

Wednesday, 2 July 2025

(10.00 am)

LADY HALLETT: Ms Carey.

MS CAREY: My Lady, good morning. Can I ask, please, that Mr Hancock is sworn.

MR MATT HANCOCK (affirmed)

Questions from LEAD COUNSEL TO THE INQUIRY FOR MODULE 6

LADY HALLETT: Ms Carey.

MS CAREY: Thank you, my Lady.

Mr Hancock, thank you for returning and for your tenth witness statement to the Inquiry. I have a number of questions to ask you now about the response in relation to the adult social care sector.

By way of background, though, you were the Secretary of State for Health and Social Care from July 2018 to 26 June 2021; is that correct?

A. I was, yes.

Q. Your statement, INQ000587746, sets out your background, but it was primarily in areas of finance. Do I take it you had no professional experience of the adult social care sector before you became the Secretary of State?

A. Well, that's not quite true, no, because the nature of being a Member of Parliament means that you have professional engagement with the care sector, care homes, domiciliary care, whether registered by the CQC

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A. So there was a hodgepodge of accountability that was -- that meant that the levers we had at the centre were weak.

And in addition to that, essentially the NHS could command public attention in a way that the care sector found more difficult.

Q. I'm going to come on to the levers or lack thereof in a moment.

A. Yes.

Q. But in relation to the pre-pandemic state and perhaps reputation and indeed public attention, as you've just alluded to, within the sector, do you consider that domiciliary care was overlooked at the expense of responding to the impact of the pandemic on care homes?

A. No, I don't think that's true at all. I think that domiciliary care was incredibly important, and indeed, when we talk about the care sector, we are primarily talking about domiciliary care simply in terms of the numbers of people who are in receipt of that care. And that was very much, you know, at the front of my mind in terms of how I thought about the care sector.

The -- and of course, often, when the care sector is used as a shorthand, we don't -- people often don't think enough about care for those who are of working age as opposed to those who are frail essentially because of

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or not. So I had considerable experience on the ground in terms of supporting my local care homes.

Q. I see. But you hadn't acted in the Department of Health and Social Care prior to your appointment as Secretary of State in the role of social care; is that correct?

A. No, that's correct. My background was essentially in technology rather than finance.

Q. Before we descend to some of the detail, can I ask you just to stand back and answer this: going into the pandemic, do you consider that the social care sector was the Cinderella service to the NHS?

A. Oh, the social care sector is -- was badly in need of, and remains badly in need of, reform. I wouldn't call it the Cinderella sector but I know that a lot of people feel that way. I would say that it is badly in need of better support, better governance, better data and information flows.

Ultimately, the 1948 settlement that led to the formation of the NHS left social care as the legal responsibility of councils. The policy responsibility nominally resided with me in the Department of Health and Social Care, the funding decisions essentially came from the Treasury and were communicated through the Ministry of Housing, [Communities] and Local Government.

Q. Yes.

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old age.

Q. All right. So, from your perspective, not only was it important but it was at the front of your mind when you were making decisions in relation to the adult social care sector?

A. Yes. Now, sometimes decisions were different for the two sectors because the circumstances were different, but that was taken into account, yeah.

Q. Right. Can I ask you the same question: were the millions of unpaid carers overlooked, do you consider, at the expense of domiciliary care and the impact on care homes?

A. Well, they were -- the millions of unpaid carers were considered. It is much, much harder to get support to unpaid carers, by the nature of the care and the fact that there isn't a registration programme in any way. But we tried very hard to do that. For instance, the shielding programme was essentially focused on those who were likely to be the most vulnerable, and those -- and their carers were a critical part of the shielding programme. So that's just one example of how unpaid carers were considered, but it was much harder to have a single overall policy for them, if you like.

Q. Right. Now, you, a moment ago, made reference to the lack of levers --

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1 A. Yes.

2 Q. -- there was in relation to adult social care. And

3 you've made it clear that it's the department really, as

4 I understand it, that sets the policy but it's the local

5 authorities that commission the care that's provided, in

6 a simple form; do you agree?

7 A. Oh, absolutely. That is the -- that is the settlement

8 that's been with us since the foundation of the NHS,

9 because, of course, before 1948, local authorities were

10 also responsible for health provision.

11 Q. Okay.

12 A. And that -- this has a series of consequences. But the

13 other thing I'd put right into the top of this, as an

14 issue, is the lack of data and the lack of information.

15 So it's not really just the lack of levers; it's also

16 the lack of information that was a huge problem.

17 Q. All right. We'll come on to that, as well.

18 A. Sure.

19 Q. You said in your statement that the Department of

20 [Health and] Social Care in fact has nominal

21 responsibility. Why is it in name only?

22 A. Because the policy decisions that are taken by the

23 national government with respect to care and policy

24 towards care, have to be implemented through local

25 government's contractual arrangements, or funding which

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1 data in return for the funding.

2 But of course if a care home found it very difficult

3 to get that data back to us, they therefore didn't get

4 the funding. That was a necessary part of the lever,

5 otherwise the lever wouldn't have any traction. But

6 that itself is a difficult position to put a care home

7 in, and often some of the care homes with the most

8 challenges are the ones that also don't have that sort

9 of data in-house.

10 So there's an example of action we took to try to

11 create levers. If we simply said, from the Department

12 of Health and Social Care, "We want data on [for

13 instance] how many tests you're carrying out, and what

14 the results of those tests are", then we may well get

15 a good reply from a large chunk of the care homes but we

16 wouldn't necessarily be able to -- wouldn't be able to

17 insist or get all of the care homes, or other care

18 providers, domiciliary care, for instance, to follow

19 that requirement.

20 Q. When did you first realise that the department lacked

21 the levers that you think are necessary?

22 A. I knew that before I became Secretary of State.

23 Q. Right. And are you able to answer this sort of rather

24 global question: what would you recommend the government

25 do in future to ensure that it does have the levers to

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1 went through MHCLG, as the department was called at the

2 time, whichever government department is responsible for

3 local authority funding, where essentially the funding

4 was supplied directly to MHCLG and, through them, to the

5 councils by the Treasury.

6 So the department has policy decision making, if you

7 like, that has to be cleared across government, but it

8 doesn't then execute that policy. The policy is

9 executed through other arms of the state.

10 This is a recipe for difficulty in decision making,

11 especially in a crisis.

12 Q. Right. So when you say we lacked the levers, are you

13 able to help those who are watching, who are perhaps not

14 familiar with that term, what did you actually mean by

15 the department lacking levers?

16 A. Well, I can give you one example relating to lack of

17 data. We needed to know, as best as we could, for

18 instance, how many people were actually getting tested

19 in care homes once the -- enough tests were available.

20 In order to get data like that and others, we had -- we

21 put a requirement on the funding that -- the extra

22 funding that was given in emergency funding -- that

23 funding would only be available to a care home if they

24 made the data available. That was an innovation in how

25 we created a lever by giving extra funding and requiring

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1 support care providers if there's a future pandemic?

2 A. Well, I think there are -- there's a whole series of

3 things that need to happen now. In fact, they needed to

4 happen several years ago. You know, we are three years

5 into this Inquiry and I think the situation has got

6 worse, not better, for when the next pandemic hits.

7 I would absolutely have a requirement baked into

8 every contract for care provision that allows for

9 requirements to be put in place by central government

10 that are proportionate and medically recommended and so

11 that, in extremis, new requirements that we can't think

12 of now, may be able to be put in place.

13 Immediately there's a series of concrete things that

14 should happen now. For instance, one of the major,

15 major problems that I'm sure we'll come on to, was the

16 lack of isolation facilities within care homes.

17 Q. Yes.

18 A. There should be no care home in the country today that

19 doesn't have isolation facilities. It should be

20 a requirement for the provision of care. Because we

21 don't know when the next pandemic will hit, and when it

22 does hit, it will hit fast, like this one did. And our

23 problem was, the central problem with that, the

24 discharge question, which I know we'll come on to, was

25 that there wasn't isolation facilities in every care

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1 home.
 2 Likewise, every care home should have a legal
 3 requirement to have a stock of PPE. We got PPE to care
 4 homes, free PPE, pretty quickly in the grand scheme of
 5 things, but it was very, very difficult and challenging
 6 to do that.
 7 There is -- there is a whole series of
 8 recommendations --
 9 **Q.** -- (overspeaking) -- slightly --
 10 **A.** -- that we can come to, but the levers question is an
 11 extremely good one.
 12 **LADY HALLETT:** I'm sorry, I've not followed whether you've
 13 answered it, Mr Hancock.
 14 **THE WITNESS:** Okay.
 15 **LADY HALLETT:** You've talked about the contracts between
 16 local authorities and care providers and, as you
 17 appreciate, contracts have to be fairly carefully drawn
 18 so people know if they're in breach of it or not, and
 19 I wasn't quite following what you say should go into
 20 such contracts. Are you saying things like you must
 21 have isolation facilities and you must have PPE stocks?
 22 Is that what you were saying? I wasn't following
 23 whether your answer was all together or
 24 different factors.
 25 **A.** My Lady, I apologise for not being clear enough.

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1 provision of isolation facilities and of PPE stock in
 2 every care home.
 3 **MS CAREY:** So from your perspective, Mr Hancock, do you
 4 consider that that would require legislation to bring
 5 about those changes to contractual requirements? Or is
 6 that a regulatory matter? Can you help us as to who it
 7 would be in the event that we wanted to recommend that
 8 there were such changes to contracts?
 9 **A.** It's a good question. There would be a number of
 10 different ways to do it. Probably the best would be to
 11 take a provision in legislation that such measures could
 12 be brought in by regulators. That would be, I think,
 13 the normal and the best way to do it.
 14 **Q.** Thank you. All right.
 15 Now, you've mentioned data in one of your early
 16 answers.
 17 **A.** Yeah.
 18 **Q.** And in your statement you say, "I was extremely
 19 concerned about the lack of data we had on social care"
 20 and, essentially, you considered some of the data that
 21 you had to be inadequate?
 22 **A.** Absolutely, either inadequate or non-existent, yeah.
 23 **Q.** Given that the data was inadequate and you were
 24 concerned about it, are you able to tell us what you did
 25 to try and improve the data that was available to the

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1 Firstly, I think there are a series of requirements
 2 that we could set out now that you might consider for
 3 your report. That should happen immediately that we can
 4 specify, clearly: like isolation facilities, PPE stocks,
 5 data on communicable diseases. Personally I would ban
 6 staff movement between care homes in good times as well
 7 as in pandemics because communicable diseases kill
 8 people in care homes all of the time.
 9 And then -- so there's a series of concrete
 10 recommendations of policies that can be specified now.
 11 But I would also put in place, if you like, an
 12 in extremis provision that subject to clinical advice,
 13 further measures could be brought in in the event of
 14 a pandemic. For instance, visitor restrictions, testing
 15 requirements. These are likely to be needed but we
 16 can't be certain they'd be needed, depending on the
 17 nature of the next novel pathogen, and therefore an
 18 ability of the centre to say to care homes "This is what
 19 is required" would be valuable, but you, of course, have
 20 to have a reasonableness consideration, because you
 21 would be not specifying concrete action; you'd be
 22 specifying future unknown action.
 23 But that, in a way that second part is less
 24 important than the things that we know should be
 25 happening in care homes right now, like the universal

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1 Department of Health early on in the pandemic?
 2 **A.** Yes, so in the first instance, we asked questions. So
 3 we simply asked for the information necessary. And we
 4 then brought in more and more sophisticated data
 5 requirements, both providing the technology for care
 6 homes easily to be able to provide data that was
 7 required, and then, as I mentioned earlier, to tie the
 8 provision of high-quality data to the emergency funding.
 9 Some of the emergency funding.
 10 **Q.** Yes.
 11 **A.** -- not all of it.
 12 **Q.** No.
 13 **A.** Very important that everybody got -- every care facility
 14 got some emergency funding, but to an element of the
 15 emergency funding. I mean, that was an innovation
 16 because we needed to know as much as possible what was
 17 going on. And then I suppose the third element was
 18 constructing surveys which weren't mandatory, but that
 19 almost every care provider leant into the -- providing
 20 data into.
 21 **Q.** Right. I'd like to look at just one aspect of the data
 22 with you please.
 23 And could we have up on screen INQ000274068_8.
 24 Thank you.
 25 Mr Hancock, this is a WhatsApp exchange between you

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1 and Ms Whately the Minister for Social Care, on 9 April.
 2 Can we highlight, please, on the screen, thank you,
 3 from 21.20 down -- this is about data in relation to
 4 deaths in care homes.
 5 **A.** Yeah.
 6 **Q.** And the minister says:
 7 "I'm afraid [I've] been sent [the] first proper data
 8 on care homes deaths just now and it's not good.
 9 Speaking to PHE, the CQC, Ros [that's Ros Roughton who
 10 was in the Department of Health and Social Care]
 11 tomorrow morning about it."
 12 **A.** Yeah.
 13 **Q.** You said, "Ok".
 14 Ms Whately says:
 15 [As read] "You're doing a press conference. Care
 16 home death data may come up. We expect official ONS
 17 data on Tuesday will show a big jump in deaths. Also we
 18 now have deaths of residents in care homes but there is
 19 some double counting because it includes some people who
 20 have died in hospital and non-Covid. It's not that
 21 we're not counting, it's that it's complicated. Changes
 22 to notifications will give us better data soon."
 23 And she says:
 24 [As read] "We're investigating how Covid outbreaks
 25 are occurring, how it's getting in and getting passed

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1 that we -- a point that is really important to
 2 recognise, crucial to recognise is that we knew from
 3 very early on, from January, that the greatest impact of
 4 this virus was on older people. We knew that from the
 5 deaths internationally.
 6 **Q.** Yes.
 7 **A.** So that is why this point about it didn't -- it just
 8 didn't start in March. I mean --
 9 **Q.** All right. Put that to one side.
 10 **A.** Yep.
 11 **Q.** Whenever the pandemic started from your perspective, do
 12 you consider that the death data was essential and it
 13 would have been better to have had it earlier on?
 14 **A.** The answer is yes, but I'm also going to unpack it
 15 slightly.
 16 **Q.** Okay.
 17 **A.** Because the point here in Helen's 3.34 message is really
 18 important. There are two problems with the data. One
 19 is the quality of data that's being received at the
 20 centre. The second is what is actually knowable,
 21 because when a lot of, or in a lot of -- when people --
 22 how shall I put it? Working out whether a death was due
 23 to Covid-19 or not is not a trivial task, clinically.
 24 Chris Whitty is more eloquent on this than I'm being.
 25 And therefore, working out what was non-Covid, what was

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1 on. PHE has launched research."
 2 And at 3.36 you say:
 3 "Thanks. Do you have a briefing on the deaths data?
 4 "Great."
 5 And she says she's "seen it and discussed it with
 6 Ros."
 7 And then it looks like you were probably going to go
 8 and do a 5 pm conference that evening because there's
 9 a break in the messages.
 10 **A.** Yeah. Huh!
 11 **Q.** Can you help us, Mr Hancock, with -- clearly the death
 12 data took some time to become available, if we take
 13 March as the start of the pandemic, we are five or six
 14 weeks or so in. Do you accept that that type of data
 15 was essential earlier on to inform the response
 16 alongside data on the outbreaks?
 17 **A.** March wasn't the start of the pandemic; January was the
 18 start of the pandemic.
 19 **Q.** Well, January it started but by the time we were
 20 entering the phase when we're thinking about lockdowns,
 21 the numbers are rising.
 22 **A.** Yeah.
 23 **Q.** If we take March as a rough starting point.
 24 **A.** We were thinking about -- (overspeaking) -- since the
 25 pandemic started in January, it is absolutely crucial

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1 Covid, and separating out also, you know, was -- if
 2 there was a care home resident who went into hospital
 3 and died, making sure that that doesn't double count,
 4 that's a sort of tractable administrative challenge, but
 5 then there's genuine deep clinical challenges which is
 6 when somebody who is very frail dies, what they died of
 7 is a difficult question.
 8 And therefore there were both tractable and
 9 intractable problems with the data. Does that make
 10 sense?
 11 **Q.** Yes, I understand that, and I think the answer to my
 12 question was: yes, you would have rather had it earlier
 13 on --
 14 **A.** Yes, of course.
 15 **Q.** -- but there are various practical reasons why it may
 16 not be possible to ascertain in the level of detail what
 17 is a death from Covid or a death of Covid.
 18 I understand.
 19 **A.** Death with Covid.
 20 **Q.** I see.
 21 **A.** But the answer to your question would it have been
 22 better to have data earlier? Yes. The real question
 23 now, for the country now, is, will we be in a position
 24 to have this sort of data right from the start next
 25 time? And I just would also put a note on this in that

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1 all of this discussion, almost all of it, will be with
2 respect to older-age people because this pathogen
3 happened to attack and be more deadly amongst older-aged
4 people. But the next pathogen may well be just as
5 deadly with children, and you can see that in the middle
6 of this exchange, actually. You didn't read it out, but
7 it's there.

8 And any lessons that we have for the future need to
9 respect the fact that we don't know who the next
10 pathogen will target. Well, there have been pathogens
11 in the past that have targeted men in their twenties
12 more than any other group, and therefore we can't, in
13 recommendations and in thinking about being prepared for
14 the future, we can't be -- we can't assume that it will
15 have the same impact on the age range, and therefore,
16 the data question isn't just about older persons' care;
17 it's about care for the most vulnerable in the younger
18 age and of working age as well as, of course, for older
19 age groups.

20 **Q.** When Helen Whately messaged you to say that the care
21 homes deaths data was in and it was not good, did you
22 ask for an immediate briefing or ask to see the data,
23 Mr Hancock?

24 **A.** Yes. It's here in the messages:

25 "Do you have [a] briefing on the deaths data?"

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1 Just broadening the data issue from deaths data, do
2 you agree that there ought to be a national centralised
3 database which contains relevant data about the care
4 sector?

5 **A.** Yes, I absolutely think that that's vital, and I think
6 that it should include all data on all communicable
7 diseases in care homes, in the care sector more broadly,
8 and care homes of all ages. And it should include that
9 data now, in normal times, as well as in pandemic times.
10 So, for instance, I would have a, say, weekly
11 requirement for any care facility to report communicable
12 disease to UKHSA.

13 Putting that in place would be relatively
14 straightforward, and then would allow a much, much
15 richer understanding of communicable diseases in care
16 facilities all the time. After all, flu every winter is
17 a killer, and this could be done -- this could be done
18 now.

19 **Q.** All right. Now you mentioned that communicable diseases
20 should be reported to the UKHSA.

21 Do you consider that they would be best placed to
22 run, collate the national centralised database or should
23 that be run out of the department? Can you help with --

24 **A.** It absolutely should be UKHSA. That is their job, is to
25 stop communicable diseases from damaging the population.

19

1 So, yes.

2 **Q.** You did have it, all right.

3 **A.** No, no, I asked for it.

4 **Q.** Right. Well, I understand you asked for it, but the
5 question I asked was: did you end up getting it?

6 **A.** Well, that'll be -- I did end up getting briefing, and
7 the briefing got better over time.

8 You can see it in this exchange. I say:

9 "Do you have [a] briefing on the deaths data?"

10 And Helen says:

11 "I've seen it and discussed it with Ros -- no formal
12 briefing."

13 That's because the quality of the -- we still had
14 data quality. That will be, I presume, because we still
15 had data quality issues at this point.

16 By around May we had much better data, and in the
17 second and -- in the second peak, we had what I would
18 now regard as high-quality data.

19 **Q.** Do you know whether the death data was shared with
20 stakeholders so that they could provide support and
21 safeguard residents and staff? If you don't know,
22 please say.

23 **A.** I know that we published it but I don't know when we
24 started publishing it.

25 **Q.** Right. And just -- we can take that down, thank you.

18

1 **Q.** All right. Before we turn, perhaps, to the initial
2 response to the pandemic, can I just ask you this, about
3 the engagement with the sector more generally: did you,
4 as Secretary of State, engage with stakeholders, the
5 National Care Forum, the various care provider
6 alliances, or was that something you left to the
7 minister to deal with?

8 **A.** The -- I did to a degree but largely, it was a -- that
9 was a primary task for Helen Whately. And when you say,
10 "left to the minister", that rather understates the
11 capability of Helen Whately, who was an absolutely
12 first-rate minister. And as you'll know from her and my
13 text exchanges, we had an extremely high quality and
14 professional relationship.

15 **Q.** You said you "did to a degree". Are you able to help
16 with who you actually engaged with in the sector?

17 **A.** I haven't got it in front of mind. It's all there in
18 the records.

19 **Q.** Right.

20 We know that you told us in Module 3 that you
21 visited a hospital during, I think it was,
22 January of 2021. Did you undertake any visits to care
23 homes, whether in person or virtually?

24 **A.** Yes.

25 **Q.** And are you able to tell us when that was and give us

20

1 some detail about that visit or visits?

2 **A.** Well, firstly, if I just -- I visited hospitals many,

3 many times over the course of the pandemic, when it was

4 safe to do so, not just once in 2021.

5 **Q.** No, but that was the example you gave us in Module 3,

6 which is why I alighted upon it.

7 **A.** Right.

8 **Q.** So just help us with the care homes, please, Mr Hancock.

9 **A.** Yes. Yes, I did.

10 **Q.** How many did you visit? Tell us what you saw, tell

11 us how it helped inform your response to the pandemic.

12 **A.** So I visited care facilities both virtually and, when it

13 was safe to do so, in person. Remember, visiting

14 restrictions were strong during most of this period in

15 order to protect residents. I visited, for instance, in

16 my constituency engagements, where I had good relations

17 with my -- many of my local care facilities. I'm very

18 happy to provide a list, but you have the documentation

19 that will set out when I did those visits.

20 I found it vitally important, in a leadership role,

21 to listen to what I heard on the ground. For instance,

22 the importance and the gratitude for the free PPE that

23 we supplied was something that was always brought up

24 with me on a visit to a care home after the first peak.

25 And that's one of the reasons that informs my

21

1 **Q.** Right, okay.

2 **A.** -- but I was also dealing with a national pandemic.

3 You have to remember the context. I'm also dealing

4 with driving testing, lockdowns, I had Covid myself,

5 obviously the vaccination programme. I was pretty busy.

6 **LADY HALLETT:** Mr Hancock, Ms Carey asked you about what you

7 learnt from your visits, either in person or remotely,

8 with care homes. And you mentioned two positive things:

9 provision of free PPE and the support you say that was

10 going into care homes.

11 Did you learn anything negative about what was going

12 on in care homes?

13 **A.** Well, care homes were having a terrible time. I mean --

14 **LADY HALLETT:** So what did you learn?

15 **A.** I learnt that those on the ground in care homes were

16 working unbelievably hard to try to support their --

17 those who were in their care, and they were having

18 a torrid time with it. I take that as read. Sorry,

19 I should have -- I absolutely should have -- should

20 acknowledge that. Quite rightly.

21 I also -- one of the other things that I talked to

22 the care homes I spoke to or visited about was this

23 incredibly difficult challenge of visitor policy. So we

24 knew that when there was spread of Covid in the

25 community, visitors were likely to increase the risk to

23

1 recommendation that there should be PPE stocks.

2 You know, when suddenly there was a requirement

3 for PPE -- and remember that since most care homes are

4 private facilities, purchasing PPE was a private matter

5 that the government didn't really have any input into

6 before the pandemic -- suddenly, we had, we felt, a duty

7 to get PPE to care homes, and we provided it for free.

8 So I got a lot of positive feedback about that

9 element of what we did, and the other huge amount of

10 support that we put into care homes.

11 **Q.** Free PPE I think was provided on 20 July, or that's

12 certainly when you authorised that. Are you able to

13 help with --

14 **A.** I'm not sure that's right.

15 **Q.** Well, we'll come to the detail when we look at PPE in

16 due course.

17 **A.** Sure.

18 **Q.** What I wanted to ask was, prior to the rollout of free

19 PPE, did you perform any visits to care homes in March,

20 April, May 2020? Can you recall?

21 **A.** Not physically. That would have been totally

22 inappropriate.

23 **Q.** No, I prefaced the first question with "[either] in

24 person or virtually".

25 **A.** Yeah, I can't remember. I may well have done --

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1 care home residents, which could be a fatal risk, but at

2 the same time lack of visiting is incredibly painful and

3 can be damaging, especially to -- for instance, to those

4 with dementia. And you couldn't fail to be moved by the

5 impact of the visitor restrictions.

6 And there was one point during this period when

7 I was being legally challenged both in favour of more

8 visiting and against visiting at the same time. You

9 know, in a way, visitor policy captures the fact that

10 there were just no good choices in many areas, and it

11 fell to us to try to strike the best balance. So

12 visitor policy was often something I discussed.

13 As it happens, most care homes, in my recollection,

14 strongly supported the restriction on visitors because

15 they wanted to keep their residents safe, but at the

16 same time, they acknowledged the emotional and potential

17 medical impact of that restriction.

18 **MS CAREY:** We have jumped ahead but can I come back --

19 **A.** No, but I'm grateful for the opportunity to set that out

20 more broadly than I did in my first answer.

21 **Q.** No, not at all, and we'll come back to visitor

22 restrictions. All right?

