **MH10/4 - INQ000609971**). We met again in April 2021, when among other issues, we discussed the vaccine programme and test and trace (**MH10/5 - INQ000609974**). I attended an LGA Councillors' Forum in March 2021 (**MH10/6 - INQ000609969**).

Professional bodies representing the interests of care workers; care providers and those receiving care;

35. I understand that the Department engaged extensively with these bodies, both at an official level and through the Minister of State for Care.

Ministers of the devolved administrations responsible for ASC matters;

36. I had extensive engagement with my colleagues in the Devolved Administrations. In particular, I attended six meetings of the UK Health Ministers Forum which specifically considered adult social care or closely related issues (**MH10/7 - INQ000279764; MH10/8 - INQ000279799; MH10/9 - INQ000279807; MH10/10 - INQ000279817; MH10/11 - INQ000279818; MH10/12 - INQ000279822**).

Relationships with other Government departments;

37. The Inquiry has asked me to outline the extent to which decisions taken by myself or the Department were constrained by or contingent upon other Cabinet ministers or government departments, such as HM Treasury (HMT), the Ministry of Housing, Communities and Local Government (MHCLG), the Cabinet Office or the Prime Minister's Office. I have been asked to provide details of any instances where this hindered or delayed the response to the pandemic. Within cabinet government there are always limitations on the actions that one Department can take, and given the governance of social care this is especially pertinent to Module 6, but each department worked closely together on these issues, and in particular work between DHSC and MHCLG was very effective.

38. I do not recall any instances of inappropriate political interference. No.10 took a strong interest in issues affecting ASC, and sometimes, for example, Sir Simon Stevens would go direct to No.10 to try to achieve a particular policy objective, but this was entirely appropriate and normal.

39. Some constraints were created by the fact that ASC providers are accountable to local authorities and local taxpayers, and so the Department began the pandemic with no effective policy controls or levers on ASC. The Department had very little data on social care, and so very little visibility of how many care homes were in operation across the country – each council had a separate list. I was told that no-one, including the CQC, knew how many care homes were in operation across the country. Across Government, MHCLG, through its responsibilities for local government finance, had some effective policy levers when extra money was allocated to support social care, which were important to improve the data reporting from care homes over the course of the pandemic.

40. The Inquiry has asked me to provide a list of all the formal decision-making committees groups, forums or meetings dealing within the UK Government's response to the impact of Covid-19 on the care sector and to provide a brief explanation of my understanding of the establishment, role and function of each. The Department will be better placed to answer this question.

41. The Department engaged extensively with care sector impact groups, particularly on the development of guidance. For example, I was informed that the April 2020 social care action plan would be updated to incorporate feedback from stakeholders (**MH10/13 -**

INQ000609945). I was sometimes directly involved in this exercise, other times engagement was led by Helen Whatley or officials.

42. I have been asked about my involvement with expert advisory groups and bodies in relation to the response to the care sector to the pandemic. Advice from PHE, SAGE, NERVTAG, and the JCVI, informed the entire approach taken to the ASC response, particularly in respect of our approach to testing, vaccine deployment (i.e. prioritisation of care home residents and staff), and staff movement.

43. I have been asked about the use of international comparators. I was concerned to draw on international best practice throughout the pandemic. We were particularly concerned early on in the pandemic about the experience in Spain in relation to care homes, where the army found residents in some care homes abandoned and deceased (**MH10/14 - INQ000609975**). We knew we could not accept a similar break down in the social care system in the UK.

44. For example, in April 2020 I specifically asked for advice on how different countries were dealing with the impact of the pandemic on ASC to inform our response (**MH10/15 - INQ000609943**).

Equalities

45. I have been asked to provide an explanation of how, throughout the relevant period, I considered the impact of my decisions upon people with physical disabilities; learning disabilities; Alzheimer's disease / dementia; pre-existing health conditions; those at increased risk of harm or deterioration from social isolation, changes to support structures and lack of contact; those from ethnic minority backgrounds; those from lower socio-economic backgrounds; and/or groups with existing health or care inequalities. I have also been asked whether I considered the results of any impact assessments or equality impact assessments carried out during the relevant period.

46. Considering the effect of policy decisions on the vulnerable was at the heart of the Government's strategy during the pandemic, and this also of course applied to decisions affecting the care sector. All of these groups were considered during the course of my decision-making. Many of the decisions we made were made with their protection in mind. I received expert advice from world-leading clinicians, including the CMO, on how to reduce the unequal impact of the pandemic. I also received impact assessments and equality

impact assessments from Departmental officials. This advice reinforced my decision to try and limit the spread of the virus, improve resilience in the care sector and find a vaccine as quickly as possible.

47. For example, I wanted SAGE's advice identifying risk factors for the outcome of contracting Covid-19 from April 2020 to be published so that those who were at risk of particularly acute effects of a Covid-19 infection were aware of this and could take precautions accordingly.

48. Another example is that I had received an update from the CMO prior to the circulation of the minutes of the 16 April SAGE meeting where it had been identified that black people had a higher risk of being admitted to hospital and of dying, and that a disproportionate number of BAME healthcare workers were dying **(MH10/16 - INQ000075780**). I was worried by this data, and recall discussing it with the CMO.

49. Upon my request, the CMO commissioned PHE to report on disparities in outcomes and risks from COVID-19. On 30 April 2024, I asked my special adviser to share these concerns with the media so that the public would be aware that we were taking action to look at and try to understand the basis of these potential risk factors **(MH10/17 - INQ000478888**; **MH10/18- INQ000478889).** On 12 May 2020, PHE provided a rapid interim review on the current data already available on ethnicity and health outcomes and the CMO sent me a note on the same **(MH10/19 - INQ000233807; MH10/20 - INQ000233808; MH10/21 - INQ000069220; MH10/22 - INQ000069223; MH10/23 - INQ000069218).** I also read Ben Goldacre's excellent work on these matters, which analysed the disproportionate instances of Covid-19, and highlighted the differential risks faced by different people according to their characteristics.

50. The Department will have copies of equality impact assessments prepared by civil servants and provided to me as part of the usual process of providing advice to Ministers on policy issues.

Initial response to the pandemic

51. There was very little data on the sector's preparedness for a pandemic. From January 2020 we considered that care home residents were some of the most vulnerable to the virus, because of the frailty of many residents, and the strong correlation between age and morbidity of the novel disease. Despite the Department not being directly responsible for

the provision of social care, we understood from the earliest part of the response the need to protect those in care homes and acted accordingly.

52. Pandemic contingency plans were prepared by local authorities. A note from a meeting of officials on 11 February 2020 records that I had indicated the primary responsibility for planning ASC's response to the pandemic was for local authorities, ahead of the publication of a Coronavirus plan. This was in line with our strategy for responding to a pandemic flu (**MH10/24 – INQ000049363**). I was sent the note of this meeting to review (**MH10/25 - INQ000609932**).

53. On 3 March 2020 I raised with Helen Whately that there were lots of questions about how social care would cope with Covid-19. I asked her if she was on it, and she confirmed she was chasing it, but there was a growing nervousness about the capacity of the system to cope. She had only been provided with two existing pandemic contingency plans in the sector: Hertfordshire and Essex, and her opinion was that those were inadequate. I now understand that these plans were LRF plans, shared with her by the Chief Social Worker on or around 3 March 2020 (**MH10/26 – INQ000233756**). The Essex document apparently stated that providers were required by the Care Quality Commission to have plans in place to provide safe care in the event of a pandemic and that during a flu pandemic, directors of adult social services would need to know the effectiveness of providers' plans, emerging risks and capacity to meet demand. The plans were subsequently shared with my Private Secretary on 4 March (**MH10/27 - INQ000327771; MH10/28 - INQ000233758**). I asked Helen to put some serious drive into getting the plans to a credible position and explained that the CMO had told me there was guidance for social care being developed. I noted it seemed to me like we needed to do a lot of work in this area (**MH10/29 - INQ000327767**). I was further concerned by an email I received on 5 March 2020, from a social care charity, raising concerns about preparation for Covid-19. Helen asked that this be forwarded to Departmental officials for advice (**MH10/30 - INQ000609933**).

54. I understand that Helen subsequently agreed a process for reviewing local authority plans with MHCLG and ex-Directors of Adult Social Care.

55. On 6 March 2020 I attended a meeting on 'Coronavirus + Social care' with Helen, the Permanent Secretary, Deputy Chief Medical Officers ("DCMOs"), and Departmental Officials. In this meeting, I referred to the higher risks for older people in the adult social care sector, and that this needed to be gripped as soon as possible.

56. I have been asked to outline the steps I took to address the above identified concerns. During the meeting on the 6 March 2020, I identified areas where work had to be done to address this risk, including: Workforce; financial support; data; support for non-Covid-19 illnesses; provisions of PPE and other medical supplies, including oxygen; Local Resilience Forum (LRF) readiness; collaboration with providers; communications; and the drafting of the Coronavirus Bill which would allow us to deliver measures with urgency and address the unique needs of the pandemic (**MH10/31 - INQ000049530**).

57. The Department began working on these areas to ensure preparedness around social care. For instance, in the days that followed, there were discussions between PHE and the Department regarding guidance for care homes on isolation, testing, supply of PPE and financial support (**MH10/32 - INQ000325229; MH10/33 - INQ000325228**).

58. A follow-up meeting was held on 11 March 2020 (**MH10/34 - INQ000609936**). Officials advised that three pieces of guidance had been drafted and were being tested with the sector. There was a discussion about home care. Officials flagged that a number of care providers would not be in contact with local authorities; I agreed with Helen Whately that we should use the CQC to reach these providers. I agreed with the suggestion of a discharge to assess option.

59. A civil servant noted that providers were feeling panicky, and that there would be calls with all provider organisations. I asked that guidance was published by 13 March 2020, that Friday.

60. A further meeting took place on 18 March 2020 (**MH10/35 - INQ000609941**). The note of that meeting records my concern that all procedures we put in place worked for the immediate crisis but encouraged integration of health and social care in the longer term. There was a roundtable with the Prime Minister that day to discuss Local Government's role in supporting Adult Social Care (**MH10/36 - INQ000609955**).

61. I continued to attend weekly meetings with departmental officials about ASC. Occasionally those meetings were chaired by Helen Whately.

Asymptomatic Transmission

62. I have been asked to provide an outline of how the clinical advice on the risk or prevalence of asymptomatic transmission evolved from January 2020 until the end of May 2020, and how this thinking on asymptomatic transmission informed the management of the pandemic

in the care sector. As the CMO makes clear at paragraph 5.21 of his fourth witness statement, it was a gradual process of accumulation of evidence that led to asymptomatic transmission being considered a major part of the force of transmission of the virus.

63. From January 2020 I was concerned about the extra risks that would be posed by asymptomatic transmission. On 26 January I read a report from China of the possibility of asymptomatic transmission, which I found particularly worrying (**MH10/37 - INQ000183872**). The case definition (a clinical statement of the best known understanding of the virus and the disease it caused) included an assumption of no asymptomatic transmission. I asked officials for advice on this for the next day's meeting.

64. At that meeting on 27 January 2020 (**MH10/38 - INQ000106067**), we discussed how there had been an update from the Chinese government that the virus is transmissible when patients are asymptomatic. The information we had received was limited. However, I outlined the need to plan for a reasonable worst case scenario assumption of asymptomatic transmission. The CMO considered that it was unlikely that the virus would transmit when patients were asymptomatic and there was still a lack of clarity over what the Chinese government's position was. I asked the Department to gain clarification from China on whether asymptomatic transmission was occurring and to plan accordingly (**MH10/39 - INQ000478852**).

65. At this stage PHE was adamant that a coronavirus could not be passed on asymptomatically and that tests did not work on people without symptoms. I wanted to use the meeting to push them on both of those critical points and to leave them in no doubt that we needed to expand testing.

66. Further on 27 January 2020, Germany confirmed its first case of the virus with a patient who reported feeling ill on 23 January and seemed to have caught it from her parents who had been to Wuhan and tested positive even though they showed no symptoms. I spoke to Jens Spahn, my opposite number in Germany, who I trusted. He told me that the evidence of asymptomatic transmission was tentative but that the German authorities were worried and keeping a close eye on it.

67. At a meeting on 28 January 2020, I was told that a paper on asymptomatic transmission was being prepared and would be provided to me later that day.

68. On 29 January 2020, following PMQs, the CMO asked to see me, and proposed four elements for our response to the virus: first, we try to contain isolated outbreaks, then we try to delay the spread. If containment is unsuccessful and the virus spreads to the general population, we move on to mitigating and slowing its effects; and throughout we research for treatments and a vaccine. Once again I pushed PHE about asymptomatic transmission; the paper I had been provided with said almost nothing and did not even contain a provisional finding. I could not understand why it was taking so long to get an answer on this issue, not just in the UK but around the world. I called Tedros Ghebreyesus again to have another go at persuading him to declare a PHEIC (**MH10/40 - INQ000107070**) my sense was that he was terrified of upsetting Beijing. I asked him about unofficial reports from China that there was asymptomatic transmission and he played it down, said that it was a translation error, and claimed to be impressed by the Chinese authorities' transparency. I found this response surprising.