23 Can I ask you, please, though to go back to

24 February 2020, please, and the initial response to the

25 pandemic. And you set out in your statement, at

24

1 paragraph 52 for those who are following, that:
 2 "Pandemic contingency plans were prepared by local
 3 authorities."
 4 **A.** Yeah.
 5 **Q.** "A note from a meeting with officials on
 6 11 February 2020 records that I had indicated the
 7 primary responsibility for planning [the adult social
 8 care sector's] response to the pandemic was for local
 9 authorities ..."
 10 **A.** Yeah.
 11 **Q.** And I think you are aware that you raised that with
 12 Helen Whately?
 13 **A.** Yes.
 14 **Q.** She had made some inquiries to obtain two pandemic
 15 contingency plans?
 16 **A.** Yeah.
 17 **Q.** And it was her opinion that those plans, if I may put it
 18 colloquially, were not up to scratch?
 19 **A.** Absolutely right. It was a really shocking moment,
 20 yeah.
 21 **Q.** Did you yourself look at the two plans that Ms Whately
 22 had obtained?
 23 **A.** I did. It did not take long to work out that they were
 24 wholly inadequate.
 25 **Q.** All right. And are you able to tell us in what way, in
 25

1 **Q.** Right. When you found out from Ms Whately that there
 2 were at least two out there that were inadequate --
 3 **A.** It was worse than that. She could only find two and
 4 they were inadequate.
 5 **Q.** Yes. When she found only two and they were inadequate,
 6 what did you do to try and ensure that there were decent
 7 and adequate plans in place?
 8 **A.** So at that point we realised that far from relying on
 9 the existing governance structure, we were going to have
 10 to put out guidance from the centre, and essentially
 11 make an assumption that care facilities didn't have
 12 a pandemic plan. That's what we realised.
 13 And so the first guidance to care homes went out in
 14 February. And that was -- essentially, we took a -- we
 15 decided that we needed to have a national approach to
 16 making recommendations to care homes, rather than being
 17 able to rely on care homes having, and local authorities
 18 having plans, adequate plans for themselves.
 19 So I was dealing with these two problems, which is
 20 the national plans were based on the wrong doctrine, and
 21 I realised that between the end of January and the
 22 middle of February, and the local plans were as good as
 23 useless. And therefore, we put in place national
 24 guidance which, as you know, changed over time as the
 25 clinical advice changed.
 27

1 general terms, you considered them to be inadequate?
 2 **A.** Broad brush, high level, not practical -- you know,
 3 without practical recommendations. But there's
 4 something much, much deeper, which is that -- which
 5 comes back to the point I made in my very first
 6 appearance as a witness in this Inquiry, which is about
 7 the doctrine that underpinned the medical advice, and
 8 therefore the government approach to pandemics, which is
 9 embedded in the 2011 strategy, which is that if your
 10 plan is not to try to stop a pandemic but is to deal
 11 with the consequences of a novel pathogen ripping
 12 through the community, then you just -- there are
 13 different elements -- you have a different approach.
 14 And so the plans were based on essentially trying to
 15 cope with a virus that had a bad impact on older people
 16 rather than trying to stop it from ripping through in
 17 the first place. The same -- the same doctrine problem
 18 underpinned this whole area, and it took a huge amount
 19 of effort to change that over the course -- from when
 20 the penny really dropped with me in the middle of
 21 February, over the period of the next couple of months.
 22 **Q.** Right. From your perspective, ahead of the pandemic,
 23 who had responsibility for checking the adequacy or
 24 otherwise of the pre-pandemic plans?
 25 **A.** Local authorities.
 26

1 **Q.** Right. That first piece of guidance, I think, was
 2 issued on 25 February, and can I have up on screen,
 3 please, INQ000499433, page 7.
 4 This was the guidance for social and community care
 5 in residential settings on Covid-19. And you'll see
 6 there that the guidance at that time on face masks was
 7 that face masks did not -- "do not provide protection
 8 from respiratory viruses such as COVID-19 and do not
 9 need to be worn by staff in any of these settings".
 10 **A.** Yeah.
 11 **Q.** Only if recommended essentially or advised by
 12 a healthcare worker.
 13 "It remains very unlikely that people receiving care
 14 in a care home or the community will become infected."
 15 **A.** Yeah.
 16 **Q.** Now this is PHE guidance, I appreciate that.
 17 **A.** Yeah.
 18 **Q.** But does that reflect your understanding as at
 19 25 February, that it was unlikely -- sorry, very
 20 unlikely that people receiving care in a care home or
 21 the community will become infected?
 22 **A.** No, this is -- I mean, the -- there's two problems here,
 23 obvious. One is that the clinical advice on face masks
 24 was confused for a long period of time during the
 25 pandemic, and that confusion is -- is -- it can be seen
 28

1 here. It is true that at this point, the number of
 2 infections in the UK was extremely low.
 3 **Q.** Correct.
 4 **A.** And so "it remains unlikely that people receiving care
 5 in a care home on the community will be infected", would
 6 have been true. But that word is not "be", it's
 7 "become" and by this time we knew that there was a very
 8 serious problem. So I've no idea why PHE stated that.
 9 **LADY HALLETT:** Sorry to interrupt, can I just correct the
 10 answer. You said the number of infections in the UK was
 11 extremely low. The number of infections that we knew
 12 about, was extremely low.
 13 **A.** Correct. Compared to what came, both are true. The
 14 number of infections we knew about and had -- was very
 15 low, yes.
 16 **MS CAREY:** So in short, this doesn't necessarily reflect
 17 your understanding?
 18 **A.** I was in a battle with PHE at this point, right?
 19 **Q.** Yes, or no; does this reflect your understanding as at
 20 25 February?
 21 **A.** No, I wouldn't say "become", I'd say "be", will "be"
 22 infected.
 23 **Q.** Right.
 24 **A.** You know, and this comes back to asymptomatic
 25 transmission unless you want, you know -- I -- obviously

29

1 tense, rather than the future tense. It was already
 2 clear that we were going to have a major pandemic. And
 3 that was -- to me, that was obvious. But what's even
 4 more frustrating is it was obvious to the team around
 5 me, as well, I mean this is -- this was late February.
 6 We were, you know, we'd switched into full pandemic
 7 planning mode from the end of January in the Department.
 8 **Q.** Right. That was -- that can come down, thank you.
 9 That was as at 25 February 2020. The two plans that
 10 we've just spoke about that were inadequate were sent to
 11 you on 3 March. Ms Whately told you in some WhatsApps
 12 that they were inadequate. She said to you that
 13 essentially the plans didn't really say very much --
 14 **A.** Yes.
 15 **Q.** -- as you've just acknowledged. And in a WhatsApp back
 16 to her you said this:
 17 [As read] "Can you possibly put some serious drive
 18 into getting them to a credible position? CMO tells me
 19 there's guidance to social care being developed and
 20 published. It seems to me we need to do a lot of work
 21 here."

22 And she says:

23 [As read] "Absolutely right, it's taken a week even
 24 to get these two example plans in a meeting. You are
 25 right, it needs a rocket under it."

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1 we've covered asymptomatic transmission in many modules
 2 but since the last module, it's come to my attention
 3 that on 27 January, I insisted in a meeting that -- I
 4 was concerned by reports from the Chinese government
 5 about asymptomatic transmission --
 6 **Q.** Yes.
 7 **A.** -- hold on -- and set out the need to plan for the
 8 reasonable worst-based scenario in that respect. That's
 9 INQ000106067.
 10 **Q.** Yes.
 11 **A.** So from January I was requesting the system to base its
 12 planning assumptions on asymptomatic transmission, and
 13 I didn't get PHE to take that on board until April. And
 14 this guidance from PHE is a representation of that
 15 problem.
 16 **Q.** So, from your perspective, had this been passed over
 17 your eyes for agreement or otherwise -- I'm not saying
 18 it should have been, but had it have been, you would not
 19 have allowed the guidance to go out with that line
 20 in it?
 21 **A.** If I --
 22 **Q.** Based on your understanding of asymptomatic transmission
 23 at the time?
 24 **A.** If I had read this in draft, I would have said, I would
 25 have changed -- I would have changed it to the present

30

1 **A.** A rocket. Absolutely.
 2 **Q.** And I take it from that answer you've just given that
 3 you agreed with the minister: it did need a rocket?
 4 **A.** A hundred per cent, I agreed with the minister. You
 5 know, during this period from late January through to
 6 early March, we in the Department were pushing every
 7 button we could to get action. You know, you'll recall
 8 from other modules that I was calling for COBR meetings,
 9 I was being blocked from having COBR meetings. I was
 10 trying to drive action on testing, I was being blocked
 11 by PHE from expanding testing using the private sector.
 12 I was being told that it would take five years to get
 13 a vaccine and insisting that we had one by Christmas.
 14 There was a small team of us who were driving
 15 incredibly hard, and getting blocked. For instance,
 16 I was trying to publish the recommendations on likely
 17 actions we might have to take in terms of lockdown and
 18 getting blocked by Number 10 from doing that, which
 19 eventually went out in early March. At this is just
 20 another example of it. I cannot for the life of me
 21 understand why PHE would make a statement like that when
 22 it was so clear that we were running into a major
 23 problem, and it is a deep frustration that even as
 24 Secretary of State, I couldn't get them to change their
 25 clinical guidance.

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1 **LADY HALLETT:** Can I just ask, sorry if I don't really
 2 follow it, PHE was an independent agency but responsible
 3 to the Department of Health and Social Care?
 4 **A.** Through the CMO, yes. And I spoke to the chief
 5 executive.
 6 **LADY HALLETT:** So why doesn't the Secretary of State for
 7 Health and Social Care have any levers over PHE?
 8 **A.** You may very well ask. Because of the behaviour of some
 9 of the senior officials. So for instance, when I said
 10 in January "I want the serum that we have to be made
 11 available to the private sector so they can expand
 12 testing", they didn't do it. Right? It's astonishing
 13 that we haven't got PHE senior officials at this Inquiry
 14 and they've essentially not been asked these questions.
 15 It was an enormous --
 16 **LADY HALLETT:** I'm afraid we have had officials from Public
 17 Health England and UKHSA, Mr Hancock, so ...
 18 **A.** No, the ... These questions have not really been aired.
 19 I got so frustrated with PHE I abolished them, right,
 20 because they were so poor in their responsiveness.
 21 I took responsibility for testing away from them. It is
 22 wholly unfathomable to me that they didn't change the
 23 advice on asymptomatic transmission even to acknowledge
 24 that asymptomatic transmission might happen until April,
 25 and as you can see from the -- my exchanges with Helen

33

1 strip your clinical advisers of their -- because
 2 I couldn't write clinical advice because I'm not
 3 a doctor. So what I could do is challenge clinical
 4 advice, and challenge some of the executive decisions,
 5 and but when -- this is one of the challenges of the
 6 interaction of clinical advice and policy, is that in
 7 order successfully to challenge clinical advice,
 8 I essentially had to persuade other clinicians like
 9 Chris Whitty to overrule, which they would only do on
 10 the basis of scientific evidence. And that is a -- this
 11 was an enormous challenge.

12 But you can see, you can see at the time, how
 13 frustrated we were as ministers at the lack of
 14 responsiveness in the system to this problem.

15 **MS CAREY:** Can I move three days on from the "rocket"
 16 WhatsApp, please, to 6 March, and a coronavirus and
 17 social care meeting on that date.

18 And could I have up on screen, please, INQ000049530.
 19 There's a number of matters I'd like to ask you about
 20 this document, please, Mr Hancock.

21 We can see you opened the meeting by stating that:

22 "... the impact of the virus which poses
 23 a complicated set of problems on the social care sector
 24 due to the higher risks for older people and the need to
 25 be gripped as soon as possible."

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1 Whately, as ministers, we were extremely worried about
 2 this. But when you have independent agencies that do
 3 not accept the writ of a minister, it's a challenge.

4 They were backed up by the World Health
 5 Organization, remember? So it's like: do you do what
 6 the Secretary of State with his lay understanding and my
 7 intuitions says, or do you do what the World Health
 8 Organization is telling us? Which is there's no
 9 asymptomatic transmission, you know, everybody can --
 10 everybody please calm down. They delayed calling
 11 a public health emergency of international concern.

12 You know, so it was a period of intense frustration
 13 for my ministers and I, as you can see from the text
 14 exchanges.

15 **LADY HALLETT:** But if you felt so strongly, what could you
 16 as Secretary of State not do, if you felt that an
 17 agency, for which you were ultimately responsible --

18 **A.** Yes, so eventually --

19 **LADY HALLETT:** Couldn't you insist --

20 **A.** Yes.

21 **LADY HALLETT:** -- and call people in?

22 **A.** Yes, I called people in, yes. I had them into my
 23 office. Eventually I stripped them of their
 24 responsibilities, but it took me until mid-March to do
 25 that on testing. On clinical advice, it's very hard to

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1 What did you mean when you used the phrase it needed
 2 "to be gripped"?

3 **A.** Well, at this point it had come to my attention that, as
 4 we've just discussed, that the plans that were in place
 5 in the formal accountability, line of accountability for
 6 social care were wholly inadequate. And what I mean,
 7 I think, by this, is at a national level we need to take
 8 the action that's -- that should already have been in
 9 place at a local level, and essentially we needed to
 10 take responsibility for the response. So there's -- you
 11 know, and you see this in a whole series of areas.

12 The Department took responsibility for a series of
 13 areas over this period, because we realised that the
 14 preparations had been flawed because of the wrong
 15 doctrine and that there was not enough being done in
 16 other areas. We were not formally responsible for the
 17 delivery of infection control, for instance, in the care
 18 sector because that was technically a local authority
 19 responsibility. But we had -- we needed to just do it.

20 And, you know, throughout all of these modules
 21 you've seen this in a series -- this is what it felt
 22 like, right? We've seen this in a series of different
 23 areas and I apologise that this is not an answer within
 24 solely this module but it is important for this
 25 module -- there's a whole series of areas, this,

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1 testing, vaccines, where we in the Department under my
 2 leadership with the CMO, decided to take the action that
 3 ought to have been happening or ought to have happened,
 4 and grip it.
 5 **Q.** Right.
 6 **A.** That's what I --
 7 **Q.** Yeah, but what did you actually do to grip it?
 8 **A.** Well, shortly after this we put out further advice.
 9 **Q.** Yes.
 10 **A.** We increased the amount of money, and over the next two
 11 months we put £5.1 billion in the hands of care homes.
 12 We provided free PPE. Obviously, when tests became
 13 available, we made them very high in the priority order
 14 after hospitals, and made them available for tests --
 15 for staff and residents. We took, for instance,
 16 responsibility for visiting policy which normally would
 17 have been a local question. We took those decisions at
 18 a national level.
 19 **Q.** Right.
 20 **A.** And then we got on to, once it became clear that staff
 21 movement was the primary issue, we got on to, firstly,
 22 advising against staff movement and then trying to get
 23 a legal ban on staff movement.
 24 **Q.** I understand that, and there's number of things you
 25 subsequently did --

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1 **Q.** -- in relation to raising the threshold for giving care?
 2 **A.** Yes, so this a question about a measure in the Bill, the
 3 Coronavirus Bill, to say that care should not be given
 4 for those who are -- who there is a judgment that ...
 5 It's a measure in the Bill that says -- essentially
 6 for rationing care. We did not execute this measure.
 7 It's very important to state that. And it was against
 8 policy to either -- have do not resuscitate orders
 9 without proper and due consent, and there was pressure,
 10 for instance from the BMA, to have national rules on
 11 restricting care and raising the threshold for giving
 12 care. So the doctors unions were pushing for that.
 13 I refused to do that. And Chris Whitty and I on this
 14 were absolutely as one, which is the best place to
 15 decide on the appropriate care is the doctor by the
 16 bedside, not a national policy, despite the significant
 17 pressure we came under to put that policy in place.
 18 **Q.** All right, thank you.
 19 Can we move down the page, please, to the entry
 20 beginning:
 21 "DCMO [Jenny Harries] flagged that the majority of
 22 the people that we're talking about are receiving
 23 domiciliary care too. [Secretary of State] agreed that
 24 we would be thinking about this in the following
 25 hierarchy: residential home, nursing home, domiciliary

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1 **A.** -- (overspeaking) --
 2 **Q.** But as of 6 March, what I was trying to understand is
 3 what did you actually do there and then to grip the
 4 problem?
 5 **A.** We gripped all of those issues in time. The central
 6 point about this, what I mean by "need to be gripped" is
 7 we need to take responsibility. I don't care that it's
 8 not our legal responsibility. And actually I don't care
 9 if people get upset about it. You know, one of the --
 10 we've seen -- even from this very chair -- people who
 11 were upset about me taking action that was necessary.
 12 I ruffled some feathers, they were rude about me at the
 13 time, they've been rude about me since, but it saved
 14 lives, and that was my duty as Secretary of State.
 15 **Q.** Can we come back to the document.
 16 **A.** That's what it says.
 17 **Q.** Can we come back to the document, please, and look at
 18 the fourth bullet point down:
 19 "[Secretary of State] flagged the most contentious
 20 item in the Bill [which I assume is the Coronavirus
 21 Bill] is to raise the threshold for giving care. It's
 22 a very complicated set of problems."
 23 Are you able to briefly explain to us today what it
 24 was that was being proposed --
 25 **A.** Yes.

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1 care."
 2 Can I ask you, what did you mean when you said "in
 3 the following hierarchy"? Why was there a need for
 4 a hierarchy, Mr Hancock?
 5 **A.** Well, the -- I don't know what the specifically what
 6 "this", the word "this" is referring to here. If it's,
 7 for instance, referring to provision of PPE, then it's
 8 reasonable that you might understand the order in which
 9 life saving support is needed, but I don't know
 10 specifically what it is, what this is -- which
 11 particular area of policy this is referring to.
 12 **Q.** So I understand that, I want to be clear, you can't
 13 remember now, at this remove, what the "this" is
 14 referring to; is that correct?
 15 **A.** No, I can't --
 16 **Q.** It might be PPE --
 17 **A.** It may be. I don't know.
 18 **Q.** Right. But just thinking about the actual hierarchy
 19 itself, can you help now with why residential homes came
 20 before nursing homes?
 21 **A.** No, I think -- any -- any hierarchy like that, I would
 22 take clinical advice on. So, for instance, the
 23 hierarchy of who got vaccines first, care homes were
 24 right at the top of that. Who got PPE first in the --
 25 who got testing first. In the case of those two,

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1 hospitals were at the top of the clinical hierarchy.
 2 But this would -- any question like that would be based
 3 on the evidence and I based it on clinical advice.
 4 **Q.** All right.
 5 On any view, given the number of people in receipt
 6 and indeed providing domiciliary care, can you help now
 7 with why domiciliary care is at the bottom of the
 8 hierarchy?
 9 **A.** Well, it depends what we were talking about. So it's
 10 impossible to say with precision, but, for instance, if
 11 it is about the provision of PPE, then that may well
 12 have been my clinical advice, that the order in which
 13 PPE protects most may well be that order. But
 14 I can't -- but we don't know what "this" is referring
 15 to. It's certainly not that I thought of these three
 16 elements of care services in a rank order in that way.
 17 It depends specifically what the note is referring to.
 18 **Q.** A little lower down the page:
 19 "There was a discussion on workforce, with DCMO
 20 [Jenny Harries] flagging workforce shortages and noting
 21 the majority of nursing home staff are not clinical."
 22 **A.** Yeah.
 23 **Q.** And she "flagged the risk of double counting capacity".
 24 So she's putting out there on 6 March the problems with
 25 the workforce.

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1 driving the system, because we were essentially taking
 2 responsibility from around 50 local authorities that
 3 were nominally and formally and legally responsible for
 4 this area and we were taking it on our shoulders to try
 5 to fix these problems.
 6 **Q.** Can you help me with why one of the areas that is not
 7 mentioned -- why isn't IPC mentioned in there,
 8 Mr Hancock?
 9 **A.** I don't know.
 10 **Q.** Was IPC on the radar at that stage as being a way of --
 11 **A.** Yes, it is. It's -- PPE is mentioned.
 12 **Q.** Well, PPE is a form of --
 13 **A.** PPE is one element.
 14 **Q.** Yeah.
 15 **A.** Yes. I don't know. It may well have been, and it
 16 depends whether it was not -- it was definitely on the
 17 radar, absolute hundred per cent.
 18 **Q.** So there we were as at 6 March 2020, and can I ask you,
 19 please, about a follow-up meeting on 11 March.
 20 And can we go to INQ000328131.
 21 This was a "Social Care/Coronavirus meeting".
 22 Thank you very much.
 23 Ros Roughton is flagging the importance of
 24 engagement with the sector. There are three pieces of
 25 guidance that in fact came out on 13 March, and clearly

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1 Then can I ask, please, that we go over the page to
 2 the bullet point, second bullet point:
 3 "[Secretary of State] summarised there is work to be
 4 done and issues to solve on 10" --
 5 **A.** Ten work areas.
 6 **Q.** -- "10 different areas ..."
 7 Workforce being one of them, financial support,
 8 excess deaths, data, support for non-Covid illnesses,
 9 equipment, local resilience forum readiness,
 10 collaboration, comms and the Bill.
 11 "Noting the big question is if we have got enough of
 12 a team or a system in place to be able to do everything
 13 we can ..."
 14 Were you concerned that, as at 6 March, there wasn't
 15 enough people dealing with the adult social care
 16 response within the Department of Health and Social
 17 Care?
 18 **A.** Yes, of course. We were unbelievably stretched in all
 19 areas. And I'm summarising here work needed on -- in
 20 ten different areas, in many of which -- in many of
 21 which we would not have had, as a department, a locus on
 22 in normal times. You know, financial support is not
 23 something that the Department of Health and Social Care
 24 would lead on in normal times. And so yes, of course,
 25 it was enormous pressure. What you can see is me

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1 they were being discussed.
 2 And the bullet point starting just below that:
 3 "[Secretary of State] asked about providers paying
 4 staff if they are ill ..."
 5 **A.** Yes.
 6 **Q.** "... and asked to self-isolate in order to
 7 disincentivise staff with milder conditions going to
 8 work with older people."
 9 **A.** Yeah.
 10 **Q.** I'd just like to have your explanation, please, of what
 11 it was you were worried about and why you were asking
 12 about disincentivising staff with milder conditions from
 13 going to work?
 14 **A.** So in a way this is an early indication of what became
 15 the staff movement restriction issue. The -- it was
 16 clear to me that if staff are ill, then they shouldn't
 17 be going to work. However, in this country, sickness
 18 pay is absurdly low, and many people find it difficult
 19 not to go to work because of the ridiculously low levels
 20 of sick pay, and that leads to disease spreading in the
 21 workplace.
 22 If you work in a care home, of course, that leads to
 23 disease spreading to some of the most vulnerable people
 24 in the country. This happens every winter with flu and
 25 people die unnecessarily because of it.

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1 And that's what I'm worried about: people who are
2 ill being asked to self-isolate and not being
3 incentivised to do so. Many people are paid hourly, and
4 if you don't do the hours because you're ill, you don't
5 get paid.

6 And obviously we also -- we later had this debate in
7 a much bigger sense with people who -- members of the
8 public asked to self-isolate, but it's even more
9 important if the self-isolation is isolating yourself
10 from giving some of the most vulnerable people the
11 disease.

12 **Q.** Fine. And just on final bullet point there:

13 "[Ros Roughton] flagged a number of providers will
14 not be in contact with local authorities, [the minister]
15 suggested using the CQC as a mechanism, [and you were]
16 in agreement with [that] approach. There was
17 a discussion on people who [were] on 0 hour contracts
18 and being paid through [Statutory Sick Pay].
19 [Secretary] noted working with HMT to solve this."

20 **A.** Yeah, that didn't get anywhere.

21 **Q.** Well, that's what I was going to ask: it didn't get
22 anywhere?

23 **A.** No, sick pay is -- well, I think we did increase sick
24 pay a bit for the period of the pandemic. It's not
25 something I've looked into in preparation for this

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1 insisted on the policy?

2 **A.** Yes.

3 **Q.** And you, later in your statement said, "Although I did
4 not take the decision, I take responsibility for it."

5 **A.** Yes, for two reasons. The first is it was a decision of
6 the government and I was the Secretary of State. And
7 I take responsibility for all of the decisions in the
8 area that I was responsible for.

9 The second is that whilst this is obviously
10 an incredibly contentious issue, as I also said in my
11 statement, nobody has yet provided me with an
12 alternative that was available at the time that would
13 have saved more lives. There are things that we can do
14 now, and indeed should have been doing for the last
15 three years since this Inquiry was set up, to make sure
16 we're better prepared, and we went through some of those
17 right at the start. But obviously, having wracked my
18 brains about this and thought about it incredibly hard
19 and in preparation for this Inquiry having gone through
20 all of the paperwork, I still can't see a decision that
21 would have been less bad. None of the options were
22 good.

23 **Q.** No. Do I take it that it was, from your perspective,
24 the least bad decision, the least worst decision?

25 **A.** That's exactly my view, is that it's the least worst

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1 module, but it'll be publicly available. I think we
2 increased it somewhat, but it's still -- it's now gone
3 back to ridiculously low levels. We're far below any
4 European comparator on sick pay.

5 But there you go, that's the discussion that we were
6 having.

7 **Q.** All right. So that is as we are on 11 March --

8 **A.** Also it's worth noting that Ros here is flagging the
9 number of providers not in contact with local
10 authorities, and -- because the CQC was one mechanism,
11 but there were -- but this question of where is the
12 total register of -- a full and economical register of
13 care providers was, you know, was something that we were
14 struggling with at this stage.

15 **Q.** Can I turn, please, to ask you about the hospital
16 discharge policy, Mr Hancock. And at the outset, can we
17 be clear, was it one person's decision?

18 **A.** No.

19 **Q.** Right. Who or which department's decision, was it?

20 **A.** Well, it was formally a government decision. It was
21 signed off by the Prime Minister. It was really driven
22 by Simon Stevens, the chief executive of the NHS, but it
23 was widely discussed, both in the department, with the
24 NHS, and with the centre.

25 **Q.** Yes, you said in your statement in fact that NHS England

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1 decision that could have been taken at the time.

2 **Q.** Right, but it was a decision, nonetheless, that you
3 agreed with at the time?

4 **A.** I accepted it. I wasn't the driving force, but it was
5 the decision of the government, yes.

6 **Q.** The question I asked you: was it a decision you agreed
7 with at the time?

8 **A.** Yes, yes, I defended it at the time, and whilst I wish
9 that there had been a better option, I still can't
10 find one.

11 **Q.** Now, in the run-up to the decision and the letter going
12 out from NHS England on 17 March, there were a number of
13 meetings about this and I'm not going to take you
14 through all of them; it includes COBR, various pandemic
15 meetings --

16 **A.** Yes.

17 **Q.** -- departmental meetings --

18 **A.** And then there were informal discussions, as well.

19 **Q.** Quite. Absolutely. But in amongst the myriad of
20 meetings, can you help with who was there really to
21 represent the views of the sector when these decisions
22 were being made?

23 **A.** The loudest voices in representation of the sector were
24 Ros Roughton, Helen Whately, and me.

25 **Q.** And what were you saying in your loud voice, Mr Hancock?

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1 A. Well, I was, of those three -- the other two were the
 2 louder, because my job was to balance requirements
 3 across different parts of the health and social care
 4 sector. Their position was to stick up for social care,
 5 and as you see in the paperwork, there are -- Helen
 6 Whately, in particular, was fighting a battle to find
 7 alternative ways of ensuring that you could carry out
 8 this -- a policy that was -- that would protect more
 9 lives. That was the -- that was the battle.

10 The challenge was that hospitals were likely to be
 11 overwhelmed, and that hospitals were very dangerous
 12 places because of the spread of the disease. And so the
 13 likelihood of things being worse had more people stayed
 14 in hospital is very high. So that wasn't a good option.