69. Despite these discussions, the global scientific consensus remained that there was no proof of asymptomatic transmission, and that policy should be based on this assumption.

70. The initial consensus that the virus could not transmit asymptomatically underpinned many decisions, including for example, the Department's initial advice on the management of the virus in care homes. The initial, very clear, scientific advice was not to test those without symptoms. I was told categorically by PHE that the tests would not work effectively on people without symptoms, and that to test someone without symptoms would risk a false negative, i.e. someone incubating the virus could be given a negative test result (**MH10/41 – INQ000047556; MH10/42 - INQ000151362; MH10/43 - INQ000057492; MH10/44 – INQ000074909)**. I was advised that this would be even more dangerous than not being tested, as it would give a false assurance. Instead, we initially required care homes to isolate residents going into care homes. This was consistent with the then scientific advice on testing and asymptomatic transmission, and went further than the WHO advice, which said that care homes should be expected to admit Covid-19 positive patients but subject to isolation for 10 days.

71. Given the shortage of tests at that time, we published updated advice for care homes. We knew how deadly the virus was, especially to older people, and worried a huge amount about the best way to protect them. That guidance stressed the need to isolate residents going into care homes. NHS England ("NHSE") insisted that people had to leave hospital if medically fit, because the dangers of infecting people in hospital were if anything greater

than in care homes, as isolation is even harder, as well as the need for hospital capacity to save lives of those suffering from the virus. I accepted their advice on this point.

72. On 2 April 2020, the WHO restated their position that there had been no documented asymptomatic transmission of Covid-19 (**MH10/45 - INQ000074894**). The failure of the global scientific community to accept the likelihood of asymptomatic transmission was a source of great frustration to me. That scientific consensus determined the "case definition", which I could not overrule. I was briefed on why they held this view: because no previous coronavirus exhibited asymptomatic transmission, and because the evidence for it was anecdotal not clinically validated, the scientists concluded that the existing view had not been disproved. Although our guidance documents at the time cautioned that further work was required to understand whether asymptomatic transmission was possible (rather than positively stating that it did not occur), with hindsight I should have insisted on the likelihood and dangers of asymptomatic transmission, despite the formal scientific position. However, the formal case definition of Covid-19 excluded asymptomatic transmission, and all the advice to me from PHE, based on the WHO's global advice, was based on this assumption.

73. Asymptomatic transmission is a prime example of a concept that could not yet be formally determined (as the scientific view was constantly adopting, developing and changing to reflect the emerging evidence), but where precautionary measures should have been taken until the science could demonstrate that this was no longer a risk: in my view we should have assumed, until proven wrong, that these types of risks existed, and should have taken measures to reflect that assumption, rather than waiting for "evidence", which was inevitably going to be delayed in the context of a novel emerging virus.

74. I have reflected on why I did not over-rule this advice, and insist on a reasonable-worst case assumption. The reason is that I felt that on such a scientific question, I could not have carried the system with me. Obviously with hindsight I should have tried to do so.

75. Following CDC's announcement on 3 April 2020 that asymptomatic transmission was likely to be occurring, I immediately contacted the CMO, and asked him to update his advice in light of the new information. I had been very concerned about asymptomatic transmission since January, and finally had credible scientific evidence to back up my concerns. PHE also began their own study which supported the American evidence. That was presented to NERVTAG on 24 April 2020 and further evidence was presented to SAGE on 12 May

2020 and informed Covid-19 response plans. But even before this advice was given to ministers, we had taken the decision to act on the assumption of asymptomatic transmission given the CDC evidence.

76. On 14 April 2020 I received updated advice from Sir Chris Whitty that he was now recommending testing asymptomatic people going to care homes from hospital, which I regarded as a very significant step forward (**MH10/46 - INQ000093326; MH10/47 - INQ000292604; MH10/48 - INQ000292605**).

77. On 15 April 2020 we had succeeded in driving testing up to 38,766 per day, and we were able to announce that all patients being discharged from hospitals into care homes should be tested. When the CMO updated his scientific advice to advise that asymptomatic testing was possible and changed the case definition to assume the possibility of asymptomatic transmission, we immediately acted to implement this new scientific advice. At first, we still did not have enough tests to test everyone, and the clinical advice on test prioritisation remained to test those with symptoms in hospital.

78. On 23 April 2020, I received a ministerial submission which recommended that where an outbreak had been recorded within 14 days, the testing of asymptomatic staff and residents in care homes was to be prioritised. It was estimated that this would result in 60,000 tests being carried out across 2000 care homes in the following 10 days (**MH10/49 - INQ000327855; MH10/50 - INQ000325273**). On 24 April 2020 I agreed with these recommendations (**MH10/51 - INQ000327859**).

79. On 26 April 2020, I received a written update from officials on asymptomatic swab testing. That paper noted (**MH10/52 - INQ000478887**):

> *"PHE has confirmed there is no barrier to testing symptomatic people in any setting or to including asymptomatic people where clinically appropriate. In the first instance, this will include: expanding testing to all hospital admissions to help guide improved infection control; testing more people in care homes when outbreaks occur, whether they are symptomatic or not; as well as staff in care environments to understand the prevalence of asymptomatic disease and develop protocols to minimise the number of staff in these environments who are potentially asymptomatically infectious."*

80. On 26 April 2020, I emailed Helen Whately to confirm that ministers had reviewed the advice and were content to agree to the recommendations in the submission as follows (**MH10/53 - 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 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 online.

81. By 28 April, due to the Department's rapid expansion of testing capacity, we were able to extend testing to all asymptomatic care home staff and residents.

Key decisions

Discharge policy

82. I have been asked to provide details of my involvement in guidance or policy on the issue of the discharge of patients to residential and nursing homes without testing in the early stages of the pandemic ('the discharge policy') and my understanding of why the policy was adopted.

83. By way of background, during January it was clear that the novel pathogen presented a potential risk that might require significant NHS capacity. This risk became more likely to materialise during February, as the likelihood of a global pandemic grew. At first the reasonable worst case scenario assumptions were based on a pandemic flu. The advice assumed that in a reasonable worst case scenario, significant numbers of NHS staff would be ill, so physical capacity would not be a limitation. This was incorrect, and I reached the conclusion that it was possible to expand NHS capacity in March 2020.

84. In terms of chronology, as I explained in my second witness statement, on 2 March 2020, I was briefed that SAGE had updated the reasonable worst-case scenario with the latest international data and reduced the maximum number of deaths from 820,000 to a still horrific 520,000 out of 53.5 million people showing symptoms. Around 390,000 of those might be in critical care with such bad breathing problems that they need ventilators. These figures were only stopped because of the imposition of lockdown, but we had no idea how quickly lockdown would get the numbers down, or indeed if lockdown measures would ever get R below 1.

85. On 4 March 2020, NHS England declared Covid-19 their highest grade of emergency, a Level 4 alert. This meant that Sir Simon Stevens took command of all health service resources in England. Sir Simon discussed this decision with me in advance and I was happy with it. Guidance for hospitals told them to assume they would need to look after Covid-19 cases in due course. In addition, a rule was introduced that everyone in intensive care with a respiratory infection must be tested for Covid-19. It was understood that there would be too many patients to treat on specialist Covid-19 units, so the Department had said that people could be cared for in wider infectious disease wards. At this point SAGE had advised that we were around 4 weeks behind Italy on the epidemic curve. Italy indicated that they would close all schools and universities, while Germany declared an epidemic and shifted from containment to mitigation.

86. On 4 March 2020 I had further meetings with the PM and officials to discuss the way forward and the latest data from SAGE; I had been clear the day before that we needed to dramatically increase testing capacity and protect vulnerable people, which we discussed (**MH10/54 - INQ000049513; MH10/55 - INQ000087585; MH10/56 - INQ000049516**). The Inquiry has asked who was present at the meeting where (**MH10/57 - INQ000087584**), a SAGE paper, was discussed. My Private Secretary's note records the meeting's attendees: Clara Swinson; Keith Willett; Emma Reed; Yvonne Doyle; the Minister of State for Health, the Parliamentary Under Secretary of State for Prevention, Public Health and Primary Care; Jonathan Van Tam; Lord Bethell; Hadley Beeman; Paul Cosford; Emma Dean; Allan Nixon; David Lamberti; Max Blain; Wendy Fielder; Morwenna Carrington; Callum McCarthy; Hannah Butcher; Dan Moore; **Name Redacted** David Halpern and I were present. The discussion of the SAGE paper was led by Professor Sir Jonathan Van Tam, see (**MH10/58 - INQ000049512**).

87. On 9 March 2020 I received a briefing about NHS bed demand and reasonable worst case scenario modelling (**MH10/59 - INQ000146571)**.

88. On 11 March 2020, I attended a social care meeting with Helen Whately, DCMOs, and other DHSC officials. At this meeting, I raised a concern I had about whether providers would pay staff if they were ill and asked to self-isolate to prevent staff with milder conditions going to work with older people, considering their vulnerability. Helen Whately suggested using the CQC as a mechanism to address this. In this regard, another matter that was discussed was the situation of those on zero hour working contracts - a solution would need to be found for those on zero hour contacts and whether they could be paid Statutory Sick Pay. My view was that we needed to work with HMT to resolve this issue and to ensure the highest level of protection for the most vulnerable members of our society.

89. At this meeting, I also stressed the importance of social care guidance being published by 13 March 2020 (**MH10/60 - INQ000328131**). Accordingly, on 13 March 2020, Guidance commissioned by the Department on care homes was published: 'COVID- 19: Residential care, supported living and home care guidance' (**MH10/61 - INQ000325236; MH10/62 - INQ000325233; MH10/63 - INQ000325234; MH10/64 - INQ000325235**). This guidance was geared towards supporting planning and preparation in the event of an outbreak or widespread transmission of Covid-19.

90. Early on 12 March the CMO called me to say that the country needed to raise the risk level from moderate to high. He also indicated that he thought the Government should move from the contain' phase to `delay'. I understood that he had come to these conclusions after discussions with his Scottish, Welsh and Northern Irish counterparts and they were all in agreement. The plan was to announce it at a press conference. The CMO was very straight with me and my team about what this meant: he explained that everyone was going to get infected and that the question was whether that happened before or after the vaccine had been developed. The decision to move to the delay phase was recorded in a protocol document (**MH10/65 - INQ000049539**) and announced by the PM at the press conference that evening.

91. At the same time, I was advised by PHE that they should stop all contact tracing. They advised that the growth in tests and contact tracers could never rise exponentially and that there was then so much spread that contact tracing would not be worth the effort. Their estimates of how many people would be needed to do the job were all based on carrying

on exactly as before, which I found infuriating, as it was clear that a large-scale contact tracing operation would have to operate differently, in a mechanised way.

92. After the press conference we had a debrief in the PM's study next to the Cabinet Room. We talked about the likely need for as many as 300,000 ventilators; and decided to launch a national ventilator challenge.

93. Sir Simon Stevens called to propose postponing all non-urgent operations from 15 April to free up 30,000 beds. To me this really hammered home what was coming. All those people waiting for surgery, many in pain, would now be deferred. The NHS argued that frail, elderly patients who did not need urgent treatment would need to be discharged, either to their home or to care homes.

94. I received briefing from my officials of the impact of this policy based on NHS modelling (**MH10/66 - INQ000109139**). The briefing explained "*NHSEI's bed modelling suggests a shortfall of up to 800,000 beds if there were no mitigating actions. In the 'best case' there are 100k beds required. This is the maximum number of beds available at acute hospitals, but NHS estimate only 30k beds available to be freed up, implying 70k taken up by non-elective care that can't be stopped.*"

95. Over the next twenty-four hours, from the evening of 12 to evening of 13 March, I visited Edinburgh, Belfast and Cardiff to build relationships with the three devolved Health Ministers and establish as effective co-ordinated working as possible.

96. On the afternoon of the 13 March, I joined the G7 Ministers call, which was very alarming. Counterparts in other countries were extremely worried, and several, including Roberto Speranza in Italy, detailed the very extensive actions they had taken to slow the spread. Later the CMO talked me through SAGE's latest discussions, which significantly strengthened the case for immediate action. The committee thought that there were far more cases in the UK than previously believed, that we were now just two weeks behind Italy on the epidemiological curve, and that household isolation and shielding of the elderly should come in sooner rather than later, even though there were trade-offs including the effect on peoples' mental health. SAGE now thought that far heavier measures may be needed to make sure case numbers stay within NHS capacity and they were examining options. I spoke to the Prime Minister and reinforced my view that we needed to lock down immediately.

97. I am aware that on 13 March, Helen Whately was provided with a submission detailing the development of an Ethical Framework for Adult Social Care that had been developed by the Office of the Chief Social Worker to support ongoing response-planning in respect of Covid-19 (**MH10/67 - INQ000049614**). The framework provided a set of ethical values and principles to be considered when taking decisions or developing policies at local, regional and national levels. Minister Whately was asked to review and agree to the publication of the framework on 19 March to coincide with the introduction of the Covid-19 Emergency Bill to Parliament.

98. On 13 March 2020, Infection Prevention and Control (IPC) guidance, 'Pandemic Influenza: Guidance for Infection Prevention and Control in Healthcare Settings 2020' was also updated and tailored to the pandemic to include a section on the understanding of Covid-19 transmission characteristics (**MH10/68 - INQ000325350**).

99. On Saturday, 14 March I attended No. 10 to discuss the action that was necessary. The Chancellor, the CMO, Sir Patrick Vallance, the Prime Minister's Chief Adviser and Director of Communications, Lee Cain, were present. Sir Patrick told everyone that while we had thought we were four weeks behind Italy on the epidemic curve, it was now thought that the UK was two weeks behind, which meant there was no time to lose. We struggled at the meeting with enormous issues that no one had faced before. The data pointed to our reasonable worst-case scenario of over 500,000 deaths becoming a reality unless the Government stepped in hard and fast. There were 342 new confirmed cases, taking the total over 1,000, to 1,140. In just three days, the numbers had doubled. On 13 March, eleven more people had sadly died, taking the total to twenty-one. They had all had serious underlying health problems, but we were advised that would not be the case

100. The PM set out the case for and against each option. The CMO and Sir Patrick talked through the science. The Chancellor, the PM and I debated the options, and the Prime Minister's Chief Adviser intervened whenever he thought things were going off track, as by this stage he was strongly in favour of lockdown. Lee Cain advised on communications, which were evidently going to be extremely important. A readout was subsequently circulated (**MH10/69 - INQ000233765**).

101. The streets were empty and people were cancelling engagements, which indicated that a decision to lock down the country would be supported. Because the number of deaths, at 21, was still relatively low, many were concerned that the public might not accept

the draconian measures that were needed. But the reality of peoples' behaviour made me convinced that with the right communications about helping others, the public could be persuaded. Many people were understandably frightened. Retailers released a joint letter asking people not to buy more than they need, as panic buying continued.

102. After everyone had their say, we collectively made the decision to close large swathes of society. We did not recommend closing schools at that stage. We went over the proposals, how to do it and what would be shut, including whether this would be done regionally since we had been advised that London was ahead of the rest of the country, and gave instructions to the civil service to work up the details ahead of another meeting at 5 p.m. tomorrow to finalise matters.

103. As I left the meeting and walked back towards the famous No.10 front door, I recall phoning the PM to tell him we had made the right decision and to reassure him that this was absolutely necessary. He picked up the phone and invited me back up to his office. I went back to the smaller study next to the Cabinet Room, where I found him with the Prime Minister's Chief Adviser, Lee Cain and his private office staff. The Prime Minister's Chief Adviser had a whiteboard full of numbers flowing from cases to hospitalisations to deaths, with predictions with question marks next to them and then a chart depicting hospital capacity. These figures had been in various briefing papers over the previous few days. He was doing exactly what I had called the PM to do: hammering home the point that lockdown had to happen to protect NHS capacity and prevent it from being overwhelmed.

104. Sir Simon Stevens briefed me about hospital capacity; including the excellent idea of converting the ExCel Centre in East London into an overflow hospital. Sir Simon had put a team onto it. He explained that London hospitals were already starting to see worrying increases in Covid-19 patients so we could not act soon enough.

105. On Sunday 15 March, I woke at 5:30 and spent the morning broadcasting, to prepare the public for the action we had agreed in principle to take, and setting out the strategy. Ahead of the 5pm meeting to agree the finer details of the measures, I spoke to the CMO. We were worried that the individual measures we had discussed the morning before would not be enough, and agreed that we would try to persuade the Prime Minister to say that everyone had to stop all unnecessary social contact.

106. By the end of the meeting, we had agreed to a package of restrictions, and that the PM would ask the public to end all unnecessary social contact for the foreseeable future.

Whilst no one called it a lockdown, that is what it was. It was a relief to be taking these essential steps, but it still felt surreal and to this day I am still somewhat in disbelief that we took the steps we did. It is hard with hindsight, and having experienced two lockdowns, to recall just how radical and unprecedented a step this was. It felt utterly momentous.

107. I was provided with a submission dated 15 March following the COBR meeting on 11 March and the meeting I had attended at No.10 on 14 March which sought formal clearance of the draft Coronavirus Bill (**MH10/70 - INQ000106229**).

108. Following the meeting on 15 of March, the package of proposed announcements was put to a COBR meeting on 16 March 2020 to get formal agreement on the restrictions and to ensure that the devolved administrations were in agreement (**MH10/71 - INQ000233770**, **MH10/72 - INQ000254940; MH10/73 - INQ000056184; MH10/74 - INQ000056210**). The measures which were finally approved included: a stay at home policy; social distancing guidance; and guidance on the additional precautions that should be taken by those who were believed to be vulnerable to Covid-19. There was remarkable unanimity among those in attendance with everyone recognising that the measures had become necessary and could not be delayed. Once the package of measures had been signed off at COBR, the CMO, the Prime Minister's Chief Adviser, Lee Cain and I worked with the PM to finalise the language of the public announcement.

109. At 5pm, the Prime Minister made his televised announcement to the nation, explaining that without drastic action we would lose control of the spread of the virus, which could double in speed every five or six days (**MH10/75 - INQ000086753**). He informed the public of the gist of the new measures that we had agreed, namely: asking those with symptoms to isolate at home for 14 days; stopping non-essential social contact and all unnecessary travel, including working from home; and 12 weeks' of shielding for the most vulnerable members of society. He also explained that London was a few weeks' ahead of the country in terms of the speed of spread of Covid-19, and that it was particularly important for Londoners to follow this guidance. Crucially, he asked everyone to stop all unnecessary social contact — the broader behavioural change that was needed.

110. Immediately after that announcement, I made a statement in the House of Commons (**MH10/76 - INQ000176653**). Before setting out the package of restrictions, I explained that the virus' spread was accelerating in the UK, that 53 people had sadly died, and that the Government's action plan was designed to protect the NHS, as well as safeguarding the

most vulnerable. I was also able to provide further information that the PM's announcement had not been able to cover, namely: the planned increases in Covid-19 testing to 10,000 per day; the purchase and production of additional ventilation equipment; the emergency Coronavirus Bill which was to be brought to Parliament later that week, giving the Government the ability to take control of essential services if required; and increasing communications so that the public had the best information available to them at any given time.

111. On 16 March 2020, the Department operationalised the NSDR hotline (**MH10/77 - INQ000049616**). This meant that care homes and other providers in the care sector who needed PPE within 72 hours were able to call the hotline and access supply. This was expanded to a 24 hour service on 21 March 2020, therefore providing 24/7, round-the-clock support to those who required it most.

112. Further guidance was issued on 16 March 2020 titled 'Guidance on Social Distancing for everyone in the UK'. As the name suggests, this guidance had a broad remit. However, it advised that the provision of care within the home should continue as normal essential care.

113. On 17 March 2020 Sir Simon Stevens and Amanda Pritchard sent a letter to the NHS advising on 'Next Steps on NHS Response to Covid-19, which explained the operational aim to "*expand critical care capacity to the maximum; free up 30,000 (or more) of the English NHS's 100,000 general and acute beds… and supplement them with all available additional capacity*." I cannot now recall if I was involved in discussions about this letter before it was sent.

114. The 17 March 2020 dashboard shows how grave the situation was (**MH10/78 - INQ000055918**). The R number was estimated to be 2-3. The virus's doubling time was 4-6 days. We estimated 30-40,000 people in the UK had been infected, and there had been 74 deaths, a 35% increase overnight. Modelling showed surge critical care bed capacity being exceeded.

115. A paper I received on 17 March 2020 (**MH10/79 - INQ000609938; MH10/80 - INQ000609939**) records:

a. "Discharge all hospital inpatients who are medically fit to leave. Community health providers must take immediate full responsibility for urgent discharge of

all eligible patients identified by acute providers on a discharge list. For those needing social care, emergency legislation before Parliament this week will ensure that eligibility assessments do not delay discharge. New government funding for these discharge packages and to support the supply and resilience of out-of-hospital care more broadly is being made available."

b. "The NHS have been developing enhanced discharge guidance which aims to remove barriers to discharge and transfer between health and social care, to get people out of hospital quicker. This will include **providing free out-of-hospital care and support to anyone discharged from hospital** during the emergency period. We expect this to cost £1.2bn.

c. An update on this will be available from NHS England on 18th March 2020.

d. Funding will be provided to CCGs, which they will be encouraged to pool with local authorities by using and extending existing arrangements (such as those for the Better Care Fund). Areas will appoint a lead commissioner (either from the local authority or NHS, depending on local arrangements) to be responsible for all commissioning. Any additional spending resulting from enhanced discharge arrangements will be funded through this pot.

e. Separately, the Secretary of State for Housing, Communities and Local Government has written to the Chancellor seeking an injection of funding to local government to support pressures more generally. They have asked for a total of £1.7bn of which around £1.2bn is for Adult Social Care.

f. Our latest estimate on the value of the Adult Social Care resilience funding stands at £1.2bn. This funding is intended to support care providers (both LA-funded, and self-funders) cope with workforce absences that have placed upon them by the Government's guidance on stay at home and household isolation. It will also support councils to provide additional support to support people currently supported by unpaid carers. These are not things that good employment practices or higher wages could have avoided, and therefore represent real cost pressures for providers of adult social care.

116. On 18 March 2020, I attended a meeting with the Prime Minister to discuss discharge guidance to be published between the Government and NHS, with a package from the

Treasury to fund care costs for those discharged from hospitals and social care resilience funding through local government (**MH10/81 - INQ000609937**). The briefing provided to me prior to this meeting, records that civil servants had considered the public sector equalities duty ("PSED").

117. On 18 March 2020 I also attended a meeting in the Department to discuss social care, alongside Helen Whately (**MH10/82 - INQ000609940**). We agreed:

a. to ensure that all procedures we put in place work for the immediate crisis but encourage integration of health and social care in the longer term;

b. that the social care discharge package would be agreed at the Healthcare Committee for announcement the next day. Guidance would be drafted on the social care discharge package ahead of the announcement;

c. a discharge flow chart would be agreed by NHSE and LGA by 1.30pm that day.

d. the CQC position on suspending all routine inspections and noted constantly keeping a close eye on social care easements that may be needed;

118. On 19 March 2020 I wrote to all Chief Executives and Directors of Adults' Social Services of Local Authorities in England, explaining that the £1.6 billion of funding which would be provided to local authorities could be used to support ASC providers, including dealing with staffing pressures and enhanced infection control. The letter also explained £1.3 billion of funding was being provided to the NHS to support enhanced discharge arrangements (**MH10/83 - INQ000049705**).

119. Operational hospital discharge guidance was published on 19 March to explain the need to discharge patients swiftly and the process for doing so (**MH10/84 - INQ000049702**).

120. On 25 March 2020, the Coronavirus Act was passed with the Coronavirus restrictions coming into force (SI 2020/350) on 26 March 2020. Regulation 4 of those regulations prevented individuals from leaving their homes unless various exemptions applied. The exemptions included providing care and assistance, including personal care to someone else in another home. This allowed unpaid carers to continue to provide care.

121. On 1 April 2020 I attended a departmental meeting on NHS capacity, workforce and patient safety (**MH10/85 - INQ000609934**). The Department was acutely aware of the risk

of decreased governance and system oversight, and surveillance of care quality, and given assurance of countermeasures put in place to address the need to increase front-line capacity while maintaining safety and standards.

122. The Department constantly updated its advice to hospitals and care homes on this issue (and other connected issues) based on the scientific advice that we received at the time. In summary, the guidance in relation to discharging patients to care homes was:

a. Operational hospital discharge guidance was published on 19 March (**MH10/84 - INQ000049702)**;

b. To try and assist care providers, we decided to provide specific guidance on the issue of accepting residents discharged from hospital and published updated care home admission advice on 2 April 2020 (**MH10/86 - INQ000325255**). This followed a review and comments from Helen and the DCMO (**MH10/87 - INQ000609944**). I am not aware of what work was undertaken to assess whether residential and nursing homes would be able to isolate residents; and what steps were taken to ensure that isolation procedures could be followed by either residential and nursing homes or local authorities but trusted the experts drafting this advice.

c. On 6 April 2020, following an increase in the sourcing of PPE, the Department was able to deliver PPE free to approximately 58,000 care providers (which included care homes but also extended to other organisations including hospices and community care organisations);

d. On 9 April 2020 PHE published guidance for stepdown of infection control precautions within hospitals and discharging Covid-19 patients from hospital to home settings (**MH10/88 - INQ000106344**). I am not aware that I had any involvement with this guidance;

e. On 15 April the Department published the adult social care Action Plan (**MH10/89 - INQ000233794**), which detailed advice on how to minimise the risks and transmission of Covid-19 in care settings, along with the support that central and local Government would and could provide to care providers, including in the event of outbreaks of Covid-19. In part thanks to the 100,000 target, we were able to announce in the action plan that all hospital patients would be tested for Covid-

19 prior to admission to a care home. This had the dual benefit of freeing up hospital capacity, while also giving care providers the risk mitigation that they understandably wanted and needed. Importantly, our action plan still advised that those discharged into care with a negative test be isolated for 14 days to guard against the risk of a long incubation period and false negatives. In addition, the action plan announced that there was now sufficient capacity for all social care workers who needed a Covid-19 test to access one; and

f. As of 28 April, testing capacity had been built up sufficiently to enable all residents and staff (including those that were asymptomatic) to be tested.