15 And many care homes didn't have isolation
 16 facilities. So that wasn't a --

17 Q. Right.

18 A. -- that wasn't an available option. And we didn't have
 19 enough tests. Remember at the same time I'm driving the
 20 number of tests and we get, within a couple of weeks we
 21 got to the position that there were enough tests but
 22 there weren't at this stage because the clinical advice,
 23 which I think was right, was that tests are more
 24 necessary for those who are in hospital with Covid. So
 25 it was a -- as opposed to people who aren't symptomatic,

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1 issue in any event.

2 A. Yeah.

3 Q. And then they are, if we just scroll down the page,
 4 there is an acknowledgement that there are workforce
 5 constraints, it would be a limiting factor to the
 6 ability to discharge people:

7 "There are currently ... 120,000 vacancies ... and
 8 our reasonable worst case model would have another 11%
 9 [of staff] off in the peak week of [the] pandemic ..."

10 A. Yeah.

11 Q. "... which would be another 176,000. Furthermore,
 12 [you've got] vacancy rates which are significantly
 13 higher in the South East and London."

14 So in essence, you may be discharging people to care
 15 homes where there isn't the staff either pre-pandemic or
 16 exacerbated by ill health caused by the pandemic, to be
 17 able to care for those people. Is that essentially what
 18 it's saying?

19 A. No, no, it's not.

20 Q. Well, help us, please. How would you interpret this?

21 A. It's saying that there is a challenge in the rate
 22 limiting factor. The way you put it, I think, is more
 23 extreme than the way it's considered. The -- but it was
 24 a significant pressure I think is the best way of
 25 putting it. Further context, for instance, is that

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1 and we can come to the clinical advice saying that tests
 2 were inappropriate for those who were asymptomatic.

3 So, you know, that was the nexus of problems that we
 4 were dealing with.

5 Q. Now, your statement sets out the predicted need for,
 6 I think, 390,000 people needing ventilators, that was
 7 the position at 2 March. By 9 March, there's suggested
 8 to be a deficit of 780,000 beds.

9 A. Yes.

10 Q. Eye-watering numbers on any view?

11 A. Yes.

12 Q. And I just say that to provide a little context for
 13 a document I'd like to look at, please.

14 Can we have on screen INQ000325232.

15 This is a DHSC note which outlined a number of
 16 options when considering freeing up hospital beds by
 17 discharging patients. It's dated, Mr Hancock, 12 March
 18 but according to DHSC it was presented to you on
 19 17 March, right?

20 A. Right.

21 Q. And the question is:

22 "How can we free up hospital bed capacity by rapidly
 23 discharging people into social care?"

24 They set out the number of people that there are
 25 delayed transfers of care, which was a pre-pandemic

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1 earlier in the pandemic in January, or I think in
 2 February, we'd seen examples internationally, for
 3 instance, of people dying in care homes not from Covid
 4 but because all of the staff had abandoned the care
 5 home. That example came from Spain.

6 We saw examples of outbreaks in care homes. You
 7 know, we knew that there was a very significant problem,
 8 but there was a problem on both sides that we needed to
 9 have the staff and we needed to be able to look after
 10 people.

11 Q. Right.

12 Given the constraints, though, was it not of
 13 a concern to you that there may be discharges from
 14 hospital that are expedited where there weren't the
 15 staff to be able to care for them properly?

16 A. We knew that there'd be pressures but we also knew that
 17 people were rising to these pressures. In normal times,
 18 that would be a bigger worry. We knew that people would
 19 do what they needed to do. You know, there were many
 20 instances -- remember, at the same time we're thinking
 21 about pressures in hospitals where nursing ratios in
 22 intensive care went from one to one, to one to six. So
 23 the absolute way in which you put the question is not
 24 how we were thinking about it. How we were thinking
 25 about it was in terms of the incredible pressure on

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1 adult social care staff.

2 **Q.** Right. So there is an acknowledgement by you that

3 expedited discharges would increase the pressure on an

4 already constrained workforce?

5 **A.** Yes, that's a very reasonable way of putting it.

6 **Q.** A number of options are set out there. There was

7 extending free care to speed up the discharge. There

8 was removing the continuing healthcare assessment.

9 There was rolling out capacity trackers. Greater use of

10 the independent sector and the use of live-in carers.

11 **A.** Yeah.

12 **Q.** So they were all options that were being considered

13 around the time of the discharge decision.

14 **A.** Yeah.

15 **Q.** And I think in due course, can I invite us, please, to

16 look at page 2 of the document. There's, under the

17 section dealing with joint arrangements, Mr Hancock can

18 you see the underlined section:

19 "To note: We need a clinical decision on whether

20 this is the right thing to do. The policy implies that

21 emptying the hospital is more important than protecting

22 residential or domiciliary care capacity to support

23 people currently in the community. We would need this

24 to be taken on a clinical basis."

25 **A.** Yes.

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1 transmission --

2 **A.** Yes.

3 **Q.** -- but there was no scientific agreement about the

4 extent to which it was a problem?

5 **A.** That's correct.

6 **Q.** As at 17 March do you agree that there was not enough

7 PPE in care homes at that stage?

8 **A.** It depends what you mean by "not enough". There were

9 definitely -- we definitely would have wanted more, and

10 we were pushing very hard to get more. And that was

11 a major issue, yes.

12 **Q.** Do you agree that at 17 March IPC training had not yet

13 been rolled out to the care homes to help them with

14 donning and doffing, and the like?

15 **A.** That was needed, it was absolutely needed, yeah, as part

16 of this package.

17 **Q.** And the guidance that accompanied the discharge did not

18 advise the care home to isolate any patient being

19 discharged from hospital, did it?

20 **A.** That was -- that is absolutely true, and that comes back

21 to this clinical advice that -- on asymptomatic

22 transmission that we've covered in other modules, and

23 the emphatic advice from PHE, backed by the World Health

24 Organization, until April that we should plan on the

25 basis of no asymptomatic transmission. That was

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1 **Q.** And did you see that comment on whether this was the

2 right thing to do?

3 **A.** Of course. This was something that was, as you said

4 earlier, it was a question of what is the least worst

5 solution to this terrible problem. And the clinical

6 advice was obviously a critical part of the policy

7 making.

8 **Q.** Do you agree that the policy implies to some that it

9 does look like that the emptying of hospitals and

10 freeing up NHS capacity is more important than the

11 impact that it had on the care sector?

12 **A.** What I care about here is the substance. The substance

13 at the time is that I can't find a better least bad --

14 a less bad solution than the one we went ahead with.

15 Then the consideration for the future is about the

16 preparation that's needed now to avoid exactly this sort

17 of impossible choice.

18 **Q.** And so we come to 17 March, when the NHS England letter

19 goes out to health boards, trusts, et cetera, saying,

20 "Please start the discharge."

21 As at 17 March 2020, do you agree that there was not

22 enough testing capacity to test all patients being

23 discharged?

24 **A.** Absolutely, yes.

25 **Q.** You've told us that you were worried about asymptomatic

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1 a mistake. It was a mistake I challenged at the time,

2 but as a non-clinician it was not a mistake I could

3 overrule.

4 **Q.** Right, and as at this time, staff movement as between

5 care homes is not banned or even advised against?

6 **A.** No, at this point, because of the lack of understanding

7 around asymptomatic transmission, consideration had not

8 yet been given to banning staff movement, and we came to

9 that later.

10 **Q.** Right. So taking all of those factors into account can

11 you help then, against that background, how people in

12 care homes were to be protected as at 17 March?

13 **A.** Well, at that point, the best thing that could have

14 happened to somebody leaving hospital would be to treat

15 them as if they had Covid, and to isolate them as such.

16 Those sorts of facilities were not universally

17 available, though.

18 **Q.** Do you think it was an error now to not have directed

19 that all untested patients should have been isolated

20 when they were transferred to a care home?

21 **A.** With hindsight, that is absolutely right. At the time,

22 with the clinical advice on asymptomatic transmission,

23 that is not what was clinically recommended. But

24 absolutely.

25 **Q.** We know that in due course you gave a daily press

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1 conference, on 15 May, which included you saying:
 2 "Right from the start we've tried to throw
 3 protective ring around our care homes. We set out our
 4 first advice in February, and as the virus grew, we
 5 strengthened it throughout."
 6 And you went on to set out the measures that you say
 7 the government had taken, and you said again:
 8 "From the start, we've worked incredibly hard to
 9 throw that protective ring around our care homes. Yes,
 10 it has been difficult. These viruses reserve their full
 11 cruelty for those who are physically weakest, the
 12 elderly, the frail, and the already sick."
 13 Now I appreciate, Mr Hancock, that you've already
 14 acknowledged that, notwithstanding all the measures,
 15 there was no unbroken circle, to use the phrase that was
 16 put to you in Module 2.
 17 **A.** Yeah.
 18 **Q.** But can I ask you why, as at 15 March, was it suggested
 19 that there was a protective ring, given all of the
 20 absence of things that we've just looked at?
 21 **A.** Well, we've also been looking at all of the things that
 22 we did do. So by 15 March, we'd brought in 88 separate
 23 measures, including over £5 billion of funding, and
 24 testing by that stage available to all staff and
 25 residents. We've discussed the free PPE. We had

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1 actions to start to get free PPE at care homes.
 2 **MS CAREY:** Yes, in March I think there was a drop that
 3 resulted in about 300 face masks going to each care
 4 home, Mr Hancock. So on any view that's not going to
 5 last particularly long, is it?
 6 **A.** I don't think it's appropriate to belittle the efforts
 7 that started in March. There was a huge amount of work
 8 to get free PPE out to care homes, and it started in
 9 March, and it grew over time. But I don't think --
 10 I don't think laughing at that is appropriate.
 11 **Q.** I'm not belittling it --
 12 **A.** Well --
 13 **LADY HALLETT:** If anybody laughs at any evidence,
 14 Mr Hancock, I'll be the one to direct them, thank you
 15 very much.
 16 **MS CAREY:** Her Ladyship's question though was, if you look
 17 at the position as at 17 March, what was the protection
 18 provided to care homes as at the date the letter went
 19 out saying to discharge anyone who is medically fit?
 20 **A.** Well, at that point we were starting the work of getting
 21 the PPE out. Remember that PPE was the responsibility
 22 of care homes themselves before the pandemic. We come
 23 back to the 6 March meeting when I said we needed to
 24 grip this, ie the department needed to take
 25 responsibility. It was from then that we got going on

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1 brought in advice and support, we'd given a clinical
 2 lead for each care home. There were a whole series of
 3 measures that we had brought in.
 4 I would stress, you know, in that piece of rhetoric,
 5 that what I said is that we had tried. It was not
 6 possible to protect as much as I would have wanted. And
 7 that is the central task of the Inquiry: to work out
 8 what we can do right now -- frankly, what should have
 9 already been happening in care homes -- because there
 10 has not been enough action to prepare for the unknown
 11 date, which could be tomorrow, when we will get the next
 12 deadly pathogen. And in fact the national debate on
 13 this has gone backwards, with prominent people saying
 14 that even the actions that we did take were a mistake.
 15 So it is a -- it is urgent now that this action is taken
 16 for the future, but I hope that's my explanation of why
 17 I used those particular words based on the substance at
 18 the time.
 19 **LADY HALLETT:** Could we just rewind for a second.
 20 Ms Carey very carefully asked you the question,
 21 focusing as at March, what was the protective ring, and
 22 you mentioned, for example, PPE. I thought Ms Carey
 23 told me earlier that that wasn't available until
 24 20 July. So could --
 25 **A.** No, that's not right. In March we made the first

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1 ensuring a supply of PPE, which started, I -- you know,
 2 you have -- which started with as much as we could get
 3 our hands on, and grew over time.
 4 **Q.** So it may be me. I'm just trying to understand, if we
 5 don't have testing, there is an inadequacy of PPE, you
 6 can't isolate, and the advice doesn't say isolate,
 7 you're not banning staff, what was the protection for
 8 the care homes, Mr Hancock?
 9 **A.** The question we faced was what is the best policy --
 10 **Q.** That's not what I asked you.
 11 **A.** It may not be what you asked but it was the question
 12 that was valid at the time. You see, if you take these
 13 questions out of the context then you are not asking the
 14 real question that we faced. The protection at the time
 15 was clearly not as much as we would have liked. But the
 16 alternatives were even worse.
 17 **Q.** Now, you say it was not as much as we would have liked,
 18 but what was it? That's what I'm trying to understand.
 19 **A.** Well, we started the flow of free PPE. We were testing
 20 those with symptoms, we were not testing
 21 asymptotically because of the clinical advice and the
 22 shortage of tests, the expansion of testing, which we
 23 were in the middle of, which we expanded rapidly in the
 24 days following that announcement. And in particular,
 25 over the month of April. We were -- these were all the

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1 protections that we were putting in place.

2 We were trying to put as much protection in place as
3 possible.

4 The -- you know -- and all I can do is take you back
5 to the actual decisions and the resources that we had at
6 that moment. They were -- we did not have enough -- we
7 did not have enough. Right? The preparation had been
8 inadequate. The Department, I, had taken the decision
9 to take responsibility for a series of things that had
10 not been done. I am held accountable for those actions
11 but the actions, I've reviewed every piece of paper in
12 preparation for this module and what I can tell you is
13 from the moment we gripped this, we started, one by one,
14 solving these problems.

15 You do not have to tell me how great the challenges
16 were. How little protection there was for the public.
17 There wasn't enough PPE for -- there wasn't enough
18 testing. Right? There wasn't enough PPE. We didn't
19 have the right -- the public health authorities had the
20 wrong attitude and the wrong doctrine, okay? All of
21 these things needed fixing and one by one, we did
22 everything we could to fix them. The challenge we have
23 now is to say what is -- what is ready for next time,
24 okay? And that's the answer. It's the only answer
25 I can give, is the answer based on the truth of what the

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1 care homes faced, pandemic or not. It felt like we were
2 the sacrifice, a cull of older people who could no
3 longer contribute to society."

4 A. Yes, I've seen that evidence. I understand that we're
5 not stating who it is from, so it's anonymous, but they
6 also go on in that evidence to say, "We're grateful for
7 the money," and various other elements of support that
8 came to care homes. Well, that came from the same
9 people. So, you know, I could quote people who got in
10 contact to say, "Thank you". I don't think it is
11 instructive or helpful of the Inquiry to exchange
12 brickbats like this. The importance of this Inquiry,
13 and by God we've had long enough, right? It's
14 three years since this Inquiry started, and we still
15 haven't made the changes to this country that are
16 needed. We've waited three years to come to probably
17 the most important and sensitive element of it because
18 of the modular system, and here we are still, I think,
19 in a worse situation than before.

20 And so sure, I ruffled feathers in getting stuff
21 done, but -- and people have had a go at me over it.
22 But I've been through everything that we did as
23 a Department, big team effort, and we were all pulling
24 as hard as we possibly could to save lives. That's what
25 I meant by saying that we tried to throw a protective

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1 situation was at the time.

2 Remember, at the time, I also had Dominic Cummings
3 and a load of people causing all sorts of problems for
4 me. And I had Covid.

5 Q. All right. Let me ask this and then, perhaps, my Lady,
6 we'll take our mid-morning break if we may.

7 At the time you stood at that press conference, did
8 you believe it to be true when you said we had tried to
9 put a protective ring around the care homes?

10 A. Yes, and I will stress the word "tried", we were trying
11 to do everything that we possibly could. We were in
12 bleak circumstances, and from any international
13 comparison, everybody had the same problem: which is
14 that the care of those people who were the most
15 vulnerable were also those caring for the most -- those
16 who were most vulnerable to Covid.

17 Q. I asked you that because I think you are aware of some
18 evidence that has been obtained by the Inquiry, where
19 people considered you to have lied in that press
20 conference, Mr Hancock. One person, in particular,
21 said:

22 [As read] "He blatantly lied about the situation in
23 care homes, there was no blanket of protection. We were
24 left to sail our own ships. He wasn't heart felt. He
25 had no understanding or appreciation of the challenges

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1 ring around it. Of course it wasn't perfect. It was
2 impossible. It was an unprecedented pandemic and the
3 context was exceptionally difficult.

4 Q. Right. You've told us in both your statement and,
5 indeed, in your evidence a moment ago that this was
6 rhetoric by you. Can we be clear, what do you mean by
7 the word "rhetoric"?

8 A. Right. I mean, it was a form of words rather than the
9 substance. We've been -- I've repeated the substance of
10 what we were doing to support the care sector.

11 Q. I ask, Mr Hancock, because some take "rhetoric" to mean
12 it sounds impressive but it lacks substance so I wanted
13 to be clear what you meant by the word rhetoric?

14 A. I meant it's a form of words, but what you should look
15 at is the policy support that was put in place from the
16 centre, and that is what -- that's what we did, and all
17 I can tell you is that the other options available,
18 given the clinical advice I had at the time, were worse.

19 Q. Right. On the day that you gave that press conference,
20 I think you had access to sitrep data which showed the
21 number of deaths in care homes as at that stage, which,
22 depending on which database you used, was somewhere
23 around 8,000-odd people in care homes who had died. And
24 at that stage, on 15 May, 37% of care homes reported an
25 outbreak, and in the northeast there was 48.9% of care

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1 homes reporting an outbreak.

2 **A.** Yeah.

3 **Q.** Were you aware of this data at the time you said in the

4 press conference that there was the protective ring?

5 **A.** Of course I was aware of it. Of course I was aware of

6 it. I was the Secretary -- are you -- it's very

7 strange, this questioning. I was the Secretary of

8 State. I had taken personal responsibility for this

9 area, despite not having the formal accountability for

10 it. At the same time, on the same day, we had the

11 announcement of a further funding allocation. So yes,

12 of course I was aware of it. And the action that I and

13 the team were taking, and Helen Whately and Ros and

14 everybody else in the department, was to try to save as

15 many lives as possible.

16 And perfectly reasonable for you to question the

17 exact words that I used, but what I care about is the

18 substance of what we did, the protections that we put in

19 place, and most importantly, what we can do in the

20 future to ensure that the options available are better

21 than they were last time.

22 **Q.** All right. Finally this, please, on this topic: do you

23 think a member of the public or indeed people running

24 care homes would interpret what you said as a piece of

25 rhetoric?

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1 **Q.** So can we just look at perhaps some of the guidance that

2 touched on the discharge policy. Clearly there was the

3 policy that came out on 17 March. There was guidance on

4 19 March. There was updated and admissions guidance on

5 2 April.

6 And can I have up on screen, please,

7 INQ000325255_0005.

8 This was the admissions guidance as at 2 April.

9 Again, as with the PHE guidance that we looked at from

10 25 February, you can see, when it's dealing with

11 admissions of residents, reference there to:

12 "The care sector looks after many of the most

13 vulnerable people in our society ... As part of the

14 national effort, the care sector also plays a vital role

15 in accepting patients as they are discharged from

16 hospital -- both because recuperation is better in

17 non-acute settings, and because hospitals need to have

18 enough beds to treat acutely sick patients. Residents

19 may also be admitted to a care home from a home setting.

20 Some of these patients may have [Covid], whether

21 symptomatic or asymptomatic. All of these patients can

22 be safely cared for in a care home if this guidance is

23 followed."

24 Now, do you remember seeing this piece of guidance,

25 Mr Hancock?

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1 **A.** Yes, I think largely people in -- running care homes

2 would understand that what I was trying to say was that

3 we have put in -- we have tried to put in a huge amount

4 of support. That was the -- that's the lived experience

5 I have from talking to people in care homes.

6 You know, there may be campaign groups and

7 politically-motivated bodies that say other things.

8 What I care about, though, is the substance. And

9 frankly, that's what this Inquiry should care about

10 after all the millions of pounds that have been spent

11 on it.

12 **LADY HALLETT:** And I can assure you, Mr Hancock, it is what

13 I care about.

14 On that note, we'll come back at 11.45.

15 **MS CAREY:** Thank you, my Lady.

16 (11.28 am)

17 (A short break)

18 (11.47 am)

19 **LADY HALLETT:** Ms Carey.

20 **MS CAREY:** Thank you, my Lady.

21 Mr Hancock, I'd like to finish with a few questions

22 more about the hospital discharge policy and then I'd

23 like to move on to staff movement and attempts to

24 restrict staff movement, all right?

25 **A.** Yeah.

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1 **A.** I was not closely involved in writing it, but it was

2 signed off by the department.

3 **Q.** Right. Did you think, as at 2 April, all patients

4 discharged, whether symptomatic or asymptomatic, could

5 safely be cared for in a care home if the guidance was

6 followed?

7 **A.** Well, that was based on the best clinical advice.

8 I can't recall exactly how I felt about it at that time,

9 whilst this was -- this was developed, this guidance,

10 whilst I myself was at home with Covid.

11 **Q.** Right. It was before, so that you recall, a change in

12 testing pre-discharge which came on 15 April?

13 **A.** That's right, and it was published, I think, on the 2nd.

14 I think it was published the day before the CDC changed

15 the international advice on asymptomatic testing and

16 when -- and the changes, and that finally got PHE to

17 change on that position.

18 **Q.** Right. What I wanted to ask you about was some

19 questions about some developments between 2 April

20 guidance that we've got on screen and the 15 April

21 action plan when there was the change to the testing --

22 **A.** Correct.

23 **Q.** -- at pre-discharge. All right, so can we just think

24 about that period of time, please.

25 **A.** Yeah.

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1 Q. And if it may help you, Mr Hancock, if we have up on
 2 screen, please, some WhatsApps that you had with
 3 Helen Whately.
 4 And if we have up INQ000475068 on screen and there
 5 are number of different topics that are in this WhatsApp
 6 but I just want to try to look at the ones that impinge
 7 on the discharge policy.
 8 And at 10.16 can we see there a message from Helen
 9 Whately?
 10 A. Yeah.
 11 Q. "The discharge policy [is] my biggest concern."
 12 She says:
 13 "That's an argument with Simon ..."
 14 Presumably Simon Stevens?
 15 A. Yeah.
 16 Q. "... clearly.
 17 "Dom's [Dom Cummings] asks for some more detail on
 18 testing and PPE" --
 19 A. Not necessarily. That may be Dom Raab.
 20 Q. Right, thank you. Either one of them --
 21 A. I think it will have been Dom Raab, because I think
 22 Dom Cummings was away at this point.
 23 Q. All right. So possibly Mr Raab asks -- his asks are:
 24 "... for more detail on testing and PPE ..."
 25 They are:

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1 "That sounds messy."
 2 Now, are you able just to give us an overview of
 3 what is the argument or disagreement or concern, as at
 4 13 April, in the run-up to the publication of the action
 5 plan?
 6 A. Well, at this point, of course, the assumption, the
 7 clinical assumption around asymptomatic transmission had
 8 changed, and therefore I am concerned that advising
 9 local authorities to secure appropriate alternative care
 10 arrangements is going to be complicated. My
 11 recollection is that Helen was pushing for the NHS
 12 setting aside certain NHS settings, because by now the
 13 numbers in hospital, we'd got some further -- we'd got
 14 the Nightingales up and running so there was more
 15 capacity, I think.
 16 The -- Helen was driving for the NHS to keep people
 17 in an NHS setting and the NHS were not accepting that.
 18 And so clearly, a policy compromise had been made, which
 19 is advising local authorities to secure appropriate
 20 alternative care -- (overspeaking) --
 21 Q. So can I see if I've understood this correctly. The
 22 argument really is before discharge should they be
 23 quarantined in the NHS, in a hospital estate, or should
 24 they be quarantined post-discharge in a care home? Is
 25 that the two competing sides?

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1 "... the same as [hers] have been for the last few
 2 days."
 3 A. Yes.
 4 Q. "No one seems able to give it!"
 5 Then the thread picks up again, in fact, later that
 6 evening, at 21.56.
 7 So could we go to page 2, please.
 8 A. Right.
 9 Q. And it's not that I'm deliberately skipping over
 10 something, but different topics crop up in the WhatsApp.
 11 A. Yeah.
 12 Q. But to return to the discharge policy, there we are now
 13 at 9.45 in the evening.
 14 A. Yeah.
 15 Q. You saying to Helen Whately:
 16 "Have you agreed a discharge policy with NHSE?"
 17 And Helen says:
 18 "Nhs won't keep them in an Nhs setting if fit for
 19 discharge. We can't force care homes to take them if
 20 covid infection risk -- however, some may have
 21 isolation/covid positive zone so can...and if not, we
 22 advise local authorities to secure appropriate
 23 'alternative care arrangements', eg an [local
 24 authority]-commissioned isolation facility."
 25 And a little bit -- you say:

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1 A. Well, really the question is where to quarantine people.
 2 Q. Yes, where?
 3 A. Yes.
 4 Q. In hospital or --
 5 A. Nobody thought that it was a good idea to keep them in
 6 a standard general hospital setting. Right?
 7 Q. Right. I follow you.
 8 A. But would there be NHS, other NHS settings? For
 9 instance, earlier in the pandemic we'd used NHS nurses'
 10 facilities.
 11 Q. Right.
 12 A. But, you know, the question is: where do you isolate
 13 people?
 14 Q. Right.
 15 A. Hence my recommendation now that every care home needs
 16 to have isolation facilities.
 17 Q. Right. We'll come back to that.
 18 A. So this is the policy row that's going on between Helen,
 19 essentially between Helen and Simon Stevens, and you'll
 20 have to ask Helen about the details of it. Because
 21 Helen is so competent and such a good minister, I was --
 22 I delegated a lot of responsibility to her because she
 23 was highly competent.
 24 Q. All right. Thank you.
 25 Now, if we just go on, that helps us contextualise

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1 the two sides of the debate, if you like.

2 **A.** Yeah.

3 **Q.** Can we go to 14 April and page 3 of --

4 **A.** Hold on, hold on, can we just stick on this one because,

5 actually, the remainder of this page is also extremely

6 important in this context.

7 **Q.** Yes.

8 **A.** Firstly:

9 "Who is speaking for NHSE here?"

10 Answer, Ian Dodge, and Ian Dodge, in my experience,

11 never did anything without Simon Stevens' sign off. And

12 then I say:

13 "Can you please write your preferred language into

14 the document taking into account genuine NHS concerns

15 and we will take that forward."

16 So my instruction was that Helen should take into

17 account genuine NHS concerns, but obviously I knew she

18 was also deeply concerned about the care sector because

19 that was her primary responsibility, and then I said,

20 "And we will take that forward."

21 I also know that at the same time, that evening,

22 I was having a text exchange with Simon Stevens when he

23 came to me at said, "This isn't agreed, I'd agreed some

24 policies with Ros, and Ros said she would handle Helen

25 Whately."

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1 hospital but do need to be in -- do need to be

2 quarantined."

3 **A.** Yeah.