123. Prior to publication of the Action Plan, we had planned for patients to be quarantined within NHS settings before they were discharged to care homes.

124. On 13 April 2020 I messaged Helen Whately and asked her if we had agreed a discharge policy with NHSE. She explained the NHS wouldn't keep patients in an NHS setting if they were fit for discharge, but we couldn't force care homes to take patients who were an infection risk. While some care homes had an isolation or covid positive zone, if not we would advise local authorities to secure appropriate alternative arrangements. I replied that this sounded messy, and asked why the NHS wouldn't keep them. I asked Helen to write her preferred language into the document, taking into account genuine NHS concerns, and we would take that forward. **(MH10/90 - INQ000609946)**

125. At a meeting with the Prime Minister on 14 April 2020, Sir Simon Stevens was insistent that patients not be quarantined in hospitals before they were discharged to other settings (**MH10/91 - INQ000050029**).

126. In the meantime, as discussed above, on 14 April 2020 I received updated advice from Sir Chris Whitty that he was now recommending testing asymptomatic people going to care homes from hospital. I requested that an instruction would be issued to hospitals to carry out tests prior to discharge to a care home from 16 April 2020 **(MH10/92 - INQ000292609)**.

127. This meant that in the social care action plan we were able to confirm that those who were discharged from hospital into a care home would have been tested, but where tests were negative we would still recommend isolation for 14 days. Where people were discharged who had tested positive, we explained that some care providers would be able to provide isolation of cohorted care, but if that was not possible the local authority would

be asked to secure alternative appropriate accommodation and care for the remainder of the required isolation period, using the funding we have provided to support enhanced discharge (**MH10/89 - INQ000233794**).

128. I have been asked by the Inquiry whether I was aware of any concerns regarding the discharge policy and the extent to which the issues raised were considered.

129. A widespread concern was that patients who were being discharged from hospital were the main source of infection in care homes. I understand why many held this view, however we now know that this was not the case. We learned in the summer of 2020 that staff movement between care homes was the main source of transmission. As I will later discuss, we acted on this and asked for urgent work to be undertaken to restrict such movements.

130. Further concerns were raised about the discharge policy by care home operators. Some were reluctant to accept patients who had been discharged from wards even if they had tested negative as they were worried about being sued. To counter this, we worked on an indemnity scheme, which Helen led on.

131. I have been asked to set out any attempts I made to understand the impact of the discharge policy on Covid-19 infection rates, recipients of care, and the impact on residential and nursing homes, including residents and staff. We made extensive efforts to understand the impact of the discharge policy on rates of infection, deaths, and capacity, as well as the impacts on residents and staff. This was done both through efforts to improve the data we were receiving about what was going on in care homes, and contacts with the sector and representatives of families, residents and staff, which Helen led. We had to assess these risks alongside the risks of patients staying in hospital. There were no good options.

132. I have been asked to outline any reflections I have on the appropriateness of the discharge policy and whether any alternative approaches could have been adopted. Having considered all the facts now available, and reflected in some detail on this decision, I believe that all the other options available at the time were worse. Had we left these vulnerable people in hospital, infections inside hospitals would have been much higher and more people would have died from the virus. Infections in care homes would have been almost exactly as high, as research has found that the vast majority of infections came into care homes from the community, not from new residents. Tests were not available in large

enough numbers to test everyone going into a care home, and if tests had been redirected from their use within hospitals, more people would have died.

133. Even with the advantage of hindsight, having thought long and hard about this decision, and listened to all of the discussion on this very sensitive and important decision, I have not been able to identify a credible alternative that would have led to fewer infections and deaths. Even had asymptomatic transmission been assumed, any option at this point had to contend with three points of fact that made the situation extremely difficult:

a) There were not enough tests, and tests of ill people in hospital saved more lives;

b) Tests on asymptomatic patients, plus the 4-day turnaround time of tests, would have given false negatives; and

c) Isolation facilities in care homes were not as good as needed.

134. It is my honest view that given the nature of the virus and what was available to us at the time, the policy decision made was the least worst of all the options alternative. Managing a pandemic is often about finding the least bad of a series of bad options. If a better option had been available I would have strongly supported it. There were no easy choices or good options.

135. The most important lesson to draw is that there should not be staff movement between care homes: that is how the virus mostly got in – asymptomatic transmission from staff. Instead, most of the debate focuses on the wrong lesson: the movement of patients out of hospitals into care homes. I understand how this is intuitive, but the evidence, including PHE's 'A data linkage approach to assessing the contribution of hospital-associated SARS-CoV-2 infection to care home outbreaks in England 30 January to 12 October 2020' dated 1 July 2021 (**MH10/93 - INQ000234332**) and the SAGE Social Care Working Group 'Consensus statement on the association between discharge of patients from hospitals and COVID in care homes' (**MH10/94 - INQ000215624; MH10/95 - INQ000107085**); shows it was a small part of the problem. There were no easy answers to what to do with people in hospital who were medically fit to discharge and had no symptoms. We did not have enough tests to test everyone, and I accepted the advice that this was the way to save most lives. At that time, I was advised:

a. that testing those without symptoms would lead to false negatives, which could be worse than no test result.

b. that those in hospital medically fit for discharge had to be moved to a more appropriate setting.

c. that asymptomatic infection was not proven.

d. that the number of cases was growing exponentially and that there was a chance the NHS would be overwhelmed

e. that leaving people in hospital who were medically fit for discharge put them at more risk

f. that every option other than that we chose would likely lead to more deaths

136. I have reflected on and considered this particular policy decision in detail. Although I did not take the decision, I take responsibility for all actions taken by the Department in the pandemic. I have yet to be presented with a policy that would have saved more lives than the one we took. For the future, it is vital that all care homes have isolation facilities available, and that testing can be scaled quickly. Had these two policies been in place then better options would have been available than the options that, in reality, were available to us.

Designated Settings Policy

137. I have been asked to summarise the Designated Settings Policy, enacted following discussions with the Prime Minister on 18 September 2020.

138. I was present at a COVID-O meeting on 23 October 2020 (**MH10/96 - INQ000090293; MH10/97 - INQ000090302**) in which the progress in setting up isolation units was discussed. At this meeting, the Minister for Care explained that in order for all residents who would be leaving hospital with a positive test to be able to go into an isolation unit, within the next 2-3 weeks, the CQC required all local authorities to notify them of their designated units.

139. I am aware that the 'Designated Settings Guidance' was subsequently published on 16 December 2020 **(MH10/98 - INQ000234652)** and was updated on several occasions between its publication and the 11th February 2022. It would not have been practicable to take this step at an earlier stage of the pandemic, and we worked very hard with local

authorities to support making sufficient and appropriate accommodation for those discharged from hospital.

140. I have been asked to outline how the decision making process in relation to the care sector changed at the outset and throughout the relevant period. I understand that this has been addressed in detail in the Department's corporate statement.

141. I have been asked whether I consider that DHSC oversight of the care sector was sufficiently clear and the governance arrangements effective to ensure that care providers were adequately listened to and supported by you and the DHSC during the relevant period. My view is that Helen and civil servants did their very upmost to ensure care providers were adequately listened to and supported by the Department. The lack of levers available to the Department meant initial oversight of the sector was very poor, though we were subsequently able to use funding, particularly the Infection Control Fund, as a more effective 'lever' to encourage providers to comply with best practice and provide data to the Department.

Outbreaks

142. I have been asked to provide an overview of my understanding of the procedures in place for residential and nursing homes with suspected or confirmed outbreaks of Covid-19. My understanding was as set out by the Department.

143. I was very concerned that we were monitoring outbreaks in care homes in order to inform decision making about visiting and staff movement, amongst other measures.

144. By mid to late April, over 25% of care homes had declared a Covid-19 outbreak and the infection rate was considered by PHE to be higher than in the general community. It was recognised that yet further measures were needed to control the spread of the virus and to protect vulnerable residents as well as care home staff. The Department began work on a further intensive support package, led by Helen Whately as the Social Care Minister throughout April and into early May, (**MH10/99 - INQ000233797; MH10/100 - INQ000088490**).

145. The support package was published approximately one week later (**MH10/101 - INQ000050497**) and included: increased access to direct sources of national support in the form of funding, PPE and testing; local authorities providing support, including step down or quarantine facilities to prevent infection risk where necessary; additional funding for local

authorities to support care providers, which the Department requested local authorities to urgently direct to care providers; training in infection control; assistance from PHE Health Protection Teams (`HPTs') upon an outbreak being declared, including mass testing and tailored infection control advice; support from the NHS including access to medical equipment and infection control to prevent Covid-19 positive patients from being discharged into care homes and additional staffing.

146. Those enhanced support measures resulted in an update to the admissions care home guidance on 19 June 2020: (**MH10/102 - INQ000106486**).

147. In a meeting on the 26 June 2020, I approved the Department's plans to progress testing (**MH10/103 - INQ000051079**). Those plans were developed following advice the Department received from SAGE. Key points from the plan included implementing the SAGE recommendation of weekly testing of staff in care homes without outbreaks, an initial round of testing in extra care and supported living.

148. I have been asked about my comments at a press conference on 15 May 2020 that we had tried to throw a protective ring around our case homes. It is my view that the above-described actions helped to throw a protective ring around our care homes. While this was clearly a piece of rhetoric, we really did do our best to take all of the actions we could to protect those in care homes from the virus in incredibly difficult circumstances.

149. I have been asked about a WhatsApp message my special advisor sent me on 13 May 2020 about a comment I made to the Prime Minister that we had locked down care homes before the rest of the country. That statement had likely been based on the 13 March 2020 guidance, which was sent to care homes, encouraging them to review their visiting policies, asking no one to visit who had suspected Covid-19 or was generally unwell, emphasising good hand hygiene, and keeping contractors on site to a minimum. The guidance demonstrates that we did encourage restrictions in care homes before the rest of the country.

Staff Movement between Care Homes

150. I have been asked to address the finding of the 'Technical Report on the Covid-19 Pandemic in the UK' (1 December 2022) (**MH10/104 - INQ000203933**) that *"the majority of outbreaks were introduced unintentionally by staff members living in the wider community...*

Interventions to mitigate this through asymptomatic testing and avoidance of cross-deployment were only partially successful at times of high community prevalence."

151. As I have discussed in previous statements, restricting staff movement became a priority as soon as I became aware of the initial evidence from PHE that staff movement was the main source of transmission. I pushed hard to limit, and then ban, staff movement. There was opposition to this, including that staff were essential for the sector, which of course they are, but my view was that it was more important to stop infections getting into care homes.

152. As outlined in my third statement, I asked my team to undertake urgent work to restrict such movement. For example, on 11 May 2020 I wrote to the Prime Minister setting out a further support package for care homes. In that letter I noted that we had considered the option of banning staff movement but considered it too fraught with operational risks at that time (**MH10/105 - INQ000292616; MH10/106 - INQ000292617**).

153. On 15 May 2020, we announced the Care Home Support Package which recommended that care homes restrict staff from working in more than one care home supported by the ASC Infection Control Fund (**MH10/107 - INQ000106429**).

154. On 19 June 2020, we published further guidance to that effect (**MH10/102 - INQ000106486**). As a result, our actions, 90% of care homes acted to restrict staff movement, and as a result, over the summer of 2020, staff movement between care homes fell dramatically (**MH10/108 - INQ000292626; MH10/109 - INQ000292663**), and infections in care homes were much lower in the second wave.

155. We wanted to go even further than that and to reduce staff movement to zero. I chaired meetings on 3 and 28 July 2020 with the Minister for Care, Helen Whately, and Departmental leaders where we discussed how to reduce staff movement to zero and options for legislating against such movement (**MH10/110 - INQ000233875; MH10/111 - INQ000233921**).