4 **Q.** "My understanding is [that the] LGA and ADASS agree (&

5 NHS clearly). Can be funded out of the £1.3 billion

6 that went to NHS for discharges. The question is one of

7 how they do it, eg by commissioning a specific care home

8 for the area, or hotel accommodation ... Some are

9 already doing this."

10 She says:

11 "I realise you may disagree and want to revert to

12 NHS."

13 And then you say at 11.27:

14 "I'm very happy for it to be via [the local

15 authorities]."

16 **A.** And then I say, I obviously consider it for seven and

17 a half minutes, and then say:

18 "Best to include in the wording on discharge: 'as

19 agreed locally between the NHS and local authorities'."

20 **Q.** Yes.

21 **A.** Ie, I'm trying to get to a joint position.

22 **Q.** Right, so --

23 **A.** But in the -- anybody who has worked in this area knows

24 that the communication and the co-working between the

25 NHS and local authorities, in terms of discharge, in all

75

1 And that implies that they thought they could

2 present an answer to Helen, she's clearly unhappy with

3 the answer, and I am backing Helen.

4 **Q.** Right.

5 **A.** And then there was a -- I was also working on a whole

6 load of other things, and when we came back to it in the

7 end, we did not have the text that Helen had signed off.

8 It was a messy battle.

9 **Q.** Right. So there is Helen at this stage, as I understand

10 it, advocating for the quarantining to take place

11 perhaps not in a hospital but under the umbrella of the

12 NHS, and --

13 **A.** Correct.

14 **Q.** -- the NHS are saying that they don't want that, there

15 are the machinations behind the scenes that you've just

16 spoken of.

17 **A.** Yeah.

18 **Q.** Can I turn to 14 April, please, to round off this

19 exchange.

20 **A.** Yeah.

21 **Q.** Because by 10 o'clock the next morning, if we see there

22 the message at 10:10:07 from Helen Whately, she says:

23 "For discharges -- I concluded last night it does

24 make sense for [local authorities] to have

25 responsibility for people who don't need to be in

74

1 normal times, it is extremely difficult. In some areas

2 it works well; in other areas it works badly. It is

3 a very, very complicated intersection. And anybody who

4 has had a family member, maybe a parent who has had to

5 go from hospital into a local authority setting, knows

6 that getting the funding package for that is a real

7 nightmare. So this is a standard problem in a much,

8 much, much worse context.

9 **Q.** All right. But what I wanted to ask you, Mr Hancock,

10 was when you said, "I'm very happy for it to be via the

11 local authorities", why did you plump for that side of

12 the coin as opposed for it to be being quarantining on

13 the NHS side of the coin?

14 **A.** Because I'm taking Helen's advice. So my two key people

15 here are Helen and Simon Stevens, and Helen obviously

16 advised by Ros. Helen has overnight, essentially,

17 considered the NHS option further, as I'd asked her to

18 do on the previous page. I'd said, "Write into the

19 document what you want, taking into account the NHS's

20 real world concerns." She had then -- she has then come

21 back to me the next morning to say, she says, "I've

22 concluded last night that it does make sense for local

23 authorities."

24 So in my view, if she's come to that view,

25 essentially representing internally the view of the care

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1 sector, and she's agreed it with Simon Stevens or his
2 delegates, then I am content with that outcome. That
3 was -- in this area where you have two extremely
4 competent people in Helen and Simon, and if they agree
5 on a policy, I would have to feel very strongly to then
6 overrule it.

7 Q. All right, okay.

8 A. But as you can see, I then add a sort of coda to it,
9 which is "Please can everybody work together",
10 essentially.

11 Q. No, that's fine, and in due course it was the local
12 authorities that were to be responsible if they couldn't
13 isolate in a care home providing an alternative --

14 A. Yes.

15 Q. -- setting or an arrangement for care homes where there
16 weren't isolation facilities, and that was written into
17 the action plan?

18 A. Right.

19 Q. So that's where we get to.

20 A. Yes.

21 Q. Do I take it from everything that you have said this
22 morning that you consider that the discharge policy
23 should have advised isolation from the get-go?

24 A. If that had been available, yes.

25 Q. Right.

77

1 the care homes, from small providers with five or
2 six beds to 50, 80-bed care homes, how realistic is it,
3 in your view, for every care home to have an isolation
4 policy, given the huge diversity in the size of care
5 homes?

6 A. I would make it a requirement. And of course it will
7 have a cost added, but preparing -- pandemic preparation
8 has a cost attached. And we've talked before about how
9 I think it's ludicrous how little money has been put
10 into pandemic preparedness. You know, even in the
11 latest spending review, the UKHSA budget is radically
12 underfunded. It is a dereliction of duty of the
13 government to put so little money into pandemic
14 preparedness. This is just another element of pandemic
15 preparedness.

16 You know, we're talking about radically increasing
17 about the amount of money we speak on physical defence,
18 but biodefence is as important and gets 100th of the
19 resources of the state. It's an enormous ongoing
20 failure that is getting worse not better.

21 Q. All right. We know in due course, by the winter of 2020
22 going into 2021, there was the designated settings
23 policy, which required, I think, at least every local
24 authority to have at least one care home --

25 A. Yes.

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1 A. But it wasn't. So it depends -- if -- so it would have
2 been -- it wouldn't have worked to advise that where
3 isolation hadn't been available. It comes back to
4 preparation, and it comes back to the doctrine.

5 Q. I tell you why I ask it in that way: because you've
6 commended to her Ladyship the need, potentially, in
7 future for all care homes to have isolation facilities?

8 A. Yes, I haven't recommended that potentially, I've said
9 it absolutely, but yes, hundred per cent.

10 Q. But taking that to be something that you feel strongly
11 about, Mr Hancock --

12 A. Yes.

13 Q. -- back in March 2020 is the position that you didn't
14 know which care homes did or didn't have isolation
15 facilities?

16 A. Yes, that's correct, yes.

17 Q. All right.

18 A. And they would have been up to -- we wouldn't have known
19 the standard of isolation either. So, for instance,
20 later, in the second wave, when we did require
21 isolation, we then got the CQC to go round all the care
22 homes to check how high quality the isolation procedures
23 were. And that's the sort of thing that needs to happen
24 in peacetime now as well.

25 Q. Right. May I ask you, though, given the varying size of

78

1 Q. -- where they could take discharges of Covid-positive
2 patients?

3 A. Yes, and I think this was a response to precisely the
4 point you've just made, which is that there may be some,
5 especially small, care homes where an isolation facility
6 is not possible.

7 Remember, an isolation facility could still be used
8 when there's no outbreak as a bedroom. It's just that
9 you need the ability to then create isolation areas
10 where -- when the need comes.

11 Q. Right.

12 A. And this should be used for flu as well. I mean, flu --
13 you know, we have an epidemic every winter in care
14 homes, so there is no excuse to be waiting.

15 Q. Right. The question I wanted to ask you there about the
16 designated settings policy is you said in your
17 statement:

18 "It would not have been practicable to take this
19 step at an earlier stage of the pandemic ..."

20 A. Yeah.

21 Q. Can you help us, please, with why it was not practical?

22 A. For the reasons that you set out: that there are many
23 different care homes, some of which would have been able
24 to do it but others wouldn't.

25 Q. Right. And one of the other measures that was taken

80

1 back in March 2020 was to buy capacity from the
 2 independent sector?
 3 **A.** Yes.
 4 **Q.** The private hospitals?
 5 **A.** Yes.
 6 **Q.** And, indeed, you will know from Module 3 and your
 7 experience, there was the three-month pause on elective
 8 surgery --
 9 **A.** Yes.
 10 **Q.** -- to free up bed capacity?
 11 **A.** Yes.
 12 **Q.** I think somewhere around 20,000 to 30,000 beds
 13 potentially freed up.
 14 Do you think it was possible to have delayed the
 15 expedited discharges until such time as 15 April, when
 16 testing was available, by using the spare beds that had
 17 come from cessation of elective care or the spare beds
 18 that had been bought from the private sector?
 19 **A.** No. It would have been better if that had been
 20 a credible option but it wasn't.
 21 **Q.** Can you help us with why?
 22 **A.** Yes, the reason is very straightforward, unfortunately,
 23 and clear in the data, which is that we ran out of NHS
 24 capacity. We used -- if we hadn't built the
 25 Nightingales, we would have had hundreds of people

81

1 as one of the big successes. It was designed by --
 2 essentially by Jenny Harries at a clinical level, and it
 3 was a -- and then others, including from the private
 4 sector, came in to make it work.
 5 **Q.** You've set out in your statement your overall
 6 reflections on the appropriateness of the discharge
 7 policy. And does it come to this, Mr Hancock: there was
 8 no good decision from your perspective, and you consider
 9 that the hospital discharge policy to be the least worst
 10 decision?
 11 **A.** Yes.
 12 **Q.** All right.
 13 You say in your statement -- can I have up on
 14 screen, please, 0030 of Mr Hancock's statement, and
 15 paragraph 129. Yes, thank you very much.
 16 I want to look at the practical effect or otherwise
 17 of the discharge policy, and you say in your statement
 18 there:
 19 "A widespread concern was that patients who were
 20 being discharged from hospital were the main source of
 21 infection in care homes. I understand why many held
 22 this view, however we now know this was not the case."
 23 **A.** Yeah.
 24 **Q.** "We learned in the summer of 2020 that staff movement
 25 between care homes was the main source of transmission.

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1 without the ability to be treated. The -- or the
 2 Nightingale, the ExCeL London Nightingale Hospital.
 3 We -- the -- even having taken the policy of
 4 discharge, we still didn't have enough NHS capacity. So
 5 it's just a matter of fact that the NHS became full, and
 6 thankfully we had the Nightingale capacity. Not nearly
 7 all of the Nightingale capacity was used but some was,
 8 and that -- which demonstrates that there wasn't --
 9 there wasn't that spare capacity, even having done the
 10 discharges.
 11 **Q.** Right. Of course, a number of people discharged from
 12 hospital were discharged back to their own homes?
 13 **A.** Yes, in fact far more than went to care homes, yes.
 14 **Q.** Yes. Did you consider the impact on the reduction of
 15 access to care, and the early discharge of patients on
 16 those and their family carers who were doing their best
 17 to try to look after their loved ones?
 18 **A.** Yes.
 19 **Q.** Can you help us, please, with what was done to provide
 20 support to the unpaid carers that were looking after
 21 people that went back to their own homes?
 22 **A.** Yes, so the primary response to that problem was the
 23 shielding programme.
 24 **Q.** Right.
 25 **A.** And we've considered that in other modules. I regard it

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1 As I will later discuss, we acted on this and [we] asked
 2 for urgent work to be undertaken to restrict such
 3 movements."
 4 We're going to look at staff movement in a moment,
 5 but your reference there to learning in the summer 2020,
 6 can you help us now with what study or research or
 7 report it was that that sentence is based on?
 8 **A.** Well, as we've seen in discussion this morning so far,
 9 we were worried about issues relating to staff from
 10 March, and the -- a number of different pieces of
 11 evidence were brought to bear. And ultimately, it was
 12 a PHE -- it came from PHE that staff movement was likely
 13 the main source of transmission.
 14 Once you have taken the position that asymptomatic
 15 transmission is significant, then it becomes more
 16 intuitive that staff movement, and indeed visitors, are
 17 likely to be the main source of infection, simply
 18 because there are far, far more entries into a care home
 19 by members of staff than by residents.
 20 You know, residents --
 21 **Q.** So your recollection is it was a PHE study that is
 22 essentially being referred to when you say, "We learned
 23 in the summer of 2020"?
 24 **A.** Yes, the reason I've phrased it like that is because
 25 I don't know the precise source of where that became --

84

1 where that insight came from.

2 **Q.** Right.

3 **A.** I know that it wasn't my insight. What I know is that

4 once I saw that that was -- once I saw that evidence,

5 I seized on it and tried to change policy on the basis

6 of it, and that carried on for the next year --

7 **Q.** Were you --

8 **A.** -- the rest of the year.

9 But, you know, sometimes -- anyway, I don't know

10 where it came from exactly, but somebody spotted this

11 issue.

12 **Q.** All right, let me see if this helps you at all, and

13 please say if it doesn't. Were you aware of the

14 findings of the Vivaldi Study that started to emerge in

15 June of 2020?

16 **A.** Well, Vivaldi was one source of this, but I wouldn't

17 stress the Vivaldi Study. SAGE, for instance,

18 considered a very wide range of scientific advice in

19 this space and -- including but not limited to Vivaldi.

20 **Q.** If given some time, would you be able to find the

21 PHE study that you're referring to in the summer

22 of 2020?

23 **A.** I'm very happy to write to the Inquiry with more detail

24 if I can find it.

25 **Q.** Please do. I ask you that because we're aware of

85

1 studies, a PHE report from July 2021.

2 **A.** Yeah.

3 **Q.** A consensus statement in May 2022, but can I just,

4 before we have to descend to the detail, if we do,

5 I take it you are not suggesting that the discharges did

6 not cause some infections in care homes?

7 **A.** Of course. The word "main", it's critical here. You

8 know, the 2021 PHE study suggests that the percentage is

9 under 2%.

10 **Q.** Yes.

11 **A.** You know, it -- you want that down to zero, right?

12 **Q.** -- (overspeaking) --

13 **A.** You want to get it down zero. The aim here is to -- as

14 much protection as possible.

15 **Q.** Of course. Let me call up the PHE study so that

16 everyone else knows what we are talking about,

17 INQ000234332, page 3. This is a PHE report dated

18 July 2021. I think, in fact, you had resigned on

19 26 June 2021, but here's the published report. And as

20 you say, PHE set out there that in fact it was 1.6% of

21 outbreaks of the tests that they had conducted that were

22 identified as potentially seeded from

23 hospital-associated Covid-19 infection, with 804 care

24 homes -- sorry, 804 care home residents with confirmed

25 infection associated with these outbreaks.

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1 a study that they did in July 2021 --

2 **A.** Oh sure, yeah.

3 **Q.** -- which is a long time after this --

4 **A.** Yeah, I know the 2021 study, and -- but that is

5 obviously an -- analytical and backward looking. What

6 I can't remember is who came up with the idea -- the

7 point that staff movement is likely to be a problem and

8 therefore we needed to do something about it. What

9 I remember is that, you know, once that penny dropped we

10 got onto it.

11 **Q.** Can I ask you this: you say there that "We learned in

12 the summer of 2020 staff movement was the main source of

13 transmission" --

14 **A.** Yes.

15 **Q.** -- Vivaldi says it was a source of transmission, not the

16 main source of transmission. Are you able to help us

17 now with what it was that led you to believe it was "the

18 main source" of transmission as opposed to "a source"?

19 **A.** Well, the -- as I said, I'll have to write to you with

20 that exactly. We know it's the main source from all the

21 scientific work that's been done since. I would not put

22 the stress on Vivaldi as a sole source of truth on this.

23 It was helpful but not the only piece of scientific work

24 in this space.

25 **Q.** All right. There have been subsequently a number of

86

1 "The majority of these potentially hospital-seeded

2 outbreaks were identified in March to mid-April 2020,

3 with none identified from the end of July until

4 September where a few recent cases have emerged."

5 So you're right, the PHE data is suggesting a small

6 proportion of patients discharged from hospital

7 accounted for care home outbreaks, but do we not have to

8 factor into that, Mr Hancock, that there was limited

9 testing up until 15 April?

10 **A.** Yes, but there was also limited testing from everywhere,

11 so that applied -- the limited testing applied across

12 the board so it doesn't invalidate this finding. My

13 point here is not -- I don't have any additional

14 scientific input into this question. It's an important

15 question. I have -- what I'm stating in my -- in my

16 witness statement is based on the best scientific

17 evident available. What is the assessment here? In

18 a way, my policy point, and that what matters now, is

19 that staff movement is a major issue for a novel

20 pathogen, especially one where there's asymptomatic

21 transmission.

22 And indeed, some say that since care home workers

23 sometimes are also bank workers in hospitals, then you

24 should take that into consideration, because there's

25 potential spread there too, as well, in the ban on

88

1 working in multiple places that I recommended. So, you
 2 know, it's a -- that's the point.
 3 **Q.** Can I just ask you, before we leave this page, clearly
 4 the conclusion in the exec summary is:
 5 "The findings of this report suggest hospital
 6 associated seeding accounted for a small proportion of
 7 all care home outbreaks. Policies on systematic testing
 8 prior to hospital discharge for patients discharged to
 9 care homes, and where a test result was still awaiting,
 10 the patient would be discharged and pending the result,
 11 isolated ... were introduced on 15 April ... This may
 12 have supported the decline seen in these ... outbreaks
 13 contributing to an overall reduction in care home
 14 cases."
 15 **A.** Yeah.
 16 **Q.** So that essentially is supporting the need for
 17 pre-discharge testing, would you agree?
 18 **A.** Absolutely, but you've got to remember there were no
 19 tests.
 20 **Q.** No.
 21 **A.** Yeah.
 22 **Q.** No. The absence of tests, though, in March to
 23 mid-April, do you agree does make it difficult to
 24 reliably assess the extent to which the discharges
 25 caused infections in care homes?

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1 unintentionally by staff members living in the wider
 2 community. Interventions to mitigate this through
 3 asymptomatic testing and the avoidance of
 4 cross-deployment were only partially successful at times
 5 of high community prevalence."
 6 **A.** Yes.
 7 **Q.** That's what the four CMOs wrote up.
 8 **A.** Yes.
 9 **Q.** Do you agree that in reality, the three main routes of
 10 transmission into the care homes were either staff, the
 11 visitors, or the admissions themselves?
 12 **A.** Yes.
 13 **Q.** And I want to just look at the staff transmission route.
 14 Could we have up on screen, please, a Covid strategy
 15 meeting on 6 May, INQ000146701.
 16 Now, Mr Hancock, this was a -- I think what is
 17 sometimes called a deep dive?
 18 **A.** Yes. Could you remind me of the date of this?
 19 **Q.** Yes, 6 May. Now, you are not present.
 20 **A.** Okay.
 21 **Q.** Helen Whately is. The meeting was about care home
 22 delivery plan, and for what it's worth, nosocomial
 23 infection rates, all right?
 24 **A.** Yes.
 25 **Q.** But I just want to ask you about some of the things that

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1 **A.** It makes -- yes, absolutely. It makes it difficult to
 2 assess all of these things. You know, we were working
 3 in an environment of low and unreliable data. Of course
 4 we were. Hence why the acceleration of testing capacity
 5 was so important, which, you know, we were doing at the
 6 same time. So yes, that -- all these things were true.
 7 You know, in fact, even in this study, 1.6 is what
 8 was measured in this report, but that is -- it does seem
 9 to me, you know, a spurious level of accuracy, the .6,
 10 but, you know, what it's saying is it's relatively low
 11 in this report. What -- the policy consequence of this
 12 is to ask where is the 98% coming from? But also at
 13 a human level, 1.6 is still too high, right? It may
 14 only still be 1.6% but if the impact of that is that one
 15 of your relatives dies in a care home, as one of mine
 16 did, it matters.
 17 **Q.** That's why I want to come on to staff movement between
 18 care homes, please.
 19 A number of the documents that we have looked at,
 20 indeed, that you will have seen, Mr Hancock, comment on
 21 the unintentional infections caused by staff movement
 22 and indeed, the CMO's technical report, as I think you
 23 are aware, and indeed you quoted it in your statement,
 24 makes the point that:
 25 [As read] "The majority of outbreaks were introduced

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1 are said in the deep dive.
 2 At that strategy meeting:
 3 "The Director General [so Ros Roughton at the time]
 4 said that DHSC had worked with care providers to
 5 identify several measures aimed at reducing the spread
 6 of infections in care homes. One measure proposed would
 7 be to restrict the movement of staff between care homes.
 8 However, this had presented some key implementation
 9 challenges for care providers."
 10 **A.** Yeah.
 11 **Q.** "She said that care providers needed a larger workforce
 12 pool to ensure they had the capacity to restrict
 13 intra-care home movement. She said that some staff were
 14 concerned about the financial consequences of
 15 restricting shifts to one care home and many staff would
 16 not be willing to work in this way. She said further
 17 work was needed to understand the funding consequences
 18 and the resource requirements to implement the
 19 proposal."
 20 And so she has made the attendees of the deep dive
 21 aware of the challenges here with limiting staff
 22 movement.
 23 **A.** Yeah.
 24 **Q.** Do you -- although you weren't in that meeting, you're
 25 familiar with those challenges, no doubt, Mr Hancock?

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1 A. Yeah, of course, yeah.

2 Q. And do you think it was therefore known at an early
3 stage that mandating restrictions on staff was not
4 really going to work without either a larger workforce
5 pool, and/or financial consequences, to try and
6 compensate those who were now having to limit the way in
7 which they worked?

8 A. Yes, and I think I articulated this at the time. I've
9 seen that in the paperwork. The conclusion we came to,
10 which I announced on 15 May, was strongly to recommend,
11 but then -- and that did reduce the infections in care
12 homes and in the second wave the problems in care homes
13 were much, much lower. What I would say, though, was
14 that having brought that -- I think we ended up with
15 about a 90% reduction in staff movement, ie, number
16 of -- the number of staff in the system working in more
17 than one care setting.

18 I then, over the autumn, tried to drive that to zero
19 with the mandated solution and couldn't get that
20 through.

21 Q. We're going to look at that.

22 A. Okay.

23 Q. There's one thing I want to ask you before we come to
24 the autumn efforts.

25 A. Yeah.

93

1 consideration" and as we'll see when we go through the
2 autumn, the legal considerations were significant.

3 Q. Now, I don't want you or anyone else to be confused.
4 There were clearly, when you were thinking about
5 mandating restrictions on staff movement, legal
6 considerations --

7 A. Yeah.

8 Q. -- but were you aware whether there was a reason why the
9 pilot didn't go ahead?

10 A. No.

11 Q. Right. Following, I think, that meeting, I think you
12 were considering banning staff -- and indeed you wrote
13 to the Prime Minister.

14 A. Yeah.

15 Q. And I'd just like to have a look at the letter, please,
16 INQ000292617.

17 A. Do we have a date for this?

18 Q. Yes, it was 8 May.

19 A. Right, okay.

20 Q. So just a couple of days after the deep dive.

21 Just forgive me one moment. I just need to call up
22 ... my document.

23 We can see there it relates to the care homes and
24 nosocomial transmission. You say:

25 "Following the ... deep dive," the letter sets out

95

1 Q. Can we see lower down the page reference to:

2 "The First Secretary of State, Mr Raab, said that
3 care homes were a decentralised system and
4 a recommendation should go to the Prime Minister on the
5 Government mandating the restrictions of movement of
6 care home workers in between care homes for one month,
7 subject to legal consideration."

8 A. Right.

9 Q. Now, bearing in mind you weren't it, though, were you
10 aware that there was a potential for a one-month trial
11 period, or pilot, call it what you will, to restrict
12 movement.

13 A. Yes, I would have been -- I expect that I would have
14 been debriefed on this meeting by Helen, as you could
15 see, our relationship was very good, and also, I would
16 have seen these minutes.

17 Q. Minutes, yeah.

18 A. I would have just not been able to go to the meeting
19 because I would have been doing something else.

20 Q. We're not aware that the one-month pilot or trial, call
21 it what you will, in fact happened.

22 A. Right.

23 Q. Are you aware of whether there was such a pilot?

24 A. No, I don't recall it being -- getting anywhere, not
25 least because it says here "subject to legal

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1 the Department's plans.

2 A. Yes.

3 Q. You've got there reference to the latest Public Health
4 England evidence showing that:

5 "There is asymptomatic transmission ... via both
6 residents and staff. [It's] similar to transmission ...
7 in the ... community ..."

8 And you set out the five steps.

9 And if we could just go down to paragraph 4 -- thank
10 you -- you say:

11 "At its heart, the core [of the] problem of managing
12 social care is that accountability for delivery falls to
13 us, while the levers are held by the local authorities."

14 As we touched on this morning.

15 "This makes delivery of sensible policy proposals --
16 like reducing staff movements between providers -- very
17 difficult. We need to change this through legislation."

18 A. That has not yet happened.

19 Q. No. Just bear with me because we will get there.

20 A. Yeah.

21 Q. "But in the mean time, the most effective way we can
22 drive specific policy directly is to tie adherence to
23 funding: to give funding to those providers who act in
24 the correct way."

25 A. Right.

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1 Q. Now, pausing there, a number of questions that flow from
 2 that. Can you help us with why there was no legislation
 3 immediately proposed in May 2020, given that you are
 4 fully alive to the problem of staff movement?

5 A. The decision that was taken was to go for
 6 a non-legislative recommendation. The -- getting
 7 legislation through takes time, and we were putting
 8 through a huge amount of emergency legislation, mostly
 9 relating to lockdown measures, and so this -- so getting
 10 legislation through would have been a serious
 11 consideration, and remember at this point we are all
 12 exceptionally busy.

13 Therefore, in the meantime, being able to put out
 14 a piece of guidance was a good anyway of getting started
 15 on this, and so we did, on the 15th. And it made a big
 16 impact.

17 But I didn't let go of the need to then drive this
 18 further, although that never happened.

19 Q. All right.

20 A. In a way, why I didn't go for legislation at this point
 21 is demonstrated by the fact that I then worked until
 22 Christmas to try to get legislation. Whereas getting --
 23 standing up at this press conference and saying, "Please
 24 stop movement as a recommendation", you know, we could
 25 enact only 11 days -- well, nine days after this advice

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1 What ability did DHSC have to ensure that local
 2 authorities did pass on the funding in accordance with
 3 the intention?

4 A. DHSC had no levers over that.

5 Q. Right.

6 A. In a way, you know, the -- this paragraph and the
 7 previous paragraph are -- absolutely reflect the
 8 discussion we've already had. I mean, I'm a bit like
 9 a broken record on Statutory Sick Pay. And I didn't
 10 know -- I hadn't seen this document in preparation for
 11 this session, but it's safe to say that my views remain
 12 the same today.

13 Q. And so on 15 May, there was guidance which asked
 14 essentially care homes to ensure that members of staff
 15 only work in one care home wherever possible?

16 A. Mm.

17 Q. This includes staff who work for one employer across
 18 several homes or members of staff who work on
 19 a part-time basis for multiple employers?

20 A. Yeah.

21 Q. And I think on that date you indeed announced the
 22 infection control fund?

23 A. Yes.

24 Q. Which was deliberately designed to try and recompense
 25 workers who were having to limit their movement. It had

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1 to the PM.