156. On 15 September 2020, I attended a COVID-O where Helen Whately presented the Department's Covid-19 Winter Plan for Adult Social Care (**MH10/112 - INQ000233991; MH10/113 - INQ000233992**). Central to the plan were various measures designed to reduce staff movement in order to prevent and control the spread of infection in care settings. I pushed for measures that went beyond what was proposed in that paper, which

included prohibiting in law care staff from working in more than one social care setting (**MH10/114 - INQ000233987; MH10/115 - INQ000233988; MH10/116 - INQ000233989; MH10/117 - INQ000233990; MH10/118 - INQ000233993; MH10/119 - INQ000233994**). The Committee discussed rising rates in care homes, and particularly among staff. We decided that the Department should take legal powers to ban staff movement between care homes in order to reduce transmission (**MH10/120 - INQ000090180; and MH10/121 - INQ000090012**).

157. On 23 September 2020 and 15 October 2020, I received advice on the legal options to restrict the movement of staff between care homes. It proposed that Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 be amended to include a requirement that care homes not use staff who attend more than one care setting (**MH10/122 - INQ000234022; MH10/123 - INQ000058362; MH10/124 - INQ000234101; MH10/125 - INQ000234100**). Note that the advice at **(MH10/126 - INQ000234023)** recorded that a policy of restricting movement would have impacts on equalities but officials did not consider any negative impacts were disproportionate given the threat to public health of staff movement. At that point, I wanted the regulations to be implemented by the end of October 2020. However, on 19 October 2020, I was advised that there would need to be a consultation on the proposed regulations (**MH10/127 - INQ000234146; MH10/128 - INQ000234145; MH10/129 - INQ000234148**). The consultation ran during November 2020.

158. On 3 December 2020, the Minister of State for Care was provided with a further submission on the scope of the proposed regulation to prohibit staff movement, accounting for the consultation responses, which I also reviewed (**MH10/130 - INQ000234205; MH10/131 - INQ000059167**). We were content with the recommendations in the submission (**MH10/132 - INQ000234211**). I expressed the need to press ahead with this as soon as possible, and we sought urgent cross Government agreement.

159. On 22 December 2020, I attended a Covid-O where we discussed the proposed regulations on restricting staff movement. My view was that, to protect the most vulnerable living in care homes, and despite the much lower death rate in care homes since we had introduced the guidance against working in more than one care setting, we should deliver on the policy of zero staff movement between care homes, particularly in the face of the more transmissible Alpha variant of Covid-19 which had emerged in December 2020. I pressed the need to ensure that funding was put in place to support the policy, specifically

to pay care staff for foregone hours as a result of being limited to one setting. The Committee agreed subject to the Department and Treasury agreeing a more detailed proposal to ensure funding support for staff was provided (**MH10/133 - INQ000091133**).

160. It became clear over the following fortnight that HMT was reluctant to fund a scheme to support staff affected by the proposed regulation, and the implementation of the plan was delayed again.

161. On 7 January 2021, I finally accepted that a full ban would not be possible (**MH10/134 - INQ000234277; MH10/135 - INQ000292642; MH10/136 - INQ000328029; MH10/137 - INQ000234269; MH10/138 - INQ000234270; MH10/139 - INQ000234271; MH10/140 - INQ000059411; MH10/141 - INQ000234273; MH10/142 - INQ000234276**). This was because of opposition from key system partners, particularly in light of the vaccine rollout and the decision to bring in the second lockdown. Nevertheless, we maintained the guidance against staff movement between care homes (**MH10/143 - INQ000292656; MH10/144 - INQ000292662**).

162. I have been asked what measures providers were advised or expected to take to minimise staff movement between care homes to stop infection spreading. As per DHSC guidance 'Coronavirus (Covid-19): care home support package' dated 15 May 2020 (**MH10/145 - INQ000325278, page 4**), subject to maintaining safe staffing levels, providers were expected to employ staff to work at a single location, subject to maintaining safe staffing levels. In addition, providers were encouraged to support care workers they employed in taking steps to minimise their risk of picking up COVID-19 outside of work.

163. The Annex to the Guidance contained additional steps that providers could take – it was recognised however that not all actions would be possible or appropriate for every provider. Some examples of steps that could be taken included:

- Extending restrictions on working in one care home to agency staff;
- "Cohorting staff" to individual groups of patients or floors/wings, including segregation of COVID-positive and COVID-negative patients;
- Actively recruiting staff where additional staff were needed to restrict movement between or within care homes;

- Limiting the use of public transport by encouraging staff to walk or cycle to work where they did not have their own private vehicle and supporting this with changing rooms or facilities.

- Considering how to provide accommodation for staff who proactively chose to stay separately from their families in order to limit social interaction outside work.

164. In terms of the support that providers received to implement appropriate measures, as detailed in the Guidance, additional funding was put in place for local authorities – £1.6 billion on 19 March 2020 and a further £1.6 billion on 18 April 2020. On 13 May 2020, the Department announced an additional £600 million to support providers through the Infection Control Fund. The fund was intended to provide support for adult social care and providers to reduce the rate of transmission in and between care homes and support wider workforce resilience.

165. The action we took to restrict staff movement reduced infections significantly (**MH10/146 - INQ000087229; MH10/147 - INQ000233997**).

166. I have been asked why my approach to banning staff movement changed between 11 May, when I wrote to the Prime Minister indicating that a legal requirement to limit *"cross-deployment"* was *"fraught with operational risk"* (**MH10/106 - INQ000292617**), and September 2020 when I decided to legislate to ban staff movement. The answer is that we gained much more detailed scientific knowledge about the urgency of limiting staff movement over the summer of 2020.

167. On reflection, one extremely important lesson is that in the face of infection disease, staff movement between care settings should be restricted. This is not to blame staff, because the problem of asymptomatic transmission meant they could not have known they had the virus. I would argue this should happen, by law, in every flu season, as well as in any pandemic.

Infection Prevention and Control

168. The Inquiry has asked about my involvement in guidance or policy on infection prevention and control ("IPC') measures and support, advice and training for (i) residential care and nursing homes; (ii) domiciliary care; and (iii) unpaid carers.

169. Before addressing my involvement in these particular areas, as a preliminary matter, and as set out in the Department's Statement IPC is a key component of normal healthcare and social care where there are regulatory requirements which underpin the need for employers to keep staff safe. These remained in place throughout the pandemic. The Department assisted employers to meet these requirements during the pandemic but did not replace the employer responsibility to keep their employees safe. As addressed in the Department's Statement, the Department was not involved in the formulation of IPC guidance. This was the remit of PHE.

170. On 8 May 2020 I wrote to the Prime Minister about the Department's plans for an intensive support package for care homes to meet our objectives to supress infections, building on guidance issued in February and March 2020, and financial support already provided to the sector. My letter explained we were taking action on five fronts; infections prevention and control, building up the workforce, stepping up NHS clinical support, comprehensive testing and oversight and compliance at the local government and national level **(MH10/148 - INQ000609953)**.

171. My letter noted "*at its heart, the core problem of managing social care is that accountability for delivery falls to us, while the levers are held by local authorities. This makes delivery of sensible policy proposals - like reducing staff movements between providers - very difficult. We need to change this through legislation. But in the meantime, the most effective way we can drive specific policy directly is to tie adherence to funding: to give funding to those providers who act in the correct way*."

172. In the letter I outlined support being provided to care providers to help them observe PHE guidance on IPC, including use of PPE, isolation/cohorting practices and decontamination.

173. The Infection Control Fund was announced on 15 May 2020. and included measures covering IPC, workforce measures, testing, and increased NHS clinical support. The infection Control Fund was subsequently extended into 2021.

174. I have been asked by the Inquiry what concerns, if any, were raised with me regarding IPC policies (question 41). In early March 2020, I was made aware of concerns regarding the general capacity of care homes to cope with the pandemic and the lack of pandemic contingency plans in the sector by Helen Whately. She had only been able to find two contingency plans: Hertfordshire and Essex. She told me that Robert Jenrick, the

Communities Secretary had similar concerns. The Essex plan that was in place was nowhere near good enough. I asked Helen to put some serious drive into getting these plans into a credible position.

175. In late March 2020, I was also made aware of concerns raised by Donna Kinnair, the RCN Chief Executive, regarding the new guidance on PPE. Her concern was that it did not give enough prior to staff doing home visits, some of whom are being refused kit even when they ask. I spoke with the NHS chief nursing officer, Ruth May, who had been leading on. She said she was going to try to broker a solution, but it had to recognise the real-world constraints on supply of PPE.

176. I do not have any recollection of concerns about ventilation in care homes being raised with me. I am aware that ventilation was considered when visiting guidance for care homes was implemented.

177. I consider IPC guidance and support during the relevant period for residential care and nursing homes, domiciliary care, and unpaid carers was as good as PHE could reasonably make it in the circumstances. The Department pushed the NHS to introduce the Enhanced Health in Care Homes Package to provide additional NHS support to care homes.

178. I have been asked what assurances I received that appropriate IPC measures were being implemented across the care sector. I was assured by the evidence. For example, and as previously mentioned at paragraph 486 of my second statement, we had introduced guidance that recommended staff work in only one care home and subsequently, the number of staff working in more than one care home fell by around 90% over the summer of 2020. It was clear that the care sector was working hard to implement IPC measures.

Testing for Covid-19

179. I have been asked to provide details of my involvement in guidance or policy with regard to testing of residents and staff of residential and nursing homes, to include any advice I received from DHSC officials or advisory groups on testing. I have also been asked to include what, if any, consideration was given to the feasibility of testing in residential care and nursing homes and the impact of testing on care providers and recipients of care. I have been asked to set out in chronological order how the guidance or policy in relation to testing of residents and staff of residential and nursing homes evolved and testing capacity increased over the relevant period.

180. The Department's Corporate Statement outlines how guidance and policy on testing developed during the relevant period, how testing was operationalised and care home compliance. I will not repeat what has been said in these statements.

181. As addressed at paragraphs 55-57 and 60 of my fifth statement, enabling care home staff to access Covid-19 tests was linked directly to NHS capacity because the prioritisation of tests was an important clinical question, and tests were in short supply. I did all I could to increase testing capacity as rapidly as possible.

182. On 10 April 2020, I announced that we had capacity to test all key social care staff and NHS staff who needed to be tested (**MH10/149 - INQ000478869**).

183. On 14 April 2020, I received updated advice from Sir Chris Whitty that he was now recommending testing asymptomatic people going to care homes from hospital, which I regarded as a very significant step forward (**MH10/46 - INQ000093326; MH10/47 - INQ000292604; MH10/48 - INQ000292605**). I attended a departmental call the same day to discuss the implications of these changes. A note of that call records my view that we needed to make sure nurses taking swabs in care homes were wearing PPE or had been tested, and that we needed a drumbeat of PPE delivery (**MH10/150 - INQ000609947**).

184. On 15 April 2020, I had succeeded in driving testing up to 38,766 per day, and we were able to announce that all patients being discharged from hospitals into care homes should be tested. There was subsequently a change in scientific advice due to operational constraints, as I discussed in my third witness statement at paragraph 53d.

185. As I have addressed above, in late April 2020, Helen Whately and I received submissions and advice on the prioritisation of testing for asymptomatic staff and residents which resulted in a significant expansion to testing (**MH10/50 - INQ000325273**).

186. On 26 April 2020 I received a written update from officials on asymptomatic swab testing. That paper noted, emphasis added, *"PHE has confirmed there is no barrier to testing symptomatic people in any setting or to including asymptomatic people where clinically appropriate. In the first instance, this will include: expanding testing to all hospital admissions to help guide improved infection control; testing more people in care homes when outbreaks occur, whether they are symptomatic or not; as well as staff in care environments to understand the prevalence of asymptomatic disease and develop*

protocols to minimise the number of staff in these environments who are potentially asymptomatically infectious." (**MH10/52 - INQ000478887**).

187. I have been asked about pilots for testing whole care homes. On 28 April 2020, I announced that all care home residents and staff in England, with and without symptoms, would be able to address testing. In the first phase of that testing, the Department prioritised providing test kits to care homes with residents over 65 and or with dementia. This was in line with PHE and SAGE advice (**MH10/151 - INQ000609958**).

188. On 9 May 2020 I approved a plan to expand testing in care homes, to test all staff and residents within three weeks from 11 May 2020 rather than 30 days as originally planned. Note that the submission appears to have a typographical error in its date (**MH10/152 - INQ000609952; MH10/153 - INQ000609951**).

189. On 22 December 2020 I approved a plan to increase testing across the care home workforce given the increasing virus prevalence, new variant and introduction of tier 4 (**MH10/154 - INQ000609967; MH10/155 - INQ000609966**).

190. I have been asked to provide details of my involvement in guidance or policy with regard to testing for domiciliary care providers, unpaid carers and those receiving care in the home, to include reference to whether the policies differed and the rationale for such differences. The Department's Corporate Statement A, details the testing regimes that applied to homecare workers, including domiciliary care workers. The Department's Corporate Statement provides further information on testing policies and guidance that were applicable at the time.

191. In a meeting on 15 May 2020, I asked that officials action a plan on an early test and trace system in local areas on domiciliary care workers (**MH10/156 - INQ000609954**).