2 Q. Yes, all right. I just want to look at one other
 3 paragraph over the page, please, on page 2. You say
 4 there to the Prime Minister -- paragraph 10, please,
 5 just a little -- thank you very much:

6 "As we are looking to compensate workers for the
 7 financial impact of restricting where they can work,
 8 I am strongly of the view that we must ensure that those
 9 social care staff that need to isolate do so on full pay
 10 rather than on statutory sick pay. To date we have been
 11 encouraging providers to adopt this policy wherever
 12 possible, however we know that many are not, citing that
 13 many local authorities have not passed on the funding
 14 which we announced in March, a large proportion of which
 15 was intended for this purpose."

16 Then you say you'd like it to be "more directive".

17 So, as I understand it, here you are pushing for
 18 recompense.

19 A. Yeah.

20 Q. But help us with the section that says:

21 "To date we have been encouraging providers to adopt
 22 this policy ... however we know that many are not" --

23 A. Yeah.

24 Q. -- "citing that local authorities have not passed on the
 25 funding ..."

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1 other functions, as well, don't misunderstand me, but
 2 that was one of the main aims of the fund, was it not?

3 A. Yes, without -- I just ... yes. What you can see from
 4 that combination of things, the fund, the purpose of the
 5 fund, the innovative use of the fund to require
 6 behaviour changes on the ground, the limitations to
 7 staff movement, you -- I hope you can understand what
 8 I was trying to communicate when I summed that up with
 9 a -- the piece of rhetoric that we discussed before the
 10 break. We felt like we were doing everything we
 11 possibly could to support. That is how it felt. We
 12 were really leaning into this problem. And, you know,
 13 hence I used a form of words that subsequently has
 14 been -- I've been criticised for.

15 But that -- but, in a way, the discussion we've just
 16 had demonstrates the huge amount of work and
 17 consideration we were putting into how to try to
 18 continue to improve things on the ground.

19 Q. Right. Now you said the fund itself, and indeed the
 20 guidance, resulted in 90% of care homes acting to
 21 restrict staff, and you say in your statement:

22 "We wanted to go even further than that and to
 23 reduce staff movement to zero."

24 A. Yes.

25 Q. Right. And I'd like to ask you, please, about just some

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1 of the things that you did over the autumn of 2020 to
 2 try to bring in the legislation.
 3 **A.** Yeah.
 4 **Q.** Can I just have a look at a few documents with you,
 5 please, Mr Hancock.
 6 Can we have up on screen, please, INQ000233987.
 7 This is 14 September. And there's a paper -- there
 8 are a number of papers over that autumn on this topic,
 9 but you say:
 10 "... the paper is not strong enough ...
 11 "• We need to propose the rule that working in more
 12 than one social care setting is illegal under public
 13 health law.
 14 "• Likewise we need to mandate self-isolation for
 15 social care staff, and make the care home responsible
 16 for that."
 17 Were you taking legal advice at this stage about
 18 bringing in a new law or amending an old law? Can you
 19 help?
 20 **A.** I think that the reference to "under public health law"
 21 means my goal here is to use the existing legislation to
 22 find a legislative hook, if you like, that could be used
 23 based on -- because there's a number of very strong
 24 powers in the 1984 Act that allow a wide degree of
 25 discretion for policy, if it is based on the advice of

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1 individually who is ill and who is not from -- or who
 2 has got a positive test, from Whitehall. That has to be
 3 an on-the-ground decision.
 4 **Q.** I want to jump. There was a -- various Covid-O meetings
 5 about this topic. Can I ask you, please, about just one
 6 of them.
 7 Can we have up on screen, please, INQ000090180, at
 8 page 4, please. You were present at this meeting,
 9 Mr Hancock, which was on 15 September. And a little bit
 10 lower down that page, please, can we see the sentence
 11 that begins:
 12 "More could be demanded of the sector."
 13 Let's just pause there. I'll just wait for it to be
 14 highlighted, Mr Hancock.
 15 But there's a sentence, I hope you've got it?
 16 **A.** Yes.
 17 **Q.** "Some of the recommendations would be uncomfortable for
 18 the social care sector. More could be demanded of the
 19 sector. The measures included a strengthened CQC
 20 inspection regime, and legal powers to: prevent staff
 21 movement ... require full payment of wages ... when
 22 isolating; to stop visiting; ... comply with PPE [and
 23 a number of things]. The government should consider
 24 going stronger on staff movement restrictions and sick
 25 pay in particular, and legal powers to enforce these

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1 clinical advisers, and that is -- this is where I've got
 2 to in terms of legislation. Instead of new legislation,
 3 I'm trying to use the existing legislation.
 4 I would have thought it would be a -- it would
 5 require a statutory instrument under the 1984 Act.
 6 **Q.** Yes. And I think in due course you received advice
 7 about amending various regulations that were in place as
 8 a potential way of bringing in this law.
 9 **A.** Right.
 10 **Q.** I don't want to get into a legal --
 11 **A.** Sure. It's second order.
 12 **Q.** Yes. Can I ask you about this though:
 13 "• Likewise we need to mandate self-isolation for
 14 social care staff and make the care home responsible for
 15 that."
 16 What did you mean when you said you wanted to make
 17 the care home responsible for mandating self-isolation?
 18 **A.** I am not exactly sure.
 19 **Q.** All right.
 20 **A.** As in I can't remember now the mechanism that was in
 21 mind my mind when I wrote this.
 22 **Q.** Putting the mechanism aside, can you help us with why
 23 you wanted it to be the care home's responsibility?
 24 **A.** Because they're on the ground, they'll know who does and
 25 doesn't need to self-isolate. You can't decide

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1 would not face the same backlash that had been seen
 2 earlier in the year due to the existing guidance."
 3 Can you help me with that guidance? What was the
 4 backlash that was being referred to there?
 5 **A.** I don't know. You'll have to ask Helen.
 6 **Q.** All right.
 7 She said:
 8 "... this was a 'stick', that needed to be
 9 accompanied by an incentivising 'carrot' of additional
 10 funding through the Infection Control Fund. A further
 11 'stick' to consider was a move to greater transparency
 12 through publishing care home test rates."
 13 **A.** Yeah.
 14 **Q.** Can I go to page 7 of that document, because it then
 15 sets out a number of things that were discussed in the
 16 meeting and I wonder if you could help us with (j)
 17 there. In the course of the discussion, there was
 18 reference to "the sector had not done enough to protect
 19 those in its care, nor its staff".
 20 **A.** So I -- maybe I --
 21 **Q.** Can I ask the question?
 22 **A.** Yes, of course.
 23 **Q.** Thank you.
 24 Can you help us, please, with what that was
 25 a reference to?

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1 A. Yes, of course. So I -- the best way I can describe
2 this and answer that question is to explain what these
3 points are in Cabinet subcommittee minutes, which this
4 is an example of.

5 What happens is that the chair and the main
6 policyholders set out their position or the paper, for
7 instance, that you're discussing, and that's the block
8 of text we were looking at a moment ago, was Helen
9 setting all that out.

10 It demonstrates, by the way, the degree of
11 confidence I had in my junior minister that she was the
12 one giving the presentation rather than me. That is not
13 normal in these situations.

14 Then, there is a discussion around the table,
15 including with the ministers who are -- come from policy
16 areas not responsible for this, and they are -- those
17 comments, without the name of the minister, are put in,
18 in these. And this is -- Cabinet papers are all the
19 same like this, as well.

20 Q. Yes.

21 A. So what this means is a minister present but not the
22 chair, not Helen and not me, because we would have our
23 names put against it, has said, "The sector hasn't done
24 enough to protect those in its care, nor its staff".
25 I've no idea who said that or what he or she meant by

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1 Q. Right. In due course, in response, you made a number of
2 observations about the ICF and you say:

3 "Regulations on staff movement would require careful
4 exemptions, for example GPs that serve more than one
5 care home."

6 But I just wanted you to contextualise that so
7 people didn't misunderstand that comment.

8 A. Yes.

9 Q. Now, to come back to where we were, you wanted a policy,
10 essentially, therefore, of zero staff transfer as
11 I understand it.

12 A. Yes, we would -- it would end up being -- it would end
13 up being slightly more complicated than that, but that
14 was the thrust of it.

15 Q. All right. You had sought legal advice as to whether
16 you could change existing legislation to mandate that?

17 A. Yes.

18 Q. And in due course, you wanted to provide money for staff
19 who would not be able to work so many hours if they
20 could only work in one care home.

21 A. Yes.

22 Q. And indeed, I think you brought that up with the
23 Treasury?

24 A. Yes.

25 Q. And were you able to secure funding to achieve your aim?

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1 it. You often get, how shall I put it, broader
2 considerations brought to bear in these comments.

3 Q. All right. But that certainly should not be taken to be
4 either you or the minister --

5 A. No, it --

6 Q. -- considering --

7 A. It is definitely not either of us.

8 Q. All right. But can I ask you this: if you didn't agree
9 with that, and you clearly don't, Mr Hancock --

10 A. Yeah.

11 Q. -- can you help with why the notes don't say, "Minister"
12 or Secretary of State said that's simply not right"?

13 A. Because if in Cabinet subcommittees like this you
14 rebutted every point you disagreed with, you'd be there
15 for a long time.

16 Q. Right.

17 A. What you do is they normally come to you at the end, you
18 respond across the board, and then the chair sums up and
19 the summing-up of the chair is the policy of the
20 government. In this case Michael Gove was in the chair,
21 he strongly agreed with Helen and I, and generally, as
22 an overall approach, and I haven't seen the summing-up
23 but those areas -- those minutes are normally more crisp
24 and more action oriented, because that's the bit that
25 turns into policy.

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1 A. No.

2 Q. Equally, it was not possible to legislate to bring in
3 such a ban, was it?

4 A. It was possible. I was not authorised to do so.

5 Q. Ah.

6 A. It was perfectly possible.

7 Q. It may be my misunderstanding. No, you're quite right.
8 You said you finally accepted on 7 January a full ban
9 would not be possible. It was because of opposition
10 from key system players, particularly in light of the
11 vaccine and some of the opposition was that there was
12 concern there wouldn't be enough care staff to provide
13 good quality care.

14 A. Yes, I didn't think that consideration merited much
15 confidence, given that we'd reduced staff movement
16 from -- by 90% over the summer, and it hadn't had that
17 consequence, going the final 10% was also not going to
18 have that consequence. You know, the dates here are
19 instructive. The papers we've just been looking at are
20 from September. I then fought a battle that autumn to
21 get this put into place. In fact, I had dates of
22 announcement of this policy agreed a number of times
23 over that autumn, and there was a rearguard battle
24 somewhere in government to stop it happening.

25 And in the end, I got the go-ahead that I could

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1 launch it if we compensated people and I could secure
 2 funding from the Treasury. But since the Treasury are
 3 the unilateral decision makers on funding and they said
 4 no, that was effectively a killer blocker.
 5 I still, to this day, don't know who stopped this
 6 policy from happening. But as you know from earlier
 7 modules, there are number of people who were prepared to
 8 use all sorts of tactics to try to stop things that I
 9 thought were necessary to save lives, and, you know,
 10 sometimes that boils up, and sometimes it's done
 11 quietly.
 12 **Q.** You obviously -- and it's set out in your statement and
 13 I'm not going to go through it all -- made a number of
 14 efforts to try to bring this legislation in if at all
 15 possible --
 16 **A.** Yes.
 17 **Q.** -- or at the very least to find some way of restricting
 18 staff movement. And do I take it that you think that is
 19 something that should happen in non-pandemic times?
 20 **A.** Yes, I do because of the number of deaths in care homes
 21 from flu and other infectious diseases, yes.
 22 **Q.** Do you think it is a matter that should be brought in via
 23 legislation?
 24 **A.** Yes, and I think in normal times, you could do it in
 25 a very considered way, thinking about the exemptions
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1 care setting, for example?
 2 **A.** Yeah.
 3 **Q.** There are also, I think, about over a million and a half
 4 jobs on zero-hours contracts.
 5 **A.** Yeah.
 6 **Q.** And so to pick up on her Ladyship's questioning, how
 7 feasible or realistic is it to ban staff movement when
 8 people are relying on having two jobs?
 9 **A.** It's a perfectly reasonable question but I think that
 10 it's entirely feasible because you could --
 11 **Q.** Help us.
 12 **A.** You could easily re-jig the employment arrangements so
 13 that, if two care homes each employed people part-time,
 14 and then each of them could take a fewer number of
 15 people full time. It would lead to a decrease in
 16 flexibility, that's absolutely true, but you could still
 17 work in one care home on a zero-hours contract and do
 18 something else when there weren't any hours coming from
 19 that care home for instance.
 20 But why should we have care home workers on
 21 zero-hours contracts anyway? Don't people in care homes
 22 deserve highly professional, highly organised support
 23 with the staff who are in reliable employment? I think
 24 it's a sort of -- you know, we should have been more
 25 ambitious for the care we give to the most vulnerable in
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1 that you might need, the levers that you'd use, and the
 2 enforcement mechanisms that you'd put in place.
 3 **LADY HALLETT:** Is it possible -- forgive me for
 4 interrupting. Is it possible when you have a very
 5 limited workforce?
 6 **A.** Well, we don't have a limited workforce. There's
 7 2.5 million people and we managed to bring this in with
 8 90% effectiveness without causing a -- there was more
 9 pressure, but not a disruptive negative consequence on
 10 the workforce. So it's absolutely doable. And it comes
 11 down, in a way, it comes down to the cost of looking
 12 after people in care homes. Do we think that it's right
 13 that we allow people to go to work in a care home with
 14 the flu, knowing that that may well spread the flu to
 15 people in care homes who might then die.
 16 **LADY HALLETT:** I am not questioning the wisdom of the
 17 policy, I am just questing whether it's practical.
 18 I thought it had 100,000 vacancies?
 19 **MS CAREY:** Yes, can I -- may I can pick up on that, my Lady,
 20 and to help you, Mr Hancock. There was a DHSC briefing
 21 in November that estimated that 22,500 staff in
 22 residential care held a second job in social care.
 23 **A.** Yes.
 24 **Q.** And the majority are understood to hold two jobs:
 25 perhaps one in residential care and one in a domiciliary
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1 society.
 2 **Q.** Same topic from a slightly different angle. Were there
 3 ever any plans to try and restrict staff movement in
 4 domiciliary care?
 5 **A.** No. I don't recall that. Domiciliary care is different
 6 because you are, by your nature, in the community all
 7 the time. So it doesn't, in a way, if you worked for
 8 two different employers in domiciliary care you'd still
 9 be visiting dozens of different houses to look after the
 10 clients, no matter who was paying the bill.
 11 **Q.** It brings me on to -- I want to ask you about
 12 domiciliary care because clearly there would be real
 13 practical difficulties with restricting staff movement
 14 in domiciliary care for the reasons you've just given.
 15 **A.** But also it would be less important. Because, you know,
 16 if you're --
 17 **Q.** Why would it be less important?
 18 **A.** Well, say, you're a domiciliary care worker who looks
 19 after 15 people and you go into their home. If you did
 20 that for one company, you'd still be visiting the 15
 21 people in their homes. If you did it for two companies,
 22 you'd be visiting 15 people, just being paid through two
 23 different companies. It wouldn't make a difference to
 24 the spread, to the clinical outcome. So it's less
 25 important. Whereas a care home is a physical setting
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1 that -- where infection can occur within the setting.

2 **Q.** Yes. Although a domiciliary care worker going from

3 house to house to house providing close contact is

4 equally providing a care in a closed getting?

5 **A.** Yes, but -- yes, what you'd have to -- to make it work,

6 you'd have to say that domiciliary care workers could

7 only work with one person or a smaller number of people,

8 and that would probably have been impractical.

9 **Q.** In relation to domiciliary care, though, given that on

10 any view, workers had to move from house to house to

11 house --

12 **A.** Yeah.

13 **Q.** -- and acknowledging, as you do, that you can't restrict

14 their movement, and you can't isolate the person in the

15 house because the carer has to provide the care, the

16 washing, and the like.

17 **A.** Yes.

18 **Q.** Can you help us then, please, with what was done in

19 relation to PPE for people providing domiciliary care?

20 **A.** Yes, well, we provided PPE to domiciliary care workers,

21 but we ... and again, in non-pandemic times, that is the

22 duty of the company involved. They're not all

23 companies, but nearly all domiciliary care is provided

24 by the private sector. And we provided free PPE. It is

25 a less defined sector, by its nature. And so it's

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1 built up that PPE supply, but PPE was in incredibly

2 short supply globally. We've had a whole module on it.

3 So the answer, the substantive answer to the substantive

4 question, is that we did everything that we could, and

5 went the extra mile to get as much PPE as we possibly

6 could in the circumstances.

7 **Q.** Was that -- does it come to this: that that's all you

8 could afford to give at the time?

9 **A.** It wasn't about affordability, no.

10 **Q.** No, but that's all that was available --

11 **A.** That's all the resources that were available at the

12 time, given the clinical prioritisation of PPE into

13 hospitals.

14 **Q.** Now, there was a further drop of PPE to the local

15 resilience fora in April.

16 **A.** Yeah.

17 **Q.** And I think you were informed of a plan by way of

18 submission.

19 And can we have a look at that, please, at

20 INQ000551555.

21 This went to you on 4 April. It was an emergency

22 PPE drop to the 38 local resilience fora. Are you able

23 to help us with the background as to why there was this

24 need for an emergency drop at the beginning of

25 April 2020?

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1 harder to be absolute about how many people -- what

2 proportion of people benefited from that.

3 **Q.** I want to look at some of the efforts to provide free

4 PPE that were taken up during the course of the

5 pandemic, particularly at the beginning.

6 Now, you've made the point, obviously, that formal

7 responsibility for PPE distribution rests with the

8 individual institutions, and care homes. And prior to

9 the pandemic, the NHS Supply Chain would only supply the

10 main hospitals --

11 **A.** Yeah.

12 **Q.** -- whereas, of course, in social care they provided PPE

13 for themselves.

14 **A.** Yeah.

15 **Q.** Just to provide the context for everyone.

16 And on 13 March, there were 7.5 million masks

17 delivered to the 25,000-odd care homes in England. All

18 right? That amounted to about 300 face masks per

19 CQC-registered provider, and I think you chastised me

20 earlier for laughing at you, and I certainly wasn't, but

21 I'm asked to ask you why so little PPE was provided to

22 that number of care homes when it amounts to,

23 Mr Hancock, 300 face masks per care home, which would be

24 gone through in no time.

25 **A.** Well, that was just the start of it. And obviously we

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1 **A.** Because there was a shortage of PPE. I mean, we knew

2 that from March. The challenge was getting as much PPE

3 as possible. And we also were trying to invent

4 a distribution system as well, because the -- in some

5 cases the private sector distribution system worked, in

6 other cases it didn't.

7 **Q.** All right. You've arranged -- you can see there:

8 "DHSC have ... [arranged] a one-off drop of PPE to

9 each [local resilience forum] in England to help respond

10 to local spikes in need and blockages in the supply

11 chain ..."

12 **A.** Yeah. So, you know, in some of the many criticisms

13 about what happened with PPE, sometimes people say, you

14 know, "We had to go outside the government system and

15 got PPE."

16 Well, we regarded that as a good thing. If you

17 could get your hands on PPE thorough private procurement

18 or through your own efforts, then of course that's good.

19 It's all -- you know, it was all shoulders to the wheel.

20 This was the additional PPE that we could direct

21 from the centre to go into this space.

22 **Q.** All right. But this PPE was not solely for the adult

23 social care sector, was it? It included prisons and any

24 other enclosed setting that the local authority felt

25 there was a need for PPE?

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1 A. Yes, that was a matter for the LRF to decide the --
 2 Q. Okay, but I don't want anyone to misunderstand this was
 3 a solely social care-related emergency drop?
 4 A. No, I think I'd describe it as a primarily social
 5 care-related emergency drop, yeah.
 6 Q. The highlighted section there says, in the final
 7 sentence:
 8 "We do not expect that NHS Acute Trusts or Ambulance
 9 Trusts will need to draw from this supply given they are
 10 already being supplied via the NHS."
 11 A. Correct.
 12 Q. Were you aware that the PPE supplies for NHS were being
 13 prioritised at the expense of the adult social care
 14 sector?
 15 A. That was not my assessment of it. There was a clinical
 16 prioritisation, and that was based on advice. It wasn't
 17 something I would interfere with.
 18 I am absolutely aware that people, for instance some
 19 people in LRFs, felt there was a prioritisation, and
 20 that the NHS hoarded PPE. I didn't ever find evidence
 21 of that happening. What I found evidence of was, in
 22 a situation of desperately short supply, everyone was
 23 trying to get their hands on PPE, and if they got their
 24 hands on PPE then they would tend to hold on to it.
 25 So I don't ascribe any negative intent on some of
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1 Q. I take your point. There was never any directive, was
 2 there, from DHSC to say that the NHS should get PPE
 3 first?
 4 A. Or should be able to buy, you know --
 5 Q. Yes.
 6 A. -- and others not allowed to buy it. That wasn't how it
 7 worked.
 8 Q. No.
 9 A. But having said that, I'm -- all I'm doing -- I'm not
 10 defending the system, I'm describing the system. And
 11 what I'm -- you know, the truth is, a lot of people felt
 12 like this.
 13 Q. Right. Forget the use of the word "requisitioning".
 14 A. Okay.
 15 Q. Can we just look at the examples that are given by the
 16 NCF. They told the Department that:
 17 "Many of [their] members report[ed] that their
 18 suppliers have stopped delivering PPE to them or have
 19 had their deliveries diverted to the NHS."
 20 Then there's some quotes.
 21 A. Yes, I understand that.
 22 Q. "When we tried to place [our] orders with our usual
 23 suppliers for sanitiser (and some other products) we
 24 were told they weren't taking orders because everything
 25 has been requisitioned for the NHS."
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1 these behaviours and accusations that we've seen in this
 2 space. I totally understand why people complain about
 3 it, but at the same time, this was a desperate situation
 4 in terms of PPE supply.
 5 Q. All right. Can I ask you about an email chain that has
 6 been provided to you, please.
 7 Can we have up on screen INQ000572355.
 8 You are not copied into it, but I want to know if
 9 issues like this came to your attention.
 10 This is an email chain between the National Care
 11 Forum and people at the Department of Health.
 12 And could we go to page 4, please.
 13 The National Care Forum are setting out to the
 14 department a number of concerns they've got, but they,
 15 in the course of the email, make reference to "NHS
 16 Requisitioning Stock". This is, to help you, 1 April,
 17 Mr Hancock --
 18 A. Yeah, I suppose this is an example -- I didn't know you
 19 were going to bring this up, but this is an example of
 20 what I was saying, which is that, you know --
 21 "requisitioning" is the wrong word. Requisitioning
 22 means mandating taking something.
 23 What was happening was the NHS were also buying, and
 24 in some cases they would be bidding against each other,
 25 outwith the government effort to provide PPE.
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1 A. Yes.
 2 Q. Next quote:
 3 "Our suppliers have told us that all four major
 4 manufacturers/wholesalers have been barred from
 5 supplying to anyone but the NHS."
 6 And indeed, at the bottom there:
 7 "A number of items, eg thermometers are completely
 8 unavailable. These are crucial pieces of equipment for
 9 services which remain open and have potential drop in
 10 services. The bottom line is Google has become our
 11 procurement source."
 12 A. Yes, so this is absolutely the lived experience.
 13 Q. Right.
 14 A. And what I'd say about it is, on the last point, "The
 15 bottom line is that Google has become our procurement
 16 source", if Google can provide you a thermometer and you
 17 need a thermometer, in a crisis, that's okay. You know,
 18 it's less bad than not getting a thermometer. But it's
 19 obviously not the best situation. It's not how you'd
 20 want it to be.
 21 My role in this, if you like, was in trying to
 22 ensure that there wasn't overall a national shortage of
 23 it. And, you know, we've been through that. But this
 24 is a totally fair representation, that -- we were aware
 25 of this concern at the time.
 120

1 Q. Right. So notwithstanding you're not copied in on this
 2 particular email, this does echo and resonate with
 3 concerns that you were being made aware of?
 4 A. Yes, mostly by Helen. I mean, Helen would come to me
 5 and tell me these sorts of things.
 6 Q. Right.
 7 A. Yes.
 8 Q. So there are -- before the emergency drop to the LRF,
 9 there is clearly concern within the sector about their
 10 ability to get their hands on PPE?
 11 A. Absolutely.
 12 Q. All right.
 13 A. As there was, by the way, across the NHS as well. So,
 14 you know, care felt like this, some parts of the care
 15 system felt like this. The NHS also felt like there
 16 were challenges in PPE availability. So it was just
 17 that the world suddenly started using PPE at a radically
 18 faster rate.
 19 Q. Okay. So back to the LRF emergency drop, please.
 20 A. Yeah.
 21 Q. The plan was to make, I think, over about
 22 30 million items of PPE available to the local
 23 resilience fora. And I'd like to ask you, please, about
 24 an email chain, at INQ000325261.
 25 And could we go to the final page first, it's on
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1 A. I've no recollection.
 2 Q. Over the page, please, then to emails that you are
 3 copied in on, and we can see you at the top:
 4 "Hi all,
 5 "Linking in Private Office subs list. DHSC
 6 ministers approve the sub and have the following
 7 comments ..."
 8 You asked for an annex to be sent. And the
 9 ministers said:
 10 "• [We] Would like to be stronger than saying we
 11 don't 'expect' acute trusts to [supply this], there
 12 [was] already a ... line for [the] NHS ...
 13 "• Thinks [that] the letter should include
 14 a stipulation that the LRFs do a stocktake of their
 15 available PPE to give better data to inform future
 16 drops.
 17 "• [They] Questioned why there are so many
 18 FFP3 masks ..."
 19 I don't need to ask you about this. But you, there
 20 at the bottom:
 21 "... agrees with the following feedback ...
 22 "• This needs to be pitched that this is
 23 a significant drop; LRFs are to use it judiciously as we
 24 cannot guarantee when the next drop will be."
 25 How does that tally, Mr Hancock, with the comms
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1 page 3, and then work back to the front of the e-mail.
 2 Just to help you, Mr Hancock, there was a submission
 3 on the PPE and an explanation about the drop.
 4 And then can we go to page 2. This says:
 5 "... our comms handling on this drop is below."
 6 And can you see the section there says "Media
 7 handling":
 8 "Given the uncertainty about how this drop will
 9 fulfil local demand and the possibility of criticism at
 10 a local level we would not recommend a proactive media
 11 approach for this drop and MHCLG and DHSC will liaise on
 12 developing strong reactive Q&A."
 13 Can I ask, was there concern that this was going to
 14 a drop in the ocean, effectively, Mr Hancock?
 15 A. I've no idea. I can't recall seeing this.
 16 Q. All right.
 17 A. I'm not copied into it. But it's a totally -- you know,
 18 it seems -- given the concerns that we were hearing from
 19 stakeholders, it's not an unreasonable judgment for
 20 a comms official to have made.
 21 Q. Right, but you're going to make an announcement
 22 that: here we are, we're going to give you 30 million
 23 pieces of PPE. But equally, are you acknowledging that
 24 that might not be sufficient to help out the sector? Is
 25 that how the announcement went?
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1 media handling that we need to be careful, because there
 2 may be criticism about how --
 3 A. If you read the next bullet:
 4 "• However, we should not overblow the volumes or
 5 over pitch it."
 6 So it seems totally reasonable. I'm saying: be
 7 honest about where we're up to.
 8 Q. Right. But --
 9 A. You know, 30 million is a significant number, but "we
 10 [shouldn't] overblow the volumes or over pitch it" seems
 11 totally ...
 12 Q. All right. And did it seem to you to be an
 13 acknowledgement that this wasn't really going to be
 14 sufficient to help out the adult social care sector,
 15 this drop?
 16 A. I think, you're -- if I may say so, you're focusing
 17 a little too much on the comms handling of this. Here
 18 it says:
 19 "SofS agrees with the following agreement from
 20 MHCLG ..."
 21 Q. Yes.
 22 A. So what will have happened here is Rob Jenrick will have
 23 said "This is my feedback", and I will have read it and
 24 just put a tick next to it and moved on to the next
 25 thing. This is the comms handling. For me it was
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1 second order. You know, this was as much as we could
2 get our hands on and get out to the system. Of course
3 it wasn't enough, because the world didn't have enough
4 PPE. We didn't have enough PPE. We were out there
5 buying it, and the PPE module has gone into great detail
6 about the lengths we went to buy it. And indeed, you
7 know, a bit like visitor policy, I've been criticised
8 for buying too much and criticised for not buying
9 enough. You know, c'est la vie.

10 Q. I want to deal with one topic before we break for lunch,
11 my Lady. It's just this: it's in relation to use of
12 face masks or coverings in the adult social care sector.

13 Now, Mr Hancock, we know that on 5 June you
14 announced that staff in hospitals should wear face
15 masks --

16 A. Yes.

17 Q. -- and visitors should wear face coverings.

18 A. Yeah.

19 Q. But that policy was not brought in until 2 July --

20 A. Yeah.

21 Q. -- in the adult social care sector.

22 A. Yeah.

23 Q. Can you help us with why there was a delay between it
24 coming in at hospitals, and it being introduced for
25 adult social care?

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1 Done. In social care, decision making just is not like
2 that.

3 Q. Help us, why couldn't you, as the Department, say,
4 "We're bring this in two weeks' time? We're announcing
5 it today and in two weeks' time everyone going into
6 social care needs to wear a mask"?

7 A. What's the lever? How could we have -- what were we
8 going to do if people didn't have --

9 Q. What were you going to do in the NHS if they didn't
10 do it?

11 A. The NHS is a hierarchical organisation. The --
12 NHS England put out a circular saying this was going to
13 happen and that's the decision because you're -- that's
14 how the NHS works. And it was under a centralised
15 system, emergency system, where if NHS England said
16 something was policy, that's what people did.

17 Q. And if the Secretary of State for Health and Social Care
18 said, "In two weeks' time we're bringing in masks in
19 social care", why would that not have worked,
20 Mr Hancock?

21 A. Because I didn't -- this is a precise example of not
22 having a lever.

23 Q. But what lever did you need? Why couldn't you just say
24 it and it would be adopted?

25 A. A bit like staff movement, I could have said it as

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1 A. So the clinical advice was that this was more likely to
2 be an important measure in hospitals, but also, it comes
3 back to the very first thing we discussed, which is that
4 in the NHS, we could just make this decision and get on
5 with it. In the world of social care, we had to get
6 cross-government agreement for a decision like this and
7 it took a whole lot more effort.

8 So I remember very clearly the decision in the NHS.
9 There was a huge toing and froing, you'll remember from
10 the public debate at the time about face masks. There
11 were even some ministers going into shops with face
12 masks on, others not. It was a huge area of contention
13 and the scientific evidence was extremely conflicting.

14 I then agreed with Simon Stevens and with Ruth May,
15 the Chief Nurse, that we would require face masks in all
16 NHS settings. We checked that we had broadly enough
17 face masks to do that, and then we agreed it, got
18 Number 10 clearance, and I and Ruth announced it at
19 a press conference.

20 Q. Yes.

21 A. Right? In the NHS you can just make policy decisions
22 like that because there's a straight-up line of
23 accountability from Chief Nurse recommends to Chief
24 Executive of NHS, recommends to me, recommends to
25 Prime Minister, four people agree, check it's practical.

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1 a recommendation. However, before saying it as
2 a recommendation, I would have needed MHCLG clearance,
3 I would have needed cross-government clearance because
4 if a policy affects more than one department it needs to
5 go to cross-government's clearance rather than just be
6 inside the Department. It comes back to the very first
7 point we made, we discussed, about accountability and
8 levers being -- resting in different places.
9 Essentially, I didn't have any legal authority to say
10 that, and so it took a month to sort it out.

11 But remember, at the same time, the clinical advice
12 was that this was more important in hospitals because of
13 the more acute nature of people's illness in hospitals,
14 and frailty, and therefore, both -- it was
15 administratively harder to do it in social care, and the
16 clinical advice was saying it's more important in
17 hospitals. So both of those things together explain the
18 difference.

19 But, you know, this is just -- it's just another
20 lesson in how government works, and in some places works
21 better than in others. Where there are straight lines
22 of accountability, things work better, full stop.

23 Q. There were, equally, ill and frail and old people in the
24 care homes, Mr Hancock, and so I'm not sure I follow why
25 you couldn't have said, "Well, if that's the clinical

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1 advice for hospitals, we'd better do the same in care
2 because they're just as vulnerable."

3 **A.** No, I -- sorry, that's a non sequitur. If the clinical
4 advice is this is more important in hospitals, I can't
5 just say that's not the clinical advice. That was the
6 clinical advice, first. Secondly, I've tried to
7 explain, I'm happy to go through it again, that in
8 government, policy making over social care is harder
9 than policy making over the NHS because of the way it's
10 set up. Because of the fact that local authorities have
11 the contracts, MHCLG has the relationship with the local
12 authorities, formally. Treasury has the money and the
13 Department of Health has the policy accountability,
14 albeit not the levers. This is exactly what I was
15 talking about, this is an example from when we were
16 talking at the start about the lack of levers. That --
17 I'm not defending that. I think that's a mistake.
18 I think it's an error. I think it needs to change.
19 I wish it had changed already. I was working on
20 changing it when I was in office.
21 It's wrong, okay? But it's the truth.

22 **Q.** Okay. It's not the position, then, that the decision to
23 bring face masks in social care was because social care
24 was an afterthought?

25 **A.** No, it's not.

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1 "Can we ... clear the operational guidance on
2 nosocomial infections including face coverings in NHS
3 settings. Dido says it can be pulled off by 5 pm."

4 I presume that's a reference to Dido Harding?

5 **A.** Yes, and 5 pm is the press conference.

6 **Q.** Is the press conference. And Natasha Price says:
7 "Jenny Harries is concerned about this ..."

8 **A.** Yes.

9 **Q.** "... this announcement doesn't cover the care sector --
10 she said it would look bad if it doesn't, and we haven't
11 warmed up care home stakeholder to it."

12 **A.** Yeah.

13 **Q.** Ignore the references to Mr Powis, who was coming to
14 help you announce the --

15 **A.** And the Mr Pearson as well.

16 **Q.** Yes -- but -- over the page, sorry, to page 2, one of
17 your, I think, advisers says:
18 "Why are we not saying it for social care? Can't we
19 say that when social care visitations are relaxed, face
20 coverings will be required? Or just have some language
21 that shows some ..."

22 I presume that's some "legs", is it?

23 **A.** Some leg, as in language -- I mean, Jamie is
24 an absolutely extraordinary communications professional
25 and what he means there is language to show that we

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1 **Q.** All right. Can I ask you, please, before we break just
2 to look at a WhatsApp exchange, please?

3 **LADY HALLETT:** Can I just ask before you get it brought up
4 on the screen, is the point you're making Mr Hancock
5 that whereas with the NHS you can impose a requirement
6 on the staff, but unless you make it law, you can't
7 impose a requirement on private providers?

8 **A.** You've put it better than me, Chair.

9 **LADY HALLETT:** Sorry, I just thought it was the short
10 answer.

11 **A.** Yes, there is a -- and hence we brought in requirements
12 in return for getting the emergency cash, because that
13 was like a way to try to short-circuit precisely that
14 problem.

15 **MS CAREY:** All right. Can we have a look at the WhatsApp?

16 **A.** Can I just add one little thing? I'll try to be quick.
17 I totally understand why, if you're in social care,
18 it looks like you're getting things afterwards. I'm
19 trying to explain why, if you care just as much about
20 each of them, it is still harder to deliver in one space
21 than the other.

22 **Q.** I follow that. All right. Let's just look at this
23 exchange and then break for lunch.
24 Here you are on 5 June which is the day you
25 announced the mask wearing in hospitals, and you say:

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1 understand this potential criticism. Because if you go
2 back to the top exchange in this WhatsApp group, it
3 says, "Jenny Harries" -- she's not -- she's a clinical
4 adviser, she's not raising a clinical concern; she's
5 raising a comms concern. It would look bad, okay?

6 If we go down again, Jamie is saying, considering
7 that we all recognise that we would get this criticism
8 that you have articulated, he's saying can't we show,
9 for instance, we will in the future do this in social
10 care? Or, as he says, "when social care visitations",
11 as in visitor policy, "are relaxed, face coverings will
12 be required"?

13 He wants to demonstrate that we understand this,
14 whilst nobody is challenging the substance of the
15 decision, which is executable in the NHS far more
16 rapidly than it would be.

17 **Q.** Right. She says:
18 [As read] "Jenny's view is that because we haven't
19 spoken to care home stakeholders are all -- [that should
20 probably be "at all"] -- they are likely to be unaware
21 of this and be critical of this rapid expectation, so
22 would advise against announcing today, could speak
23 to her."

24 **A.** Yes, so she's saying do not announce for social care
25 today.

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1 **Q.** Yes, because you haven't spoken to the care home
 2 stakeholders to prepare them for the announcement?
 3 **A.** Yes, because there's a whole series of things you have
 4 to do in that sector that you don't have to do in the
 5 NHS.
 6 **Q.** Why weren't they done by 5 June?
 7 **A.** What? Because we're moving incredibly quickly. The
 8 clinical advice on face coverings only changed just
 9 before this, and the decision essentially -- that
 10 question implies that I should have waited within the
 11 NHS and done it with social care, because of comms
 12 concerns. I cared about savings lives. I appreciated
 13 that this might cause some criticism, but I cared about
 14 the substance and saving lives. And over and over
 15 again, in the pandemic I faced this dilemma. I might
 16 get criticised for a decision, but it might save lives,
 17 and my decision always was to save lives.
 18 It's why I can -- you know, I can explain all these
 19 decisions that I took, even when there have been broad
 20 criticisms of them, and some of them more acute than
 21 others, but there are reasons behind them based on the
 22 substance. And that is why -- that's why I get so
 23 frustrated when we -- when at other points we have moved
 24 off the substance.
 25 Here, this is a classic example. I could have

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1 **LADY HALLETT:** I think that's as far as we're going to go.
 2 **MS CAREY:** Thank you, my Lady.
 3 **LADY HALLETT:** Otherwise I'll have a stenographer on strike.
 4 2.10, please.
 5 **MS CAREY:** Thank you, my Lady.
 6 (1.10 pm)
 7 (The Short Adjournment)
 8 (2.10 pm)
 9 **LADY HALLETT:** Ms Carey.
 10 **MS CAREY:** Thank you, my Lady.
 11 Mr Hancock can we stick with a few questions,
 12 please, about PPE, then I've a number of other topics to
 13 cover with you this afternoon.
 14 At paragraph 199 of your statement, I don't need it
 15 called up on screen, but you've set out there that
 16 you've received a submission from the PPE demand team at
 17 the department on 15 July proposing free distribution of
 18 PPE to frontline, primary, and social care services,
 19 initially until March 2021; is that right?
 20 **A.** I'm sure it is.
 21 **Q.** I'm taking it from your statement.
 22 **A.** Yes, of course.
 23 **Q.** And you thereafter extended the free PPE to March 2022?
 24 **A.** Right.
 25 **Q.** All right. Obviously that post-dates the end date,

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1 delayed, but I thought it was better to keep people
 2 alive.
 3 **Q.** All right. Doesn't it imply you should have brought
 4 home -- brought forward the care sector announcement
 5 rather than delay the NHS England announcement?
 6 **A.** No, it doesn't. Jenny Harries is advising against
 7 announcing for care homes.
 8 **Q.** Yes, yes, and the reason she is, is because you haven't
 9 warmed up the care home stakeholders by this stage?
 10 **A.** No, because the policy -- the clinical advice on wearing
 11 face masks was only just changed. So this absolutely
 12 supports the decision that I made, because it's --
 13 because the only alternative -- it comes back to this
 14 question of when you don't have good alternatives,
 15 right, when there aren't good options. It comes back to
 16 that.
 17 The only alternative that you've suggested is that
 18 we delay the NHS announcement. Now, I wasn't prepared
 19 to do that.
 20 And if you say, "Well, should you have brought
 21 forward the care home announcement", well, I've got
 22 Jenny Harries saying, "Don't do that because we were not
 23 ready for it, essentially", and I hadn't got cross
 24 government clearance either, so I wouldn't be able to do
 25 it. So there you are.

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1 post-dates your leaving the department, but can I ask
 2 you about unpaid carers please and PPE for them?
 3 **A.** Yes.
 4 **Q.** And can I call up on screen, please, INQ000328012_4.
 5 Now this is a submission in fact to the minister.
 6 **A.** Right.
 7 **Q.** But I'd like to ask you about a few things in it, if
 8 I may. If I ask you something and you can't answer,
 9 please will you let me know. All right?
 10 It was a submission to Helen Whately in November of
 11 2020 asking her to amend guidance to advise PPE should
 12 be worn by unpaid carers when providing personal care to
 13 someone who they do not live with. All right? Just to
 14 help you. Okay?
 15 **A.** Okay.
 16 **Q.** And can I ask, if a submission goes to the minister, do
 17 I take it that it doesn't come to you?
 18 **A.** Correct.
 19 **Q.** Would you expect, though, a submission like this, for
 20 her to speak to you about it or to ask your views on it?
 21 **A.** No.
 22 **Q.** All right.
 23 **A.** If it's just to her, as opposed to her copying my
 24 private office or copying -- or to her, then me, I'd see
 25 it, otherwise -- and especially with a minister who

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1 I delegated a lot to.

2 **Q.** All right, fine.

3 **A.** Essentially in government the civil servants work out

4 which junior ministers the secretary of state trusts,

5 and which one he or she doesn't, and in this case they

6 will know that I would have agreed with whatever

7 decision she -- (overspeaking) --

8 **Q.** And we shouldn't take this as signifying that you

9 weren't interested in unpaid carers, this was just one

10 of many tasks that you no doubt delegated to

11 Helen Whately?

12 **A.** That's right.

13 **Q.** All right.

14 And we've seen the recommendation there that she

15 amends the guidance, and I'd just like your help,

16 please. On page 2 we have a summary of the position as

17 it was, and then what the plan was.

18 "The DHSC guidance for unpaid carers in England does

19 not currently [so as at November] recommend that unpaid

20 carers need to wear ... (PPE) when providing care,

21 unless advised to do so by a healthcare professional.

22 In May 2020 ... (PHE) advised that ... carers [who

23 didn't live with the person they were caring for] should

24 wear PPE if providing personal care. [And] ... that

25 co-resident carers ... should wear PPE if the cared-for

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1 jumped to the paragraph above to give some context:

2 "[The] Data on unpaid carers, including how many

3 there are, the types of activities they do and whether

4 they are extra-resident/co-resident, is limited."

5 Does that accord with your understanding of the data

6 available on unpaid carers?

7 **A.** Yes, I'd say it's -- it's not only that it's limited;

8 it's also a definitional question. So I would have

9 taken -- if I'd taken -- had a piece of advice like

10 this, our best estimates suggest there could be as many

11 as 7.7 million, I would have said: well what does that

12 mean? What about an elderly couple where one of them is

13 in slightly greater disrepair than the other? Does that

14 count? You know, it's really hard to define what an

15 unpaid carer is and isn't.

16 **Q.** Understood. But did the lack of a definition in any way

17 impede or hamper the pandemic response to unpaid carers?

18 **A.** The way that we handled this primarily was through the

19 shielding where there was a definition of the risk to an

20 individual, and then that individual's carers would be

21 brought into the programme, either directly or

22 indirectly. But it does mean that the whole subject of

23 policy around unpaid carers is complicated by these

24 boundary definitional issues.

25 Some people are obviously unpaid carers and nobody

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1 individual [has Covid symptoms]."

2 So that was the position with the guidance. You

3 were obviously aware that there were many millions of

4 unpaid carers.

5 **A.** Of course.

6 **Q.** Estimates vary between about 5.5 million and, I think,

7 about 7.7 million.

8 **A.** Well, it all depends how you define it, so yes.

9 **Q.** Quite. And it's obvious, isn't it, Mr Hancock, that

10 there was not going to be PPE necessarily for all

11 5-7 million unpaid carers providing personal care?

12 **A.** Well, that's a perfectly legitimate decision for an

13 elected government to make, to make PPE available for

14 free to everybody if they wanted to, but there is

15 a limit on the public purse.

16 **Q.** It's not a criticism --

17 **A.** No, no, no, indeed.

18 **Q.** -- it's just a fact here that if we wanted to provide

19 PPE for those many millions of people providing unpaid

20 care, it would obviously place significant demands on

21 the availability of PPE?

22 **A.** Yes, and the cost to taxpayers, yes.

23 **Q.** Yes, all right.

24 Can I look, please, at page 5, and paragraph 7. The

25 data on unpaid carers -- sorry, it's my fault, I just

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1 would dispute it. Others, it's just, you know, people

2 caring for each other. What does that mean in a formal

3 policy sense? It's quite hard to define.

4 **Q.** No, so that was -- to ask the question again: did the

5 lack of definition, though, in your mind, hamper the way

6 that you approached the pandemic response to unpaid

7 carers?

8 **A.** Well, the word "hamper" has a --

9 **Q.** Impede --

10 **A.** -- pejorative sense to it --

11 **Q.** Well, I don't mean it pejoratively.

12 **A.** No, well, my answer isn't a yes/no because it's not

13 really a yes/no thing. It's not a legalistic thing.

14 It's just a piece of context you have to take into

15 account when making policy in this area.

16 **Q.** Right. The paragraph says:

17 "Clearly providing all of these carers with PPE

18 would be unfeasible from a stock, supply and

19 distribution perspective."

20 **A.** Yes, and I would add taxpayer, as well. I mean, you

21 know, we spent a lot of money but there was still

22 a consideration of the taxpayer.

23 **Q.** Then the next paragraph says:

24 "It is unclear how many unpaid carers would take up

25 an offer of PPE."

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1 A. Yeah.

2 Q. "Currently, in Liverpool -- Liverpool regularly provides
3 approximately 8 unpaid carers with PPE out of an
4 estimated 52,000 ..."

5 A. Right.

6 Q. Now, I know you said the minister wouldn't necessarily
7 bring this to your attention but were you asked at all
8 for any of your views about the feasibility or otherwise
9 of providing PPE for unpaid carers?

10 A. Oh, it was an item that we discussed. I don't precisely
11 remember when, but unpaid -- essentially, you know, in
12 the continuum of concern, unpaid carers are there, but
13 less than, you know, less concerned that those in
14 hospital for instance. And, you know, so there's a --
15 of course it's a consideration, but I would say that
16 mostly, I left policy towards unpaid carers largely
17 to -- delegated it largely to Helen.

18 Q. All right, but you -- that can come down, thank you.
19 You did in fact, though, if I can remind you by
20 reference to your statement, I think you agreed to
21 a proposal of a trial of free PPE for unpaid carers in
22 November 2020 and in fact, in due course, then you
23 approved a national rollout in January 2021.

24 A. Right.

25 Q. Can you help us with why it was that you agreed both the

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1 I'm particularly close to.

2 Q. All right. Finally on the topic of PPE, I said earlier
3 this morning that you were in favour of all health and
4 social care facilities keeping PPE, a PPE supply
5 themselves for use in an emergency.

6 A. Yeah.

7 Q. Can I ask you, how practical do you consider that to be
8 for perhaps smaller care homes with less buying power,
9 less space, limited shelf life of PPE?

10 A. Well, if they're smaller, they need less PPE in their
11 stockpile. So a stockpile will be proportionate. You
12 wouldn't have the same size for a big care home as
13 a small one. Everybody's got a cupboard, and so it's
14 totally reasonable to require a degree of PPE, say
15 a month's supply, you know, you can pull any time period
16 out of a hat but a month would seem reasonable. That
17 would take, you know, in a small care home, that would
18 take a -- you would need obviously a storage facility
19 for that but it would be relatively modest. And -- but
20 the impact of it will be really great because it will
21 give you a month to sort out all these problems that,
22 you know, it took us more than that to really get the
23 system going.

24 Q. Right. What about domiciliary care? Would you make the
25 same recommendation that providers of domiciliary care

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1 trial and, in due course, the national rollout?

2 A. I imagine because they were proposed to me with Helen's
3 support and I backed her judgement.

4 Q. Right. It may be suggested to you that the trial in
5 November and the rollout in January 2021, to some might
6 look that unpaid carers are an afterthought given that
7 there was PPE provided to both care homes and the
8 domiciliary care sector before that. Are you able to
9 help with whether there was an afterthought here to
10 unpaid care?

11 A. No. The word "afterthought", which you've used a few
12 times is a rhetorical device to imply there was less
13 consideration given, which is false and wrong. However,
14 the context means that the acuity of concern was less,
15 by the nature of the group. That is an appropriate and
16 reasonable position to take, when you've got to deal
17 with a huge number of things and you therefore have to
18 prioritise.

19 Q. From your perspective, was there anything else you think
20 now, upon reflection, you could have done earlier in the
21 pandemic to provide additional support to unpaid carers?

22 A. I'm sure it's worthy of consideration. It's not an area
23 that I was particularly close to, and I'm sure it's
24 a question worth asking Helen and I'm sure she'd come up
25 with some sensible suggestions. It's just not something

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1 have their own supply --

2 A. Yes.

3 Q. -- of PPE?

4 A. Yes.

5 Q. I presume not, though, for the reasons you've just
6 alluded to, you wouldn't be in a position to make
7 a recommendation about that in relation to unpaid care?

8 A. No, I think unpaid care is different in its nature.

9 Q. Right, understood.

10 A. And also, again, there's no levers, no contract.
11 There's no -- you know, you can make a recommendation
12 but you couldn't enforce it in any way.

13 Q. All right.
14 A topic that you have also referred to this morning
15 was that of visiting restrictions.

16 A. Yes.

17 Q. Can I come back to that, please, just to get your
18 overall views. Clearly there is the protection of the
19 residents versus the impact on them and their loved ones
20 and you mentioned this morning trying to strike the best
21 balance, to use your words, in this difficult area. Did
22 you ever consider asking for studies to be done about
23 the extent to which visitors brought in Covid-19 into
24 care homes?

25 A. Yes, that was part of the understanding, and as I think

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1 you put it well earlier, when you said broadly that the
2 disease got into care homes through residents, visitors,
3 and staff. I mean essentially, through people. You
4 know, that's how the disease spread.

5 **Q.** And you are aware of the real upset, and you've
6 mentioned it yourself a couple of times in evidence,
7 that the visiting restrictions caused on a number of
8 people who could not be with their loved ones when they
9 died --

10 **A.** Of course.

11 **Q.** No -- it is not a criticism --

12 **A.** No, no, no, I didn't take it as a criticism, I just
13 think it's awful. I mean, some of the things that
14 people went through were truly ghastly and it was an
15 awful virus.

16 **Q.** I wanted just to pick up on one contributor to Every
17 Story Matters, who said, perhaps not in context of
18 elderly people or those with dementia but a resident --
19 a loved one of a resident in a care home said this:

20 [As read] "My son has severe autism and learning
21 difficulties, has no speech and limited understanding.
22 He was in a residential care home. I was unable visit
23 him for 24 weeks. I couldn't visit through a window or
24 Facetime as he would not understand, and so became
25 upset. It was a choice between keeping him calm or

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1 consideration you can bring into this, the better.

2 You know, it's -- there are -- so it isn't just
3 a binary of visiting or not visiting. It's how to do
4 the least risky visiting. Like visiting and seeing
5 people through a window, you know, is very low risk, for
6 instance, but obviously as this example shows, doesn't
7 work in all cases.

8 **Q.** No. Do I take it that had there been enough PPE, that
9 might have enabled some visiting to take place sooner
10 than it did?

11 **A.** Well, it took some time to work to know how the disease
12 spread.

13 **Q.** Yes.

14 **A.** So as visiting restrictions were lifted, then at that
15 point PPE was more widely available. And as you saw in
16 the discussion that we had when we required face masks
17 in hospital settings, one suggestion from one of my
18 advisers was to have the PPE available when visiting
19 was -- when restrictions were eased. So this is in fact
20 an area of work, again, like so many others, that
21 consideration and thought should be put into it now so
22 that more nuanced versions of policy can be put in
23 place, rather than, you know, having to invent it on
24 the fly.

25 **Q.** Yes, and do I take it that if there'd been enough

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1 upsetting us all by seeing through a window."

2 **A.** Yeah.

3 **Q.** So clearly a number of people impacted in different
4 ways.

5 **A.** Yeah.

6 **Q.** Five years on, do you think it had to be either no
7 visitors or allowing visitors? Did I have to be either
8 or?

9 **A.** Well, that is a very, very good question. I'm glad you
10 brought that example up, because the care home question
11 often ends up considering older-aged care homes more
12 because actually, for those of working age or, you know,
13 people like the example you've raised, the impact of
14 visiting would be lower because the impact of the virus
15 would be lower, and so that sort of consideration should
16 be taken into account.