PPE

PPE Supply: LRFs

192. I have been asked to provide details of my involvement in guidance or policy with regard to the provision and availability of PPE to residential and nursing homes. I have been asked to address the steps taken to ensure that residential care and nursing homes and domiciliary care providers had adequate supplies of PPE as per my Module 2 Statement.

193. As addressed at paragraph 293 of my second statement and paragraph 126 of my fifth statement, formal responsibility for PPE distribution rested with individual institutions – whether NHS hospitals, Primary Care (which is contracted by the NHS, not run directly) or care homes, which are mostly private sector. Prior to the pandemic, the official NHS supply chain only supplied the main hospitals, while primary care and social care provided for themselves. However, given the global shortage, it became extremely clear that individual organisations would not be able to provide for themselves. I therefore insisted that primary care and care homes be given PPE deliveries from our national stocks. Although this was a departure from normal arrangements (as care homes were private entities and not normally supplied with stocks by the Government), I was aware that care homes desperately needed PPE because their stocks were not designed to cope with a pandemic; this is another area where preparedness fell short. We responded as fast and as widely as possible, including giving free PPE to care homes as well as the NHS. I would recommend that all health and social care facilities are required to keep an appropriate store of PPE for the early stages of any future emergency.

194. I understand that the Department's Corporate Statement addresses how the Department tracked feedback that was received regarding the distribution and allocation of PPE and mechanisms put in place for the supply of PPE.

195. In relation to PPE, on 5 April 2020, I was informed of the plan to use Local Resilience Forums (LRF) to support the supply of PPE to adult social care, primary care and other community-based providers. As addressed in the Department's Statement, the Department worked with the Ministry of Housing, Communities and Local Government (MHCLG) to engage a network of 37 LRFs to create a further temporary emergency channel for supply and to coordinate response to local supply issues. LRFs acted as hubs for onward distribution of stock with large volumes at no cost to providers.

196. The submission that was presented to me on the use of LRFs discussed the use of embedded military planning teams to provide an advisory role to local public bodies to co-ordinate the collection, storage, accounting and delivery of PPE. The submission also set out the prioritisation of the distribution of PPE referencing the Healthcare Ministerial Implementation Group (HMIG) meeting of 2 April 2020 (**MH10/157 - INQ000083701**) where prioritisation of PPE to *"those that are having close unavoidable contact with confirmed or suspected COVID-19 cases that include highly vulnerable groups"* was agreed. The submission outlined that decision making would be the responsibility of LRFs but would

include *"adult social care (including care homes and homecare), hospices, prison hospitals and local authority adult social care services for those most vulnerable to COVID-19".* (**MH10/158 - INQ000551555**).

197. I agreed for the distribution to proceed and asked that LRFs be requested to report stock and distribution data. I also made it clear that LRFs were not to be used by NHS secondary care to obtain PPE, as there were other direct routes for them to be supplied with PPE. In addition, I agreed to a further Military Aid to the Civil Authorities (MACA) request to provide additional military planning to support the distributions.

PPE use

198. On 5 June 2020, I announced that all staff in hospitals should wear face masks continually to prevent further spread of COVID-19, and that this policy would be considered for social care. SAGE considered the policy for care homes and submitted a paper to the Department on 2 July 2020 that mirrored the recommendation for hospitals (**MH10/159 - INQ000327945**). PHE then provided updated guidance advising care homes and home care providers what PPE would be needed in different scenarios.

Free distribution of PPE

199. On 15 July 2020, I received a submission from the Department's PPE Demand Team, proposing free distribution of PPE to frontline primary and social care services until March 2021 (**MH10/160 - 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. The Department was authorised by HM Treasury (HMT) to purchase £14 billion worth of PPE to distribute across the health and social care system. I agreed to the free distribution policy on 20 July 2020 (**MH10/161 - INQ000327954**).

200. The PPE Strategy was published by the Department on 28 September 2020. This reiterated the offer of free PPE until the end of March 2021 and (**MH10/162 - INQ000234522**). Further details of the strategy are outlined in the Department's Statement.

201. On 18 March 2021, Helen Whately and I received a submission for approval that set out a number of options for how to extend provision of free PPE to health and social care providers until 30 June 2021. The decision had to be announced in April to give providers enough lead time for any changes beyond June 2021 (**MH10/163 - INQ000328084**; **MH10/164 - INQ000328085; MH10/165 - INQ000110871**). On 24 March 2021, we

agreed to extend the provision of free PPE to 31 March 2022 (**MH10/166 - INQ000328092**).

Domiciliary care

202. I understand that the Department's Statement explains there was PPE guidance produced for domiciliary workers, which included recommended PPE procedures: '*How to work safely in domiciliary care in England*' (**MH10/167 - INQ000609973**; **MH10/168 - INQ000061007; MH10/169 - INQ000061008**).

Unpaid carers

203. On 18 November 2020, I agreed to a proposal to trial a free PPE offer for unpaid extra-resident carers in five local authorities, with a view to rolling this out across the country by January 2021 (**MH10/170 - INQ000328011; MH10/171 - INQ000328012; MH10/172 - INQ000109853**).

204. On 20 January 2021, I approved a proposal to roll out the free PPE offer for unpaid carers nationally (**MH10/173 - INQ000328042**). This proposal was also approved by Helen Whately (**MH10/174 - INQ000328040**).

205. 'Guidance for unpaid carers', clarified that unpaid carers should follow the same guidance and PPE procedures for domiciliary workers: '*How to work safely in domiciliary care in England*' alongside a list of illustrative guides for wearing and removing *PPE* from PHE (**MH10/167 - INQ000609973**; **MH10/168 - INQ000061007; MH10/169 - INQ000061008**).

206. On 15 July 2020, I received a submission from the Department's PPE Demand Team proposing free distribution of PPE to frontline primary and social care services until March 2021 (**MH10/160- INQ000327950**). I agreed to the free distribution policy on 20 July 2020 (**MH10/161 - INQ000327954**).

207. On 18 March 2021, Helen Whately and I received a submission for approval that set out several options for how to extend the free provision of PPE beyond June 2021. On 24 March 2021, I agreed to extend the provision of PPE to 31 March 2022 (**MH10/166- INQ000328092**).

208. I have been asked whether I was aware of any concerns on the part of (i) residential care and nursing homes (ii) domiciliary care and (iii) unpaid carers about the inability to access adequate supplies of PPE, along with any steps I took to address these concerns.

209. As regards unpaid carers, I was aware that there was a concern among families and unpaid carers that PPE was not being provided to them. In July 2020, although the virus was still in circulation, there was a lower likelihood of an individual coming into contact with an infected case. Therefore, the recommendation was that the current policy should not change and that unpaid carers did not need to wear PPE unless advised by a healthcare professional, and the recommendation was that the current explanation in unpaid carers guidance was to be strengthened. Helen Whately was concerned that there may be instances locally where unpaid carers are overlooked and she questioned what the protocol was in the case of a locally raised Covid-19 rate. She queried specifically what the recommendation was regarding unpaid carers. She did not want this to be left to chance, given the risk of unpaid carers being overlooked (**MH10/175 - INQ000327970**). I supported Helen's comments (**MH10/176 - INQ000327979**).

210. Helen raised further concerns about the supply of PPE to unpaid carers at the start of winter 2020. On 12 November 2020, I received a submission that proposed a trial in five local authorities of a free PPE offer to unpaid carers who provide care to someone they do not live with, with a view to rolling this out across the country by January 2021 (**MH10/177 - INQ000328016**). I agreed to the proposals and the pilot began in the second week of December. On 20 January 2021, I approved to roll out the pilot nationally **(MH10/173 - INQ000328042; MH10/174 - INQ000328040**).

211. I have been asked about my evidence to Module 2 where I said that *"it was obvious from January* [2020] *there was going to be a problem with PPE"* and about Helen Whately's concerns about the adequacy of PPE supplies. The challenge with PPE was logistics. As detailed at paragraph 91 of my first statement, while the UK had a large stockpile of PPE that had been laid down in the late 2000s, the warehouse in which it was stored in the north-west was not designed for rapid access, and the distribution system was designed for delivering to 250 hospitals, but suddenly needed to deliver to over 50,000 sites including GP practices and care homes. This was compounded by the fact that formal responsibility for distribution rested with individual institutions. The NHS supply chain only supplied the main hospitals – care home stocks were not designed to cope with a pandemic – preparedness therefore fell short.

212. On 28 March 2020, when I received concerns from the RCN that PPE Guidance did not prioritise staff doing home visits, I talked to the NHS Chief Nursing Officer, Ruth May, who was leading on this issue and who was going to try to come up with a solution.

213. As detailed at paragraph 126 of my fifth statement, we responded as fast and as widely as possible to concerns we received, including giving free PPE to care homes as well as the NHS. I would recommend that all health and social care facilities are required to keep an appropriate store of PPE for the early stages of any future emergency.

Dashboards

214. I have been asked about Covid-19 Dashboards which included information about stocks of PPE. Data about PPE was first incorporated into the Covid-19 dashboard on 21 March 2020 (**MH10/178 - INQ000283617**).

215. On 20 April 2020, I asked that the dashboard better present the PPE stock picture, to better capture the full story of what was going on. In response officials suggested they would include the daily and weekly requirement number for each item, the daily stock position that we had on hand each day, and the 7 day supply forecast for each item, with a confidence level attached (**MH10/179 - INQ000478881**). This was because the dashboard had been presenting estimated days until 'stock out' based on initial modelling, but did not account for anticipated supply. For example, the dashboard may have included that we only had a certain number of days until stock out of an item, but we knew that we were about to receive a large delivery of stock of that item.

216. The Department's Corporate Statement C, describes the processes that were in place for those using PPE within the care sector to provide feedback about the quality and suitability of the PPE they were using and any other concerns they may have had. Again, I will not repeat what is said there.

Visiting restrictions

217. I have been asked about my involvement in guidance or policy with regard to visiting residents of residential and nursing homes.

218. I have also been asked to set out in chronological order how the guidance or policy in relation to visiting at residential and nursing homes evolved over the relevant period. I understand that the Department's Corporate Statement provides a detailed overview of

how visiting guidance and policy developed and therefore I won't repeat what has already been outlined.

219. The issue of visitors in care homes was a difficult one. The impact of visiting on recipients of care and their loved ones was a prime consideration, we needed to balance the need to protect residents against the impact of restrictions on mental health and wellbeing of residents and their loved ones.

220. On 8 July 2020 I was sent advice on updating guidance on care home visiting policies (**MH10/180 - INQ000327939**). The advice noted:

a. that visits remained a source of concern for many families and friends of care home residents, as at the time of the advice guidance only recommended visiting in exceptional circumstances, such as end-of-life;

b. that making changes to care home visits guidance involves an increased risk of transmission in care homes, balanced against the significant impact on residents of isolation;

c. recent advice from SAGE;

d. changes to NHS guidance;

e. the proposals have been developed by working with the Vice President of the Association of Directors of Public Health UK, PHE and the sector;

f. a previous submission had been sent to Helen Whately on 24 June 2020. This included a comparison of international approaches and was provided alongside a PSED assessment.

221. A revised version of the guidance, updated in light of Helen and stakeholders' comments was shared on 10 July 2020 (**MH10/181 - INQ000609961**). My response to the advice noted I was content for it to be published, but that we ensured that when a locality went into supported status at JBC Gold we consider rescinding visitor guidance and become stricter on visits (**MH10/182 - INQ000327949**).

222. Guidance on visiting was updated as part of the 2020 winter plan. Following comments from Helen, I approved an update to the visiting section of the winter plan on 17 September 2020, which involved tightening guidance to ensure one or two constant visitors to reduce

infection risk and increase likelihood of good IPC oversight of the visitor while managing the health needs of the individual (**MH10/183 - INQ000608153; MH10/184 - INQ000327992**). I received advice on 20 November 2020 about providing PPE to care home visitors, **(MH10/185 - INQ000609964)** which I approved **(MH10/186 – INQ000609965**).

223. There were some concerns raised with me regarding the visiting policies during the pandemic. For instance, on 21 January 2021, I became aware that ITV was preparing to run a negative piece about the suffering of care home residents because of visiting restrictions. Helen Whately wanted to find a way of allowing indoor visits again, however I took a hard line on this: we could not have Covid taking off in care homes again. We needed to save lives, as painful as this was for those affected by the restrictions.

224. On 30 January 2021, Helen Whately pushed to have visiting restrictions in care homes relaxed again. She worried that isolated residents may lose the will to live and thought that old people may start 'just giving up'. My view was that it was still too risky, however I was open to relaxing restrictions on visiting after a few weeks. I was firm on this.

225. On 22 February 2021 the Government announced the 4-step 'Roadmap' out of lockdown, which contained a plan for lifting restrictions to return to normal life. Changes to visiting restrictions occurred as the Roadmap progressed.

226. On 24 March 2021, I approved revisions to supported living visiting guidance so long as Helen's comments on the guidance were addressed, which they subsequently were (**MH10/187 - INQ000328091; MH10/188 - INQ000328101**).

227. On 8 June 2021 I received advice on options for the relaxation of restrictions on care home visiting and admissions at step 4 of the Roadmap (**MH10/189 - INQ000328134**). The advice was accompanied by an annex showing the risks and benefits of different options (**MH10/190 - INQ000609976**). I elected for option, two which meant:

> i. amending visiting-in guidance to encourage a more permissive approach to nomination of essential care givers – allowing more residents to take advantage of this provision;
>
> ii. removing the limit on the number of nominated visitors each resident can receive, whilst ensuring visitors are subject to existing testing and IPC measures (subject to the UKHSA review); and

iii. removing the 14-day isolation requirement on return from a visit out, with the exception of overnight stays in hospital or a visit deemed high-risk, following an individual risk assessment (**MH10/191 - INQ000609978**).

228. I wanted these changes to be made prior to a delayed step 4 in the roadmap (**MH10/192 - INQ000609977**).

229. As regards measures I introduced to mitigate the impact of visiting restrictions, as detailed in the Department's Corporate Statement, there were measures taken to mitigate the impact of visiting restrictions. For instance, the Department sought to ensure that there were increased opportunities for virtual visiting and visiting where people could see their loved ones through a window or screen between them.

230. On reflection, I do *consider that the timing and extent of the various iterations of guidance on visiting restrictions was appropriate*. This involved difficult decisions, and there was no perfect balance, but we did our very best to protect the vulnerable while mitigating the impacts of limitations on visits.

Access to emergency care, NHS support and visits by professionals

231. I have been asked to provide details of my involvement in guidance or policy to ensure access to emergency care, NHS support and visits by professionals to those residing in residential and nursing homes at times when visiting was restricted during the relevant period.

232. On 13 March 2020, PHE issued guidance for residential care settings, supported living provision and homecare provision, advising providers to review their visiting policy. I reviewed this guidance (**MH10/193 - INQ000609935**). This guidance advised on steps care home providers could take to maintain services and steps the NHS could take to support care homes. For example, it stated:

"Community service providers are already, or will be, taking steps to:

- *contact all local care home providers – including those who have residents who fund their own care – and local authorities, to share plans for local support networks and care provision across the area, including identifying local capacity*

• *consider how local community health services and primary care providers can support care home provision, agreeing with local authorities and care home providers how and when this can be triggered, and what the role of the NHS is in that circumstance. The collaborative approach between care homes, primary care and community health services set out in the Enhanced Care in Care Homes framework, for example, will enable this*

• *support local authorities in planning around resilience, including plans to share resources locally in an outbreak of COVID-19. This should include workforce, including the deployment of volunteers where it is safe to do so, and where indemnity arrangements are in place*

• *consider, in cases where there may be isolated outbreaks within certain providers, how best the NHS can support in recovery"*

233. On 2 April 2020, the Department, PHE, and NHSE/I published guidance on *"Coronavirus (COVID-19): admission and care of people in care homes'* (**MH10/194 - INQ000325255**) which included reference to visiting. I agreed with this guidance, as did the DCMO and the Minister of State for Care (**MH10/195 - INQ000327807**). The guidance detailed the steps that should have been taken by care providers to ensure access to hospital care where required and that the general health needs of residents were met. For example, it stated:

"If you think one of your residents may need to be transferred to hospital for urgent and essential treatment, consider the following checklist:

If a resident shows symptoms of COVID-19:

• *Assess the appropriateness of hospitalisation: consult the resident's Advance Care Plan/Treatment Escalation Plan and discuss with the resident and/or their family member(s) or Lasting Power of Attorney as appropriate following usual practice to determine if hospitalisation is the best course of action for the resident.*

…

If a resident requires support with general health needs:

• *Consult the resident's Advance Care Plan.*

•Consult the resident's GP and community healthcare staff to seek advice.

• Alternatively, contact NHS 111 for clinical advice.

Postpone routine non-essential medical and other appointments.

• Review and postpone all non-essential appointments (medical and non-medical) that would involve residents visiting the hospital or other health care facilities.

• If medical advice is needed to manage routine care, consider arranging this remotely via a phone call with the GP or named clinician."

234. On 9 July 2020, officials proposed further changes to the draft visiting guidance which were sent to me (**MH10/196 - INQ000327941**). However, this guidance was not directly concerned with ensuring access by/to healthcare professionals in care homes. It was focused on enabling easier visiting in care homes more generally, for example, by residents' family and friends. Helen Whately was responsible for approving the guidance, which was published on 22 July 2020 (**MH10/197 - INQ000327957; MH10/198 - INQ000325285**).

235. On 17 September 2020, I approved the wording of the Winter Plan (**MH10/184 - INQ000327992**). The Winter Plan 2020/2021 was published on 18 September 2020 (**MH10/199 - INQ000234495**). Parts of the Plan focused on ensuring access to NHS support and visits by professionals, including (as outlined at page 5 of the Plan):

"• local authorities and NHS organisations should work together, along with care providers and voluntary and community sector organisations, to encourage those who are eligible for a free flu vaccine to access one

• local authorities should work with social care services to re-open safely, in particular, day services or respite services. Where people who use those services can no longer access them in a way that meets their needs, local authorities should work with them to identify alternative arrangements

…

• local authorities and NHS organisations should continue to work with providers to provide appropriate primary and community care at home and in care homes, to

prevent avoidable admissions, support safe and timely discharge from hospitals, and to resume Continuing Healthcare (CHC) assessments at speed

• NHS organisations should continue to provide high-quality clinical and technical support to care providers through the Enhanced Health in Care Homes framework and other local agreements"

236. On 8 June 2021, 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 reached (**MH10/189- INQ000328134**). Helen Whately approved the guidance on 21 June 2021, and it was published that day (**MH10/200 - INQ000325337**). Again, this guidance was focused more generally on visits from residents' friends and family, rather than emergency care and NHS support.

237. As addressed in the Department's statement, the Department worked with NHSE to consider options to accelerate the implementation of 'Enhanced Health in Care Homes'. Enhanced Health in Care Homes was an existing NHSE programme to enhance clinical support in care homes. As this was an NHSE programme, NHSE are best placed to address any questions on how successfully the measures ensured health care needs were met.

Workforce and Funding

238. I have been asked to outline my involvement in guidance or policy which sought to provide support to, and increase the capacity of, the care sector workforce.

239. On 15 April the Department published the adult social care action plan (**MH10/89 - INQ000233794**). In its action plan, the Department set out measures to support the workforce and a plan to increase the adult social care workforce by 20,000 people over the next three months. The Department will be better placed to comment on the outcome of these workforce appeals.

240. The Department worked on a further intensive support package, led by Helen Whately as the Social Care Minister throughout April and into early May, (**MH10/201 - INQ000233797; MH10/100 - INQ000088490**). The support package was published approximately one week later (**MH10/101- INQ000050497**) and included additional funding for local authorities to support care providers, which the Department requested local authorities to urgently direct to care providers; training in infection control; assistance from PHE Health Protection Teams (`HPTs') upon an outbreak being declared, including mass

testing and tailored infection control advice; support from the NHS including access to medical equipment and infection control to prevent Covid-19 positive patients from being discharged into care homes and additional staffing.

241. At a COVID-O meeting on 11 January 2021 (**MH10/202 - INQ000325299; MH10/203 - INQ000325297**) a paper produced by the Department for the meeting made reference to developing a new proposal for funding to support workforce capacity. On the 16 January 2021, the government announced a £120 million Workforce Capacity Fund (**MH10/204 - INQ000059731**).

Vaccines and Vaccination as a Condition of Deployment ("VCOD")

242. I was very concerned that the vaccine roll out in care homes was successful, and that uptake was high. On prioritisation, we followed the advice of JCVI. On 15 November 2020 I specifically asked that we discuss a plan for care home vaccine deployment (**MH10/205 - INQ000609963**).

243. I have been asked to outline whether any consideration was given to the introduction of a policy requiring vaccination as a condition of deployment for those working in the care sector.

244. During the easing of restrictions in early 2021 it had been identified that there had been a low uptake of vaccines by social care workers, with the percentages of workers and residents who had received the vaccine reported as being below the targets which had been set by SAGE to keep the R number below 1 and prevent spread in care homes. This was a matter of extreme concern given the vulnerable people that those carers worked with, and the proven impact of the vaccine on both transmissibility and the severity of Covid-19 cases. The data on the Delta variant only exacerbated those concerns.

245. The Prime Minister and I had therefore discussed making flu and Covid-19 vaccinations a condition of work for all care home workers. Although the concept was a restriction on individual choice, there were parallel requirements in respect of other viruses and diseases, and the decision was necessary to protect the most vulnerable in society. I was in no doubt that it was the right thing to do. On 17 March 2021, at a Ministerial meeting of COVID-O, it was agreed that the Government should proceed to take steps to make vaccination a condition of deployment, while also working on non-legislative solutions in the interim, including the assessment and mitigation of any particular impacts on

disproportionately impacted groups (**MH10/206 - INQ000091817; MH10/207 - INQ000092064; MH10/208 - INQ000234310**).

246. In response to a submission on this issue, received on 25 March 2021 (**MH10/209 - INQ000234311**), I agreed that the Department should run a consultation on mandatory vaccinations for care home workers, which opened on 14 April. Following receipt and consideration of the consultation responses, it was announced on 16 June 2021 that the Covid-19 vaccination would become mandatory for care workers, with a grace period of four months to enable workers to obtain a vaccination if they had not already done so.

247. Around the same time and considering that the same public health concerns were applicable to healthcare staff who worked with vulnerable patients as well as visiting care home patients, the Department announced that it would run a second, similar consultation in relation to the mandatory vaccination of all other healthcare staff. This was dropped, without good reason. However, this science-based policy has been a very significant success. The concerns raised, especially about staff leaving these caring professions, did not materialise. One important lesson is that mandatory vaccinations for Covid-19 and flu should be extended to all health and social care staff to save lives.

Do Not Attempt Cardiopulmonary Resuscitation ("DNACPR")

248. I have been asked specifically about the use of 'do not attempt cardiopulmonary resuscitation' ("DNACPR") notices. My approach throughout was that this is a clinical matter, personalised to the patient, and appropriate consent is paramount. From early April concerns were raised about an overly broad application of DNACPR notices. For example, on 3 April 2020 at the Downing Street press conference which I chaired, with Dame Ruth May, Chief Nursing Officer, and Professor Sir Jonathan Van Tam, deputy Chief Medical Officer, we were asked a question about some elderly and disabled people being told by GPs that "*they fit into the category of do not resuscitate*." This being an operational clinical matter I handed over to Dame Ruth May to answer this question, and she replied:

> "*My clinical colleagues have these discussions all of the time with patients and their families, thinking about their wishes, thinking about what their care being planned, and that's right and proper. COVID-19 is no excuse to have those discussions in an insensitive way, but as these discussions need to happen all*

of the time with families and with patients themselves." (**MH10/210 - INQ000478865**)

249. On 7 April 2020 the Chief Nursing Officer, England, and National Medical Director wrote to Chief Executives of all NHS trusts and foundation trusts, CCG Accountable Officers, GP practices and Primary Care Networks, and providers of community health services; highlighting that DNACPR orders should only ever be made on an individual basis and in consultation with the individual or their family (**MH10/211 - INQ000192705**).

250. On 10 April 2020 I attended a meeting with officials to discuss what became the COVID-19 Adult Social Care Action Plan. My Private Secretary's note of the meeting records that I commented that the do not resuscitate ("DNR") discussion needs to note that for many people not going to hospital is the best decision, but this must be a sensitive, clinical decision based on individual needs and circumstances, not a blanket policy (**MH10/212 - INQ000478870**).

251. I gave the 10 Downing Street press briefing on 15 April 2020 (**MH10/213 - INQ000478876**). I announced the COVID-19 Adult Social Care Action Plan, and commented:

"*And we're making crystal clear that it is unacceptable for advanced care plans, including 'do not attempt to resuscitate' orders, to be applied in a blanket fashion to any group of people. This must always be a personalised process, as it always has been.*"

252. I further raised the issue of blanket DNRs at a quad meeting with the Permanent Secretary and Sir Simon Stevens on 7 September 2020 (**MH10/214 - INQ000478907**).

253. The Minister for Patient Safety, Suicide Prevention and Mental Health Care wrote to the CQC on 7 October 2020 and requested the CQC investigate and report on DNACPR decisions. The CQC issued an interim report in November 2020 and a final report in March 2021.

254. On 17 March 2021 I approved a Written Ministerial Statement in response to the CQC's report and welcomed the report's recommendation for a Ministerial Oversight Group to drive progress (**MH10/215 - INQ000478911**). I approved the establishment of the Ministerial Oversight Group on DNACPR decisions on 10 May 2021 (**MH10/216 - INQ000478913**).