17 We also, we got to a position over time that was
18 more nuanced, for instance when vaccinations were rolled
19 out, having a difference between those who'd been
20 vaccinated and those who hadn't. When PPE was more
21 widely available, allowing visiting when -- with PPE.
22 You know, for instance, with hindsight, we know that
23 Covid-19 spreads much less outdoors, so visiting
24 outdoors, and at a distance, would have -- would be
25 safer than visiting indoors. So the more nuance and

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1 testing, that might have enabled at least some
2 visiting -- (overspeaking) --

3 **A.** Yes, and I think in fact once testing was available to
4 the general public, that was used as a, you know, if you
5 have a negative test then visiting is more highly
6 recommended.

7 Again, you know, you've got to have policy and
8 sometimes policy isn't rolled out on the ground exactly
9 as you -- as intended, not least because of the issues
10 of accountability and authority that we talked about
11 just before the break. So all these things should be
12 considered, yes.

13 **Q.** All right. Can I -- I just would like to ask you about
14 one document that impinges on visiting restrictions and
15 indeed the lifting of them.

16 Can I ask to have on screen, please,
17 INQ000327939_0001, this is a submission that went to
18 both you and the minister --

19 **A.** Yes.

20 **Q.** -- in July of 2020.

21 There was a proposal to application updated guidance
22 on visiting policy and clearly it says there in the
23 timing, it was urgent.

24 "Visits remains a source of concern for many
25 families and friends of care home residents."

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1 And they were keen to publish the guidance as soon
2 as possible.

3 Can I just look at the rationale for change with
4 you, please, Mr Hancock. Clearly, as we all
5 acknowledge, there was -- making changes involves an
6 increased risk of transmission, it must be balanced
7 against the significant impact on the care home
8 residents and being isolated. ONS data, as at 3 July,
9 shows that between March 2 and June 12 of 2020, only 29%
10 of deaths in care home residents were Covid related.
11 The deterioration of the physical and mental health of
12 vulnerable people is likely to have been impacted by
13 loneliness. One only needs to look at the final line,
14 reference there to carers representatives of --

15 A. Yeah.

16 Q. -- residents who are, to quote "fading away".

17 Over the page you received -- or annexed to it,
18 I should say, was some SAGE advice that highlighted, as
19 at July, there was:

20 "... medium evidence to suggest that visits of short
21 duration, where appropriate social distancing and
22 infection control measures are adhered to, are likely to
23 pose a lower risk to residents than risk of infection by
24 care home staff."

25 And then there was good evidence about the benefits
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1 But I also -- I'd just say that on the previous
2 piece of advice that you've showed, that shows the
3 degree of thought and consideration that went into this
4 question.

5 Q. I don't think anyone is suggesting that there wasn't
6 a degree, and there's no easy answer here --

7 A. Exactly, yeah.

8 Q. -- but what I did want to come to ultimately, though,
9 was your reflections on what we should do in the event
10 of a future pandemic, vis à vis visiting restrictions,
11 when perhaps there isn't testing and there isn't a mass
12 of PPE available. Would you still propose and advocate
13 for an outright ban at the outset?

14 A. Well, I'd propose having a testing system that could be
15 expanded quickly, and having stockpiles of PPE that can
16 be picked. So let's try to avoid being in that position
17 in the first place next time round, please.

18 But taking the question at face value, visiting
19 restrictions are a reasonable measure. The more that
20 you can introduce nuance into them, the better, taking
21 into account the infection risk and the risk -- and the
22 impact of not having visiting, exactly as this piece of
23 advice did.

24 Technology is probably now more ubiquitous than it
25 was, and people, especially older people, might be more
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1 of the residents seeing their visitors and their loved
2 ones and the detrimental impact on them of not having
3 visitors for an extended period.

4 And in due course you were content for the guidance
5 to be published in July.

6 When we move forward to the winter of 2020 into 2021
7 and rising transmission rates again --

8 A. Yes.

9 Q. -- you say in your statement that you took a hard line
10 on loosening visiting restrictions. Can you just
11 explain to everyone, please, why it was you considered
12 in the winter of 2020 into '21 that that hard line was
13 required?

14 A. Because transmission rates were high and even higher
15 than they had been in the first wave. Certainly
16 measured rates were higher than in the first wave.

17 And if you look at the analysis of who had had
18 Covid, it's highly likely than the real world rates of
19 Covid were higher in the second wave, and, therefore,
20 visiting was a significant risk, again, in a way that it
21 hadn't been by July.

22 You know, in the middle of July 2020, the number of
23 infections measured was only in the hundreds, as opposed
24 to the tens of thousands by December 2020.

25 So that's the reason.
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1 used to using it, and that helps relieve some of the
2 lack of connection and the loneliness, but of course
3 it's not the same as face to face, and face to face
4 isn't the same as physical touch. We all know that.

5 I think it would be a very useful piece of work to
6 think through in advance what is the best way to have
7 the least worst outcome in this space.

8 Q. You mentioned there testing. Just one aspect of testing
9 I'd like to ask you about, please, and it's testing for
10 domiciliary care workers.

11 A. Mm.

12 Q. Obviously, there was some access in April 2020 for
13 symptomatic testing of domiciliary care workers, but in
14 fact asymptomatic testing for domiciliary care workers
15 was not introduced until November 2020 and in fact may
16 not have been rolled out until January 2021.

17 Can you tell help with why asymptomatic testing of
18 domiciliary care workers was not rolled out until
19 November 2020?

20 A. Well, this was about the access to tests. So it's not
21 quite right exactly the way you put it, because of
22 course asymptomatic testing was available to the general
23 public by then, and so domiciliary care workers would
24 have had access to tests, just because they're members
25 of the general public, should they have wanted to, and
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1 therefore I don't think the problem is quite as acute as
 2 set out.
 3 I can't remember the exact timescales around then of
 4 when the huge quantities of lateral flow tests became
 5 available but that was essentially the breaking open of
 6 testing from a controlled to a widely dispersed issue,
 7 if you like.

8 And that was in the autumn of 2020, wasn't it, when
 9 we got the first --

10 **Q.** Yeah.

11 **A.** -- mass, hundreds of millions of lateral flows through,
 12 and made the whole issue easier.

13 **Q.** New topic, please. And I'd like to ask you about
 14 changes to the regulatory inspection regime.

15 **A.** Right.

16 **Q.** Did you agree with the decision to suspend routine
 17 regulatory inspections?

18 **A.** Yes.

19 **Q.** How were you assured of the safety and quality of care
 20 homes in the absence of those inspections?

21 **A.** I thought two things on that. The first is that
 22 whistleblowing was still possible in the worst extremes,
 23 and the second is that it was a necessary short-term
 24 measure, given the -- everything else that was going on
 25 and the risk of bringing Covid into care homes through
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1 doing their level best to do the right thing, and part
 2 of my job was to give them the tools to do that but then
 3 get out of the way of their ability to do that, and that
 4 was the overall approach that I took within the health
 5 system, and this is just one example of that.

6 You know, there are times for CQC inspections. The
 7 middle of a pandemic is not one of them.

8 **Q.** Right. Can I ask you about reference to box ticking
 9 because -- can we have up on screen, please, a text
 10 message or WhatsApp exchange you had with Peter Wyman
 11 the chair of the CQC.

12 INQ000419147_002. Thank you. I don't know if we
 13 can expand it?

14 It's from 16 March, Mr Hancock, which is the day of
 15 the announcement of the --

16 **A.** There you go.

17 **Q.** -- regulations -- sorry, the routine inspections being
 18 stopped.

19 **A.** Yeah.

20 **Q.** And you say:

21 "In return, I need CQC to pull back more than they
 22 after currently planning on inspections & data
 23 collection. We are likely going to have people in
 24 hotels & it's important" --

25 Should that be "hospitals"?
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1 inspections. But also, that many, many inspectors are
 2 themselves medically trained and were needed on the
 3 front line.

4 **Q.** In your statement you said:

5 "I supported the CQC's decision to suspend ...
 6 because I wanted hospital and healthcare workers'
 7 primary focus to be treating patients, rather than
 8 complying with inspection requirements, and to free up
 9 inspectors to work directly on the front line."

10 **A.** Yeah.

11 **Q.** The reference there to "rather than complying with
 12 inspection requirements" may to some sound dismissive of
 13 the importance of inspections.

14 Why did you phrase it that way, Mr Hancock?

15 **A.** So I'm a supporter of inspections, but the reason
 16 I phrase it that way is that these were extraordinary
 17 times. Care settings and hospitals were doing unusual
 18 and extraordinary things, and sometimes -- one of the
 19 reasonable criticisms of most inspection regimes,
 20 including the CQC's, is that they can get box-ticky, and
 21 the last thing you want is somebody making a decision
 22 based on a worry about a future imminent CQC box-ticking
 23 exercise when there is life-saving work to be done.

24 It comes back to my overall -- the way that I led
 25 the health system was to presume that everybody would be
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1 **A.** I don't think so. What date is this?

2 **Q.** 16 March.

3 **A.** Yes, so this is --

4 **Q.** Who was going to hotels?

5 **A.** Hmm?

6 **Q.** Who was going into hotels?

7 **A.** People who couldn't fit in the NHS.

8 **Q.** All right.

9 **A.** This is before the Nightingales have been built.

10 **Q.** Yeah.

11 **A.** You can see that I am worried about -- this is after --
 12 this is before we have got the legal lockdown in place.
 13 It's when rates are still climbing very quickly. So
 14 I think that we are going to have people in -- end up
 15 with people in hotels.

16 **Q.** Right, understood.

17 **A.** Remember the Italian experience a few weeks earlier --

18 **Q.** Okay.

19 **A.** -- had been that people were -- their health system was
 20 completely -- (overspeaking) --

21 **Q.** Okay, so you're worried that their -- that's the
 22 position we're going to end up in, and people are going
 23 to have to be going into hotels.

24 "... it's important people do their best without
 25 worrying about box ticking."
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1 A. Yes.

2 Q. And that may, to some, sound like you think inspections
3 are just honoured more in the form rather than in the
4 substance.

5 A. No, it's that inspections do have an element of
6 box ticking.

7 And "box ticking" is a pejorative term but what
8 I mean by that, and there's a reason that there is some
9 of this, is that in order to make inspections consistent
10 between different inspections, there are structures and
11 frameworks which naturally have to get written down,
12 which can then become box-ticking exercises. It's
13 a sort of -- it's the nature of the system that you end
14 up with box ticking. I don't like it but it's true.

15 Anybody who has had a child go through GCSEs knows
16 that to get the points, you have to do a load of exam
17 technique which is essentially box ticking. That's
18 because they have to be able to compare exams from one
19 person to another.

20 I use that analogy because it can also apply in
21 hospital inspections, and I wanted the CQC to basically
22 completely pull back from this sort of activity, except
23 where they thought there was serious harm going on.

24 Q. Yes, a safeguarding concern, or neglect or abuse,
25 I understand.

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1 as you can, feel you are able to, in this direction.

2 Q. Given that at this time there is now inspectors not
3 going in routinely to care homes, there aren't visitors
4 now going in routinely to care homes, there is an
5 increased use of remote consultation by GPs and the
6 like, do you consider that perhaps there was now a lack
7 of the checks and balances that would normally be in the
8 place, normally be in place in the care sector?

9 A. Absolutely there was a lack of the checks and balances
10 that are normally in place but I don't think that was
11 a mistake. But it was, of course, a downside
12 consequence.

13 Q. In your statement at paragraph 260 you state:
14 "At a weekly ASC [adult social care] meeting on
15 17 April ..."

16 So about after a month after the inspections have
17 stop, you specifically ask for an update on whether care
18 homes could easily flag quickly to the CQC if they were
19 facing serious issues.

20 A. Right.

21 Q. What prompted you to ask for that update, Mr Hancock?

22 A. I've no idea. It seems like a reasonable question
23 to ask.

24 Q. Do you remember now what response you got to -- no?

25 A. No.

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1 A. Exactly. And Peter Wyman, who is a very great public
2 servant, understood that. He naturally would have been
3 concerned to ensure that the CQC did its job, so I was
4 pretty firm in my request to him, remember CQC is
5 independent, rightly so, so I couldn't direct him, but
6 I was asking him, and he is coming back saying, "We've
7 pulled back on inspections; only where we think there's
8 abuse or serious harm", and that's fair enough.

9 Q. All right. So given that you were supportive of the
10 decision to suspend routine inspections, did you ask for
11 any information or assurances from the CQC as to how
12 residents would be protected and the quality of care
13 maintained?

14 A. I considered that a matter for the CQC, and I am sure
15 I would have discussed it with them, but I also wouldn't
16 have worried about my need to insist on that to them,
17 because that would -- that is their natural purpose.

18 Q. Right. So were you aware of what was planned to replace
19 the routine inspections once they were suspended or did
20 you leave that to the CQC?

21 A. Absolutely a matter for the CQC.

22 Q. Right.

23 A. It wouldn't have been appropriate for me to have done
24 that. I was basically giving a directional steer which
25 is, you know, you've got my cover, if you can go as far

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1 Q. Concerns, however, were raised with you about the lack
2 of inspections. I'd like to show you just one example
3 of a letter that you were copied into.

4 Could we have on screen, please, INQ000231915.

5 Thank you very much.

6 Although it's to the then chief executive
7 Ian Trenholm, at the bottom of it you're copied in,
8 I just want to look at some of the concerns that are
9 being raised about the lack of inspections.

10 We can see there in the second paragraph that the
11 Relatives and Residents Association say:

12 "It was clear from the outset that care services
13 would be in peril ..."

14 We looked at that Public Health England --

15 A. Yeah, we did, yeah.

16 Q. -- February 2020 guidance earlier.

17 "... CQC failed to speak out immediately to refute
18 that. CQC announced that routine inspections of care
19 homes would be suspended. With family visits banned in
20 most care homes, many residents felt totally abandoned."

21 Then they go on to talk about the CQC producing an
22 emergency framework which doesn't include detailed
23 policy or practice guidance, and concern there about the
24 lack of oversight and scrutiny that has been compounded
25 by easements and various other measures that were put in

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1 place.

2 Do you remember, perhaps not this particular letter,

3 but having those concerns raised with you by family

4 members of people who were resident in care homes?

5 A. I remember considering this as a balance, and that's the

6 challenge. You see, often in policy, especially in

7 these terrible times, we were taking actions in order to

8 preserve life. Those actions had some negative

9 consequences. We all know that. And a letter like this

10 is an entirely reasonable expression of one side of the

11 argument. And of course you see letters like this,

12 I don't know whether I saw this one or not. You have

13 considerations like this brought to you. You have

14 considerations brought on the other side and you have to

15 make a judgement. That's the nature of governing.

16 So, you know, you could read out any number of

17 totally reasonable reports of people who found it deeply

18 upsetting not to visit, not to be visited, and not to

19 have a CQC inspection. The challenge is that on the

20 other side, there were, in my view, greater risks of

21 having taken the other decision so it's just a question

22 of balance.

23 Q. Were you concerned at all about the lack of oversight?

24 A. I was concerned about it but I just think in this one,

25 in the scales of the -- this decision, the balance was

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1 "KT stood by their decision to stop routine

2 inspections. [The minister agreed] but still unlikely

3 to uncover bad cases in [the] next few weeks."

4 And:

5 "[The minister] asked if we can get more insight

6 into [the] CQC findings in terms of latest and live

7 intelligence -- especially where there are known

8 alarming cases."

9 A. Yeah.

10 Q. Now, were you made aware that there was a potential

11 concern that there was going to be inspections that did

12 start to uncover bad cases of care in care homes?

13 A. I can't specifically remember that. I may have been.

14 It might have been brought to my attention. But it's

15 also -- it's also obvious. If you're stopping

16 infections you're then -- you may find that you'll find

17 more things out later that have gone wrong. In a system

18 which hundreds of thousands of people reside, there are

19 going to -- there are always problems.

20 Again, I come back -- you know, you've got to

21 remember that the flip side of this is a very high

22 amount of death that was happening in care homes. So

23 that's the balance that we had to strike.

24 Q. Can I go to page 1 of that email chain, please.

25 You're not in it, but the minister, Helen Whately

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1 so far down on the vital importance of protecting people

2 in care homes and of getting everybody who could to work

3 on the frontline in a national catastrophe, that in my

4 view this was not a balanced decision; it was a very

5 clear decision.

6 Q. Okay. You go on in your statement to say you met with

7 the CQC on 1 July and, in fact, Helen Whately was also

8 meeting with the CQC on the same day. And I'd just like

9 to look at some documents in relation to 1 July.

10 Can we start with, please, INQ000609960.

11 This is a summary of the meeting that Helen Whately

12 was having on that day. She met with the CQC, and

13 towards the bottom of page 2, if I may. Can we see the

14 bottom two notes there:

15 "[The minister] asked KT [who was a member of the

16 CQC] whether KT [was] confident that right and timely

17 steps were taken to ensure people weren't neglected."

18 And:

19 "KT noted cautiously that whilst the right measures

20 were taken (giving example of care home ... [that was]

21 closed due to lacking basic in safety for residents), it

22 is likely we will see an increase in the [number] of

23 services that haven't been able to cope during [the]

24 pandemic and therefore a spike of these cases being

25 unveiled in the next few weeks.

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1 says:

2 "Thanks Ros ..."

3 For the e-mail -- sorry, it's being relayed to the

4 minister.

5 "... I have flagged with [the minister], but on the

6 call Kate [who is the lady from the CQC] suggested

7 a level of detail that [the minister] does not

8 recognise.

9 "Given [the minister's] real concern by Kate's

10 admission we should expect cases to emerge in the coming

11 weeks of potential neglect/abuse/poor standards of care,

12 she has asked:

13 "- Is there a way we can get them to expedite

14 inspections?

15 "- Can we get more formal information ...

16 "- Do we internally have a sense of what the scale

17 of the issue is that may be about to erupt?

18 "She was ... clear that whilst she agreed with the

19 CQC decision to stop routine inspections ... she did not

20 agree that this was done at the risk of neglect/abuse to

21 residents and Kate's [the lady from the CQC] comments

22 today did not assure her on this point."

23 So clearly the minister has got real concerns about

24 what's going on. Does that help you remember whether

25 this was brought to your attention?

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1 A. No, I'm afraid it doesn't. This level of detail is
2 exactly what I would expect the minister to do. She's
3 doing her job exactly as she should.

4 The key, to me, reading this -- obviously this is
5 the first time I've seen this and I wasn't involved --
6 the -- but the first sentence, "on the call Kate
7 suggested a level of detail that [the minister] does not
8 recognise", ie -- you know, you'll have to ask Helen
9 about it, but my interpretation of that is that she's
10 being given reassurance that everything's fine and she's
11 challenging and not getting -- and finding out that, you
12 know, the level of detail behind the reassurance is not
13 adequate.

14 That is my reading of it, but obviously I wasn't --
15 I wasn't involved. This is one level of detail, more
16 detail than I would have got into.

17 Q. Right. You --

18 A. The key point is here: she was clear that whilst she
19 agreed with the CQC decision to stop routine
20 inspections. Right?

21 So that's where I would have got involved. This is
22 essentially about: okay, where's the boundary of routine
23 inspections? Where do you need to go in? What's the
24 limitation of and implementation of that policy?

25 If there had been -- if there'd been
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1 as much as it affected people's behaviour. You know, we
2 cared about reducing the number of people who were dying
3 in their thousands, and we took decisions accordingly.

4 Q. Can I just ask you a bit more about this, please.
5 Because at the deep dive that we looked at earlier, and
6 if we can have back up on the screen, please,
7 INQ000090302_007 -- sorry, not the deep dive, the
8 Covid-O operations meetings on 23 October, there is
9 reference during the course of the discussion to there
10 being 696 breaches. We can see it there at point (i),
11 I hope, Mr Hancock, you can see it:

12 "... 696 breaches of regulations identified since
13 the start of the pandemic."

14 The most common of the breaches were in relation to
15 regulation 12, which was the regulation around the
16 provision of safe care and preventing avoidable harm or
17 risk of harm.

18 I know you've said to us that it was really a matter
19 for the CQC as to how they assured themselves that
20 residents would be protected, but you've had letters of
21 concern, Helen Whately is receiving alarming messages
22 from the CQC about what might be uncovered. By October
23 now, there's nearly 700 breaches of regulations.

24 Do you think in fact you should have asked more
25 questions for assurances about how people were going to
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1 a recommendation from Helen in response to this to say,
2 "We must go back to having routine inspections", that's
3 when it would have been brought to me.

4 Q. Right. Would you not expect, though, concerns that they
5 are going to find potential cases of neglect, abuse,
6 poor standards of care, to come to you as Secretary of
7 State?

8 A. No, I wouldn't have been -- I'm not sure whether we did
9 see that eventuality occur. You can't bring everything
10 to the Secretary of State. I think we would have -- but
11 we would have anticipated that there would be problems
12 from not having inspections. That's why you have
13 inspections.

14 But again, I come to the balance, which is you can
15 look at all of these different things that we had to do
16 to save lives, and many of them had downsides. I'm
17 acutely aware of that. They needed to be managed, and
18 what this is doing is managing that decision to suspend
19 routine inspections, and -- but without -- but with
20 a consensus on the core policy, because the alternative
21 is more people dying.

22 And I know I return to that over and over, but it
23 was our lodestar. It was the thing we were concerned
24 about more than anything. We didn't care about the --
25 you know, the personal brickbats, the comms, except in
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1 be cared for and protected?

2 A. I did ask for those assurances, and you saw right at the
3 start my text exchange included considerations around
4 this, even in the initial response from the chair of
5 the CQC. So this was clearly at front of mind from the
6 very start of this policy.

7 696 breaches of regulations in a sector that cares
8 for hundreds of thousands of people over a what, by now,
9 was a six-month period, needs to be put in that context.
10 And in the context of thousands of people in care homes
11 who were -- who'd died. So I think it's -- I think it's
12 entirely -- an entirely reasonable set of decisions.

13 Q. Right.

14 There is a contrary view, I suppose, from some that
15 given the level of transmission, the outbreaks, the
16 death data that we've looked at, and the vulnerability
17 of the people in the workforce, and the fact that
18 perhaps training and use of IPC, and in particular PPE,
19 was not as good as it was, in fact that was all the more
20 reason to have inspections. What do you say to that
21 counterargument?

22 A. I don't think it's correct. I think it's -- I think it
23 is a -- you know, there's many cases when people put
24 policy ideas or suggestions of different ways of doing
25 things that don't -- didn't take into account the fact
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1 that if you drive up contact between people, then you
2 drive up the infection rate.

3 And it sometimes isn't a popular view, but actually
4 the life-saving thing to do sometimes is to be firm on
5 these things. Add to that, in this case, the fact that
6 CQC inspectors were also incredibly important on the
7 front line, and that's their -- that's the balance that
8 you've got to put to reach an objective decision, given
9 those considerations.

10 You know, to me, the question that is really
11 important in this discussion is: were these things
12 considered when a balanced decision was taken? And they
13 very evidently were. And then a decision taken in the
14 round.

15 Q. Two final topics, please, before, perhaps, some
16 overarching observations from you.

17 You have previously given evidence to her Ladyship
18 on a number of occasions about the case for vaccinations
19 as a condition of deployment?

20 A. Yes.

21 Q. And clearly it was applicable to the consultation,
22 indeed in due course the rollout, in the social care
23 sector of that policy?

24 A. Yeah.

25 Q. Do I take it that you stand by the observations you've
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1 up as a result. It's a real social problem in our
2 modern society post the pandemic.

3 But none of that means that I change my view that we
4 have this amazing scientific device called
5 a vaccination. We have incredibly well thought-through
6 logical processes to know when it is safe and effective,
7 and since it is safe and effective and cost effective to
8 vaccinate against flu and Covid, I can't for the life of
9 me see why, if you're a care worker, and therefore care
10 about people, you should allow yourself, or if you're an
11 employer in that space, allow the people who work for
12 you, to take this totally unnecessary risk.

13 So in short, yes, I agree with the view that I
14 expressed earlier.

15 Q. Thank you.

16 Different topic, please. You set out in your
17 statement that at a Downing Street press briefing on
18 15 April, so the same day as the action plan was
19 announced, you made this statement:

20 "And we are making it crystal clear that it is
21 unacceptable for advance care plans, including do not
22 attempt resuscitate orders, to be applied in a blanket
23 fashion to any group of people."

24 A. Yes.

25 Q. "This must always be a personalised process as it has
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1 previously made about the case for why you consider
2 vaccination was necessary as a condition of deployment?

3 A. Yes, I absolutely do, and I think that we should have
4 vaccination against flu and Covid as a condition of
5 deployment in social care and in the NHS at all times,
6 because I think that, given that these diseases can pass
7 on without the person who has it knowing, it is
8 a dereliction of duty to fail to take up the most
9 straightforward and proven of scientific defences.

10 And in fact, you know, I -- again, it's something
11 that people can make unpleasant personal criticisms of
12 me for taking such a strong view of backing the science
13 in this space. When we did bring in the vaccination
14 condition of deployment, again, lots of people said that
15 there'd be thousands of people leave social care and
16 there'd be a huge gap in the workforce, and there just
17 wasn't.

18 And, you know, just before one of the breaks, you
19 read out a bit of vitriol against me. I've been and
20 looked into it, it turns out it was -- it's somebody who
21 was -- is arguing against vaccination as a condition of
22 deployment. I mean, vaccination does, for some reason,
23 cause people to feel very strongly against it, for some
24 reasons, and we can see in America that that can have
25 very negative consequences, and measles rates are going
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1 always been."

2 A. Yes.

3 Q. And we know in due course that there was the CQC report,
4 both interim report and, indeed, final report -- but can
5 I just ask you, when you stand back and look at the
6 pandemic and how it developed, do you have any
7 observations or insights as to why it might have been
8 that people felt necessary either to apply a blanket
9 policy or an inappropriate policy of DNACPRs?

10 A. I only saw this happen once, and we jumped on it, and
11 I talked about it in public at the time. It is totally
12 unacceptable to have blanket DNRs. There is a concern
13 amongst a small number of people who focus heavily on
14 this that this was more widespread. If it was, it
15 didn't come to my attention, and if it did happen, it's
16 totally unacceptable.

17 My own reading of it is that this is a one of
18 a number of narrow conspiracy theories that have grown
19 up in this space, but if I'm wrong, then it absolutely
20 must be addressed and the Inquiry should uncover that.
21 So you're quite right to ask the question.

22 I suppose the reason that it comes up as a question
23 is similar to those people who demanded that we, at
24 a ministerial level, or Chris Whitty at a senior
25 clinical level, should make policy according to who gets
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care and ration care. I disagreed with that as well.

But it's in the same category. I think it's -- I think the concept is abhorrent, and is rightly denigrated, and if it does happen, it should be stopped. In fact, I think it is illegal and if it isn't, it ought to be.