255. I asked that the Department lead on taking forward the CQC's recommendation that "*People, their families and/or representatives, clinicians, professionals and workers need to be supported so that they all share the same understanding and expectations for DNA CPR decisions*." (**MH10/217 - INQ000478910**).

256. I approved a response to a Coroner's Prevention of Future Deaths report which raised concerns about the application of DNACPR forms by paramedics in cases of self-harm and attempted suicide. The response refers to the CQC review commissioned by the Department (**MH10/218 - INQ000479883; MH10/219 - INQ000479884; MH10/220 - INQ000479885; MH10/221 - INQ000478912**).

257. I do not understand that I had any involvement with the Moral and Ethical Advisory Group and the Ethical Framework for Adult Social Care in relation to the use of DNACPRs.

Changes to regulatory inspection regimes within the Care Sector

258. I supported the CQC's decision to suspend all routine inspection activity. I was supportive of this decision because I wanted hospital and healthcare workers' primary focus to be treating patients, rather than complying with inspection requirements, and to free up inspectors to work directly on the front line. This decision was widely welcomed across the NHS, and undoubtedly freed up resources to support the pandemic response. My response to this CQC decision recognised that there would be a small number of cases where inspections would remain necessary **(MH10/222 - INQ000478858)**.

259. I have been asked whether the CQC consulted with me prior to taking this decision; the Chief Executive wrote to me on 12 March 2020 (**MH10/223 - INQ000485146**). On 16 March 2020, I provided feedback to the CQC on letters they had drafted to adult social care and healthcare providers, emphasising the importance of everyone acting in the best interests of the health of the people they serve, with the top priority the protection of life. The CQC accepted these amendments (**MH10/224 - INQ000485147**).

260. At a weekly ASC meeting on 17 April 2020, I specifically asked for an update on whether care homes could easily flag quickly to CQC if they were facing serious issues (**MH10/225 - INQ000609948**). I met with the CQC on 1 July 2020 (**MH10/226 - INQ000609959**) Helen Whately met with the CQC on the same day **(MH10/227 - INQ000609960)** and then took forward issues related to her concerns about cases of neglect being uncovered.

Deaths related to the infection of Covid-19

261. I regularly received data about the impact of the pandemic on the care sector, including deaths of both those receiving care, and those working in the sector. I received submissions about data relating to deaths on 15 April 2020 and 22 April 2020 (**MH10/228 – INQ000609949; MH10/229 - INQ000610356**). We subsequently moved to ensure a consistent measure of reporting across the Four Nations in August 2020 (**MH10/230 - INQ000609962**).

Data

262. I was extremely concerned about the lack of data we had on social care. For example, on 7 May 2020 I raised concerns and asked officials how we could get the data we needed from care homes. I expressed my preference that providers be required to provide data and asked for rapid advice on this approach (**MH10/231 – INQ000609950**). Advice was received **(MH10/232 - INQ000609957, MH10/233 - INQ000609956)** and I elected to proceed with the option to amend CQC regulations to make completion of the capacity tracker mandatory (**MH10/232 - INQ000609957**).

263. Ultimately making access to the Infection Control Fund conditional on receipt of data had led to a large increase in the supply of data (**MH10/120 - INQ000090180**).

264. As the pandemic developed, I ultimately received daily reports on ASC data, for example about vaccination (**MH10/234 - INQ000609968**).

Care Act Easements

265. I understand that the Department's Corporate Statement has addressed questions about Care Act Easements.

Conclusion

266. Responding to the pandemic posed an unprecedented challenge for every part of our society, including ASC. Making decisions in this area was challenging, and often required difficult assessments, balancing risk and responding to new information as our understanding of the virus developed.

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: Personal Data

Dated: 3 June 2025

Annex A to the tenth witness statement of Matt Hancock, Former Secretary of State for Health and Social Care

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Paragraph 30, references paragraph 270 of second witness statement [INQ000232194_0064]

270. Sir Simon Stevens called to propose postponing all non-urgent operations from 15 April to free up 30,000 beds. To me this really hammered home what was coming. All those people waiting for surgery, many in pain, would now be deferred. Simon said that frail, elderly patients who did not need urgent treatment would need to be discharged, either to their home or to care homes. He told me that he had spoken to the PM about it and was determined to make it happen. The NHS was doing all it could to increase bed numbers and to keep them above the projected figure for peak infections. Simon was also making progress on my instruction to build emergency hospitals and said he would update me on 14 March.

Paragraph 84, references paragraphs 229 of second witness statement [INQ000232194_0055]

229. I was briefed that SAGE had updated the reasonable worst-case scenario with the latest international data and reduced the maximum number of deaths from 820,000 to a still horrific 520,000 out of 53.5 million people showing symptoms. Around 390,000 of those might be in critical care with such bad breathing problems that they need ventilators. The numbers were huge and it was clear to me that there was no way the NHS would cope; it was difficult enough getting a number of how many beds the NHS had available, but on any estimate it was an order of magnitude less than 390,000.

Paragraph 152, references paragraphs 33-34 of third witness statement [INQ000273833_0008-0009]

33. In respect of staff movement between care homes, from the moment it became clear that staff movement was a vector of transmission, I pushed hard to limit, and then ban, staff movement. Various arguments against were presented, including that staff were essential for the sector, which of course they are, but I took the view that the need to stop infections getting into care homes was more important.

34. As stated at paragraph 49 of my second witness statement, as soon as I saw the initial evidence from PHE that staff movement was the main source of transmission [MH3/60 — MH3/62 — INQ000000000; INQ000000000; INQ000000000], I asked my team to undertake urgent work to restrict such movement. For example, on 11 May 2020 I wrote to the Prime Minister setting out a further support package for care homes. In that letter I noted that we

had considered the option of banning staff movement, but considered it too fraught with operational risks at that time [MH3/63 — MH3/64 INQ000000000; IN0000000000]. On 15 May 2020, we announced the Care Home Support Package which recommended that care homes restrict staff from working in more than one care home supported by the Adult Social Care Infection Control Fund [MH3/65 — INQ000106429]. On 19 June 2020, we published further guidance on 19 June 2020 to that effect [MH3/66 — INQ000106486]. As a result of the action we took, 90% of care homes took action to restrict staff movement, and as a result staff movement between care homes fell dramatically over the summer of 2020 [MH3/67 M H3/68 — INQ000000000; INQ000000000], and infections in care homes were much lower in the second wave.

Paragraph 178, references paragraph 486 of second witness statement [INQ000232194_0121]

486. From early June 2020, it became apparent that a primary contributor to Covid-19 getting into care homes was staff movement, rather than residents who had been discharged from hospitals. Care providers had constant and significant vacancy levels, which meant that agency staff particularly were working in more than one care setting to meet that need, so there was a substantial number of staff moving between care settings (MH2/442 - INQ0000000). While we had introduced guidance that recommended staff work in only one care home, and while the number of staff working in more than one care home fell by around 90% over the summer of 2020, on 3 July 2020 I chaired a meeting with the Minister for Care and Departmental leaders where we discussed how to reduce staff movement to zero and options for legislating against such movement (MH2/443 - INQ0000000). I chaired a further meeting with the Minister of Care and Departmental leaders on 28 July 2020 where we discussed it (MH2/444 - INQ0000000). I asked the Minister for care to take the lead on it.

Paragraph 181, references 55-57 and 60 of fifth witness statement [INQ000421858_0015-0016]

55. Enabling care home staff to access COVID-19 tests was linked directly to NHS capacity, because the prioritisation of tests was an important clinical question, and tests were in short supply. I did all I could to increase testing capacity as rapidly as possible.

56. On 10 April I announced that we had capacity for all key social care staff and NHS staff who needed to be tested to get a test (MH5/24 - INQ000478869).

57. On 14 April 2020 I received updated advice from Sir Chris Whitty that he was now recommending testing asymptomatic people going to care homes from hospital, which I regarded as a very significant step forward (MH5/25 - INQ000093326; MH5/26 - INQ000292604; MH5/27 - INQ000292605). On 15 April 2020 I had succeeded in driving testing up to 38,766 per day, and we were able to announce that all patients being discharged from hospitals into care homes should be tested. There was subsequently a change in scientific advice due to operational constraints, as I discussed in my third witness

statement at paragraph 53d. Testing was extended to asymptomatic care home staff on 28 April 2020.

60. On 26 April 2020 I received a written update from officials on asymptomatic swab testing. That paper noted, emphasis added, "PHE has confirmed there is no barrier 16 to testing symptomatic people in any setting or to including asymptomatic people where clinically appropriate. In the first instance, this will include: expanding testing to all hospital admissions to help guide improved infection control; testing more people in care homes when outbreaks occur, whether they are symptomatic or not; as well as staff in care environments to understand the prevalence of asymptomatic disease and develop protocols to minimise the number of staff in these environments who are potentially asymptomatically infectious." (MH5/29 - INQ000478887)

Paragraph 184 references paragraph 53d of third witness statement [INQ000273833_0014-0015]

53. During and since the pandemic, many conspiracy theories have grown up around actions taken during the pandemic, and I have addressed some below:

d. It has wrongly been claimed that I rejected clinical advice on care home testing. On the day in question, 14 April 2020, I welcomed new advice to test those going into care homes [MH3/84 - MH3/86 - INQ000093326; INQ000000000; INQ000000000].The advice changed due to an inability to operationalise the original proposal, and I acted on this subsequent advice articulated through official government channels not over WhatsApp [MH3/87 MH3/91 INQ000000000; INQ000000000; INQ000000000; INQ000000000; INQ000000000]. The fact this all happened on one day shows how rapidly we were working to keep people safe, according to the best advice. To suggest otherwise is both misleading and untrue.

Paragraph 193, references paragraph 293 of second witness statement [INQ000232194_0069-0070] and paragraph 126 of fifth witness statement [INQ000421858_0031-0032]

293. Formal responsibility for PPE distribution rested with individual institutions – whether NHS hospitals, Primary Care (which is contracted by the NHS, not run directly) or care homes, which are mostly private sector. Prior to the pandemic, the official NHS supply chain only supplied the main hospitals, while primary care and social care provided for themselves. However, given the global shortage, it became extremely clear that individual organisations would not be able to provide for themselves. I therefore insisted that primary care and care homes be given PPE deliveries from our national stocks. Although this was a departure from normal arrangements (as care homes were private entities and not normally supplied with stocks by the Government), I was aware that care homes desperately needed PPE because their stocks were not designed to cope with a pandemic; this is another area where preparedness fell short. We responded as fast and as widely as possible, including giving free PPE to care homes as well as the NHS. I would recommend that all health and social

care facilities are required to keep an appropriate store of PPE for the early stages of any future emergency.

126. Formal responsibility for PPE distribution rested with individual institutions – whether NHS hospitals, Primary Care (which is contracted by the NHS, not run directly) or care homes, which are mostly private sector. Prior to the pandemic, the official NHS supply chain only supplied the main hospitals, while primary care and social care provided for themselves. However, given the global shortage, it became extremely clear that individual organisations would not be able to provide for themselves. I therefore insisted that primary care and care homes be given PPE deliveries from our national stocks. Although this was a departure from normal arrangements (as care homes were private entities and not normally supplied with stocks by the Government), I was aware that care homes desperately needed PPE because their stocks were not designed to cope with a pandemic; this is another area where preparedness fell short. We responded as fast and as widely as possible, including giving free PPE to care homes as well as the NHS. I would recommend that all health and social care facilities are required to keep an appropriate store of PPE for the early stages of any future emergency.

Paragraph 211, references paragraph 91 of first witness statement [INQ000181825_0021]

*91. In respect of **PPE**, while the UK had a large stockpile that had been laid down in the late 2000s, the warehouse in which it was stored in the north-west was not designed for rapid access, and the distribution system was designed for delivering to 250 hospitals, but suddenly needed to deliver to over 50,000 sites including GP practices and care homes. In future, all sites should maintain basic supplies, and we need an emergency system so PPE can be distributed around the country in an emergency from storage facilities spread across the regions.*

Paragraph 213, references paragraph 126 of fifth witness statement INQ000421858_0031-0032

126. Formal responsibility for PPE distribution rested with individual institutions – whether NHS hospitals, Primary Care (which is contracted by the NHS, not run directly) or care homes, which are mostly private sector. Prior to the pandemic, the official NHS supply chain only supplied the main hospitals, while primary care and social care provided for themselves. However, given the global shortage, it became extremely clear that individual organisations would not be able to provide for themselves. I therefore insisted that primary care and care homes be given PPE deliveries from our national stocks. Although this was a departure from normal arrangements (as care homes were private entities and not normally supplied with stocks by the Government), I was aware that care homes desperately needed PPE because their stocks were not designed to cope with a pandemic; this is another area where preparedness fell short. We responded as fast and as widely as possible, including giving free PPE to care homes as well as the NHS. I would recommend that all health and social

care facilities are required to keep an appropriate store of PPE for the early stages of any future emergency.