Q. The final few questions from me, please. At the very beginning of questioning this morning I asked you about the inadequacies of some of the local authority pre-pandemic plans --

A. Yeah.

-- and we touched on that. But looking forward, who do you think should have oversight of whether those plans are in fact adequate? It's no good us just saying that they were inadequate. Who should try and ensure that they are not?

A. That's a great question, I haven't thought about that. My instinct is UKHSA may be the best placed to make a judgement on it. Again, it comes back to this problem of accountability in the care sector, because whoever makes that judgement needs to then have the teeth. So it may well be that the CQC may be the best placed to actually make the decision because then it would have teeth among the sector, because there's no point in some, you know, body with no teeth making a view clear

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A. Well, it would have meant that it would have been easier to bring in a mandatory ban on staff movement, because you had to have some way of enforcing that, and therefore of knowing who is working in the sector.

It was -- we had to find a way to define working in care sector for vaccine prioritisation, because, of course, care workers were in the first group of people able to get a vaccine.

It would have allowed us to distribute PPE, especially in domiciliary care, more effectively. And all these questions around sick pay would have been easier to address in practice. But I think, you know, that's important.

And then maybe the final point comes back to this governance issue. You know, understanding -- I hope I've been able to explain it, I haven't explained it as well as you did, my Lady -- understanding why it's hard to drive policy in this area is vital, and it is a real practical problem.

You expressed surprise when I said that as Secretary of State I couldn't do something -- that was in relation to PHE.

Secretaries of State are very powerful, but there are limits to that power, and rightly, limits to unilateral action because, you know, there's a -- we're

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on this. That was part of the problem before.

So it may be best the CQC. But if I could -- I may come back to you if I come up with a better answer.

Q. Please do.

Finally, then, we've looked at a number of different aspects of the response to the pandemic, as far as it impinges on the social care sector. You've obviously made a number of observations about limiting staff movement, we've looked at the hospital discharge policy, we've looked at visiting restrictions, is there any other area or recommendation that you would like to bring to her Ladyship's attention?

A. Well, the only other area, I think, is in terms of a register of care workers. Now, for -- to bring in vaccination as a condition of deployment, we had to have a register. Ensuring that that register is -- has been brought in effectively and is -- continues, is, I think, important.

Of course, that won't include unpaid carers.

Q. Can I just pause you there. Can you summarise in a nutshell, what value do you think the register would have had in the pandemic? If you'd have sat there on 13 March 2020 and there'd been a register, what practical difference would it have made to you and the things you could do on behalf of the Department?

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a plural democratic system. Ensuring that the accountability aligns with the levers of exercise of that power is the basis of good governance, and that is a core problem in this space.

Q. You spoke there of a number of the benefits. From your perspective, had there been such a register, who do you consider should be responsible for compiling such a register?

A. Probably the CQC, I would have thought.

MS CAREY: Mr Hancock, they are all the questions that I asked. Thank you very much.

LADY HALLETT: Thank you.

Mr Weatherby.

Questions from MR WEATHERBY KC

MR WEATHERBY: Mr Hancock, I ask questions on behalf of the Covid Bereaved Families for Justice Group, which is a group of 7,000 family members who lost loved ones across all four corners of the UK.

I'm going to start with PHE and data, if I may.

You've discussed already with Ms Carey the position of PHE generally, and its ultimate closing down, and you've discussed data, including with reliance on their reports regarding transmission into care homes.

Earlier this week, I referred to a WhatsApp exchange between you and Helen Whately on 13 July. I just want

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1 to go through that with you now. So could we have it up
 2 on screen, please.
 3 It's INQ000274068, and it's page 19.
 4 Have you got that?
 5 So it's the entry, 13 July, 18.20, Helen Whately:
 6 "We have received a PHE update on the new care home
 7 outbreaks -- some were not reported before, some are
 8 from blanket testing and some are 'suspected but not
 9 confirmed'. I find their report frustratingly vague and
 10 dismissive about new outbreaks. I have asked for
 11 a proper breakdown of how many fit into each of the
 12 categories above, going down to named individual care
 13 homes, and want to adopt a 'zero tolerance' approach to
 14 covid in care homes. Every single outbreak should be
 15 treated as a problem requiring immediate action and
 16 investigation."
 17 A. Yeah.
 18 Q. You replied:
 19 "Totally agree. We should have zero tolerance for
 20 both covid and crap data. Remember: PHE described
 21 Leicester to me as 'progressing positively' 4 days
 22 before lockdown. It was only because I blew up ... that
 23 imprecision" --
 24 A. "I blew up at that imposition", yeah.
 25 Q. Yes.

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1 not fair to criticise them for the fact that we -- many
 2 of the facts that we didn't know early in the crisis
 3 because it was a novel disease, and so --
 4 Q. Okay.
 5 A. -- getting the data sorted was really important.
 6 Q. Well, okay, that's really the question I'm coming to.
 7 First of all, when did you realise it was a problem and
 8 what did you do about it?
 9 A. Right. So we knew that there was a huge problem of lack
 10 of data on the spread of the disease very early. The
 11 chair's point earlier today on the difference between
 12 measured tests and actual numbers of cases is a vital
 13 question that we asked ourselves very early. For
 14 instance, we didn't know how many people had had contact
 15 with Covid and therefore had got antibodies --
 16 Q. Yes.
 17 A. -- until we got the ONS survey going. So this was
 18 a major issue at the start of the crisis.
 19 Q. Yes. So what did you do about it?
 20 A. We improved the amount of data radically over the period
 21 of the pandemic. And what you can see here is that,
 22 by July, I have a zero tolerance approach to crap data.
 23 By then, we were getting better and better data in
 24 certain spaces --
 25 Q. Yes.

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1 "... that they acted."
 2 So can you help us. You'd been Secretary of State
 3 since July 2018. Had you had concerns about PHE and the
 4 data they produced prior to the pandemic?
 5 A. Well, prior to the pandemic, the -- PHE's focus was
 6 almost entirely on non-communicable diseases, and that
 7 is part of the reason that they needed to be abolished
 8 to replace them with an agency that concentrates only on
 9 infectious communicable diseases.
 10 Of course I'd seen some data, but we'd discussed
 11 earlier, the data from the care sector was terrible
 12 before the pandemic.
 13 Q. Yes, well, I'm going to come on to that. But just very
 14 short order, had you had concerns before the pandemic
 15 about PHE data?
 16 A. Not specifically about PHE data, no, before the
 17 pandemic, but I did very early in the pandemic, yes.
 18 Q. Yes, okay. So very early in the pandemic you start to
 19 realise that the data that PHE are producing is poor.
 20 You get --
 21 A. Well, not all of it. I mean PHE's early scientific work
 22 was excellent. On the tests, for instance.
 23 Q. Right.
 24 A. And you've got to remember that the lack of data here,
 25 it's not fair -- I've been quite critical of PHE -- it's

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1 A. -- but clearly not good enough --
 2 Q. Not here?
 3 A. -- in this space, yeah.
 4 Q. So by July what you're expressing is not only concern
 5 about this data that's being discussed but also the
 6 general quality of PHE data?
 7 A. Well, by July, a lot of the data had got better. It
 8 still wasn't as good as it was in the autumn. You know,
 9 I'm -- I come from a tech background, I understand data.
 10 Q. Yes.
 11 A. I found it deeply frustrating, for instance, that early
 12 on, when we needed to know how many people had been
 13 infected by PHE -- infected by the virus, the first
 14 attempt to get that survey, PHE had gone to blood donors
 15 to get the blood to do the test. But of course to be
 16 a blood donor you have to declare that you haven't been
 17 ill for the last two weeks.
 18 Q. Yes.
 19 A. So it was effectively useless. So we got the ONS in to
 20 do that survey instead, and they came out with the
 21 answer, so that's --
 22 Q. Sorry to cut across you, but we've got to crack on
 23 timewise. But do you think more should have been done
 24 by you in terms of sorting data out earlier on, and
 25 recognising the shortcomings that PHE and others had in

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1 their ability to gather the data in quick time at that
 2 point?
 3 **A.** We did absolutely everything we could, and coming from
 4 a technical background in this space, it was an area
 5 that I leaned into incredibly strongly.
 6 **Q.** Should this have been something that had been fully
 7 considered in preparedness for a pandemic?
 8 **A.** Well, it absolutely needs to be sorted for next time,
 9 yes, and I think it will. You know, the quality of the
 10 data now available is significantly better, and there
 11 are, you know, there are programmes across the NHS and
 12 UKHSA to improve on this.
 13 **Q.** On 3 April 2020, you received a briefing ahead of
 14 a Healthcare Ministerial Implementation Group, from the
 15 healthcare secretariat signed off by Simon Ridley. And
 16 it included this:
 17 [As read] "We have not focused on social care to
 18 date, given immediate priorities for the NHS. However,
 19 we recommend turning to this, given the large-scale
 20 discharge from NHS that has been required, of the risks
 21 in this sector, and the need to for a strategy to manage
 22 Covid in care homes. This will assess the overall
 23 social care strategy including discharging capacity and
 24 functioning workforce and resilience and guidance to
 25 care homes."

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1 Ridley is a fine official, but his statement there is
 2 that by 3 April the Cabinet Office had not considered
 3 care homes enough. It doesn't mean that we hadn't in
 4 the Department; we'd been working on it since January.
 5 Ben Warner is an exceptionally intelligent and
 6 capable individual and he is saying at that point that
 7 Number 10 had not engaged enough on care homes.
 8 We know from Module 2 that Cabinet Office and
 9 Number 10 were making all sorts of complaints. We were
 10 getting on with trying to fix the problem. So we were
 11 engaged in trying to solve this as well as possible from
 12 January 2020, as you can see in all of the paperwork.
 13 **Q.** Yes, well, I mean, the purpose of putting those three
 14 pieces to you is that it is from the Cabinet Office,
 15 from Number 10, and from SAGE. So it's three different
 16 sources. And another way of looking --
 17 **A.** But hold on, that's not right. Because the Cabinet
 18 Office statement is that they have not turned their
 19 attention to care homes. It isn't that the Department
 20 hasn't. So it's -- the fact that you read it out
 21 without mentioning that it was from the Cabinet Office
 22 kind of demonstrates the point, that we were working to
 23 solve this problem; we had, in some areas, the Cabinet
 24 Office had been blocking the work that was needed. In
 25 other areas, they were -- Number 10 were going slow, for

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1 In Module 2 --
 2 **A.** Could you just tell me what date that was that you've
 3 read out?
 4 **Q.** That was 3 April.
 5 **A.** Okay.
 6 **Q.** In Module 2, Ben Warner, a special adviser, to
 7 Number 10, told the Inquiry:
 8 [As read] "From the start of Covid it was obvious
 9 that care homes were hugely vulnerable and I was
 10 constantly worried that there was not sufficient
 11 attention being paid to them."
 12 And Professor John Edmunds told the Inquiry, from
 13 SAGE:
 14 [As read] "That hospitals and care homes were
 15 potential high-risk environments was not a surprise.
 16 It's clear that not enough was done in February/March
 17 2020 to reduce this risk."
 18 So question to you: taking those three passages into
 19 account, do you accept that not enough was done in
 20 February and March 2020 to reduce the known risk to this
 21 highly vulnerable population in care homes?
 22 **A.** Absolutely not, in the areas I was responsible for. So,
 23 if we go through those three in turn: the first is from
 24 Simon Ridley in the Cabinet Office. It's important to
 25 mention that when you read out his statement. Simon

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1 instance on some of the publications that I wanted to
 2 make. But we, in the Department, were working as hard
 3 as we possibly could.
 4 **Q.** Okay, well, I'm certainly not trying to hide that it was
 5 from the Cabinet Office in the way that I read it out --
 6 **A.** Right.
 7 **Q.** -- but one way of looking at those three pieces of
 8 information or evidence that I've read out to you is
 9 that the "we" refers to the whole government. This was
 10 a briefing sent to you about a ministerial group meeting
 11 and the professor is talking about not enough generally
 12 being done across government, isn't he?
 13 **A.** I'm so sorry, the Cabinet Office saying that they have
 14 not considered this yet, as in the healthcare
 15 interministerial group, is not in any sense saying that
 16 there hasn't been attention paid to this. It is saying
 17 that the Healthcare Ministerial Group from the Cabinet
 18 Office, of which I was chair, had not itself considered
 19 it. That's a piece of -- it's a piece of bureaucracy
 20 which in fact came and went because it wasn't seen to be
 21 effective.
 22 **Q.** I'm not going to fence with you. The Inquiry has the
 23 material, the Inquiry can make its own mind up about the
 24 question.
 25 **A.** I am merely responding to the fact that you are

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1 misinterpreting a piece of information and in your
 2 opening statement didn't even say who said it, and then
 3 you're putting a quite serious accusation that's wholly
 4 false based on a misreading so -- (overspeaking) --
 5 Q. -- (overspeaking) -- which I think you've answered.
 6 A. Yes, thank you.
 7 Q. I'll put it again just for clarity: do you accept that
 8 not enough was done in February and March 2020 to reduce
 9 the known risk to a highly vulnerable population in care
 10 homes?
 11 A. No, I do not.
 12 Q. It appears your answer is no, you don't.
 13 A. No.
 14 Q. In a readout of a social care Covid meeting from your
 15 private secretary, it records that Ros Roughton asserts
 16 that domiciliary care is, in effect, an emergency
 17 service. Do you agree with that statement that
 18 domiciliary care is, in effect, an emergency service?
 19 A. That isn't how I'd put it. It is a vital service to
 20 those who need it, but an emergency service implies both
 21 that it might be short lived, and it might be needed in
 22 an unexpected way. Both of those may be true
 23 occasionally, but generally not; generally, it is
 24 planned rather than emergency, and generally, it is long
 25 term rather than short term.

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1 State for Health and Social Care --
 2 A. Well, the -- my recommendation --
 3 Q. -- (overspeaking) --
 4 A. -- is that there do need to be levers available. We
 5 invented them, in fact, in the early part of the
 6 pandemic, as we've discussed, with the linking of
 7 emergency payments to action, and so I've made some
 8 recommendation in that space, yes.
 9 Q. Yes, so would it be right to say, then, that your view
 10 is that it would have been preferable had those levers
 11 been available prior to the pandemic, so you could have
 12 used them straight away?
 13 A. Yes.
 14 Q. Given that they weren't, why did you not put levers into
 15 the Coronavirus Act or some other convenient legislation
 16 in the early part of the pandemic, if it was such
 17 a problem that you have -- (overspeaking) --
 18 A. Yes, it's a good question. We did bring some measures
 19 with respect to adult social care in the
 20 Coronavirus Act, and selected the measures that were
 21 available in the preparation.

22 So in the legislation that had been prepared in
 23 response to Operation Cygnus. So that had been part of
 24 the preparation. To a degree it was used, but I think
 25 that there's more to do.

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1 Q. Let me move on to levers and you've given a bit of
 2 evidence about this already so I'll be quick about this.
 3 You've repeatedly referred back to the fact that as
 4 the Secretary of State you didn't have the levers to act
 5 when it came to adult social care and that you led on
 6 policy and guidance only, for the sector. Is it right
 7 that that was something you knew before the pandemic?
 8 A. Yes.
 9 Q. And certainly early on in the pandemic?
 10 A. Yes, I knew, as I said earlier, I knew that before
 11 I became Secretary of State, yes.
 12 Q. So why did you not do something about that to increase
 13 the levers that you had, certainly to be available in an
 14 emergency?
 15 A. Because that would have required a change to the 1948
 16 settlement that set up the NHS and I wouldn't have been
 17 able to get cross-government agreement for such
 18 a radical change.
 19 Q. Right.
 20 A. Effectively, that is the way -- the only way to solve
 21 that is to bring in what would effectively be a National
 22 Care Service, which was not something that the
 23 government was considering.
 24 Q. Right. But is that something that should be done now,
 25 that levers should be available for the Secretary of

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1 Q. Right. So the fact that you refer back to the absence
 2 of levers to act --
 3 A. Yeah.
 4 Q. -- is that then an excuse for things when they went
 5 wrong? They weren't your fault? Because if you were
 6 putting these levers into place with the
 7 Coronavirus Act, or other convenient legislation, then
 8 you could use them.
 9 A. That is a very easy thing to say with hindsight. The
 10 reality of the situation is that I had to act with the
 11 tools that I had, and that's what I did, and drove the
 12 life-saving effort to make sure things weren't even
 13 worse than they were.
 14 Q. You brought levers in quite early on with the
 15 Coronavirus Act. That gave you the ability
 16 to -- (overspeaking) --
 17 A. Right, well, in this space, really the most effective
 18 things we brought in were the requirements in return for
 19 the emergency funding. That's what really brought
 20 the -- meant that we could bring to bear policy that we
 21 had not foreseen the need for before the pandemic.
 22 Q. Yes. Okay.

23 Let me move quickly on. I want to ask you some
 24 questions about Operation Nimbus.

25 And I think we're going to need the document for

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1 this, so it's INQ000195891.

2 So Nimbus, you chaired it, and it was a tabletop
3 exercise conducted on 12 February?

4 **A.** Yes.

5 **Q.** And therefore very much with the pandemic in mind, even
6 though it was an exercise of itself. No doubt you've
7 had a chance to review the notes of Nimbus.

8 Can you help us just -- from the notes it appears
9 that there wasn't any discussion about how the
10 government was going to ensure that people discharged
11 from hospitals could be discharged safely, and the right
12 time, given the known problems with the adult social
13 care sector?

14 **A.** I've discussed the problems about Exercise Nimbus
15 before. So these exercises are put to -- are developed
16 by the Cabinet Office and put to ministers, and they are
17 best done -- exercised as if real. And the main thing
18 that came out of Exercise Nimbus was the fundamental
19 problem of the wrong doctrine that underpinned it. And
20 the problem with Nimbus, it went -- it was much, much
21 worse than what you imply in your question. The problem
22 with Exercise Nimbus is that it was -- we spent however
23 long we spent, an hour and a half I think, dealing
24 with -- talking about body bags, dealing with how we
25 solve the problems that are a consequence of an

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1 **Q.** Can I ask the question --

2 **A.** No, I'm going to answer your question.

3 **LADY HALLETT:** The trouble is that Mr Weatherby has an
4 allotted time, and to be fair to his lay clients, which
5 he's trying to do, they have number of issues they want
6 put to you and he has permission to ask, so if you could
7 just listen to the question, please, to be fair to the
8 people, the bereaved that Mr Weatherby represents.

9 **MR WEATHERBY:** Thank you very much.

10 So I'm not asking you about the underlying doctrine.
11 If you look at paragraph 17, you yourself, as chair,
12 asked for an update on adult social care and the
13 problems are set out there.

14 So not only have you got the pandemic well over the
15 horizon coming towards us, so well in mind, but you've
16 also got in mind the adult social care sector's
17 inability to cope. So my question was: why wasn't there
18 any discussion of how the government was going to ensure
19 that people discharged from hospitals would be
20 discharged safely and at the right time, given those
21 known and acknowledged problems?

22 **A.** There was endless discussion of that. There was endless
23 discussion. And we've been through some of it this
24 morning.

25 **Q.** Okay.

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1 unmitigated pandemic where we don't take action to save
2 lives.

3 And I came out of Nimbus, and this was the real
4 penny drop moment when I realised that the doctrine that
5 had underpinned the pandemic planning, both in the care
6 sector but also across the board, was fundamentally
7 flawed. And this is well expressed in Module 1 -- the
8 Module 1 interim report of the Inquiry.

9 **Q.** Yes.

10 **A.** Hold on, let me just explain this point, because it's
11 critical to answering your question.

12 From 12 February, when I walked out of this meeting
13 and thought "I am not going to preside over this
14 pandemic just ripping through the population", I had to
15 change the -- not just the policy but the underlying
16 attitude across the board, in a whole series of areas,
17 and it took me the work of the next few weeks to do it.

18 The concept of lockdown was not considered in
19 Nimbus, and we had to get that going, and the
20 publication on 1 March was vital to it.

21 **Q.** Yes.

22 **A.** The testing was stopped, because that was part of the
23 underlying wrong doctrine by -- from PHE, as was contact
24 tracing. And I had to get testing going again and
25 rebuild contact tracing --

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1 **A.** The point in Nimbus itself is that the whole exercise
2 was based on the wrong doctrine with respect to your
3 question very specifically. And the point I was rather
4 at length going -- you know, explaining, is that was
5 true right across the board. And changing the attitude
6 in PHE and amongst the assumptions underpinning the
7 response in social care, and in this module and on your
8 question, was just one part of having to change that
9 attitude right across the board.

10 **Q.** Yes. Well, I've been through the note, if I've missed
11 it someone will point it out.

12 **A.** No, it's not in the note here; it's in the notes of what
13 we were actually doing in response to the actual
14 pandemic that was coming.

15 **Q.** Right. So there's been a discussion, has there, about
16 discharging patients safely to residential homes?

17 **A.** There were endless discussions about it around the time,
18 yes.

19 **Q.** It's just -- it's just not recorded?

20 **A.** No, it's in loads of the notes about real world
21 discussions we were having about the real pandemic.

22 **Q.** Can you help us as to why no one was apparently invited
23 to Nimbus on behalf of the social care sector?

24 **A.** I was invited to Nimbus on behalf of the social care
25 sector.

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1 Q. Yes, well, you're the minister.
 2 A. Yes, that's right.
 3 Q. But looking at the participants in Nimbus further up,
 4 there's nobody there, as far as I can see, from the
 5 social care sector. Why is that?
 6 A. Well, because this was a ministerial meeting, so I was
 7 there as the Secretary of State for Health and Social
 8 Care. That's the technical answer. But there is
 9 a wider point that you make that's important, which is
 10 that whereas the NHS has a chief executive who can
 11 represent them, there is no such figure.
 12 Q. Yes.
 13 A. The closest we got was David Pearson who did a fantastic
 14 job, but he did that job --
 15 Q. Okay --
 16 A. But it's not the same as having executive authority over
 17 a whole sector. It comes back to the accountability
 18 point we were making right at the start.
 19 Q. Okay, well, you say it was a ministerial meeting but
 20 you've got people from the NHS there --
 21 A. Exactly.
 22 Q. -- but you've got nobody from adult social care.
 23 I fully understand what you're saying, you've got a
 24 chief executive for NHS, but you're not looking for
 25 people to express responsibility in an operation, are

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1 committee needed to decide whether to expand the
 2 intensive care capacity at the consequence of stopping
 3 treatment to others, and following that decision, the
 4 doctors' regulations are updated to reflect treating by
 5 likelihood of survival by years of life left.

6 Now, am I right that that means that older people
 7 were less likely to be prioritised for treatment?

8 A. This was a recommendation by Simon Stevens that I
 9 rejected. I rejected it here in the exercise and then
 10 I rejected it when the BMA later made it on behalf of
 11 their doctors union later in real life.

12 Q. Right. So the answer to my question is that yes, this
 13 does reflect a view of prioritising -- less likely that
 14 treatment would be prioritised for older people?

15 A. It reflects that proposal that was put forward and
 16 rejected.

17 Q. Yes, I see.

18 And again, in those minutes, can you help us with
 19 what alternatives were actually put forward by you or by
 20 anybody else and minuted?

21 A. Alternatives for what?

22 Q. Well, this proposal is put forward; you say you rejected
 23 it.

24 A. Yes.

25 Q. But what is the rejection that's recorded in those

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1 you? You're looking for people who can put impact into
 2 how those sectors or those organisations would react,
 3 given what's going on in the exercise. That's what you
 4 really want in an exercise, isn't it?

5 A. No. This is not a stakeholder exercise; this is
 6 a ministerial exercise for decision making, so you need
 7 the people with decision-making authority, and there
 8 isn't anybody beneath ministerial level with that sort
 9 of decision-making authority in social care. It's one
 10 of the problems that we talked about earlier.

11 If you could possibly go on to page 2, you see Helen
 12 Whately is there.

13 Q. Yes, a minister.

14 A. The minister, yes. But ministers have responsibility
 15 for this in social care. That's right.

16 Q. Before I move on, would it have been improved, as an
 17 exercise, had there been somebody from the adult social
 18 care sector involved in it?

19 A. But who? That's the problem. Who? There isn't a chief
 20 executive. There isn't a Simon Stevens or Keith Willett
 21 counter party. That's one of the problems.

22 Q. Staying with Nimbus but moving to a different topic,
 23 older people. So the minutes record that you,
 24 paragraph 8 of the minutes, asked what were the key
 25 decisions to make, and NHS England clarified that the

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1 minutes? What is it that -- the alternative that you
 2 say, "No, no, no, I'm not having that" --

3 A. No. That's right.

4 Q. -- "So the way we'll prioritise treatment or the way
 5 we'll do it differently is this"; where's that?

6 A. Rejection of a change to this approach left us with
 7 exactly the same and normal approach, which is that the
 8 doctor on the ground makes the decision as to the
 9 appropriate --

10 Q. Yes --

11 A. -- please let me finish my answer because it's quite
 12 important.

13 Q. All right.

14 A. It's that the doctor on the ground should make that
 15 decision. That was my and -- my view, strongly
 16 supported by Chris Whitty, as CMO.

17 But it was exactly this sort of discussion that made
 18 me determined to ensure that we would stop the pandemic
 19 rather than just let it wash through, and that made me
 20 realise that the doctrine that had been underpinning the
 21 planning was wrong. And it is a deep irony that it was
 22 the Department of Health team who spotted that --

23 Q. Yes.

24 A. -- with me at the helm, and went on to solve all of
 25 these problems, as much as we possibly could in the

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1 circumstances.

2 **Q.** Right.

3 **A.** That is what I did. And representing some of the

4 bereaved families as you do, that is the work that we

5 had to do from this point onwards.

6 **Q.** Right, okay. So this is what is thrown up in the

7 exercise: that you realise here that what's being said

8 to you is that we need to prioritise in a way that just

9 basically discriminates against older people. And you

10 reject that?

11 **A.** Correct.

12 **Q.** So where is it in the minutes about what you're going to

13 do in the alternative?

14 **A.** Well, the alternative was -- what this led to,

15 ultimately, was the policy of lockdown.

16 **Q.** Yes.

17 **A.** Because lockdown wasn't discussed in these minutes

18 either, because it wasn't proposed as part of the plan.

19 **Q.** Exactly, there's nothing in this minute of Operation

20 Nimbus which says: Secretary of State's rejected this

21 view that was put forward, horrified at the idea of

22 discrimination.

23 **A.** Can you go on to the conclusions? Because the chair

24 was -- the chair asked what key decisions to make.

25 **Q.** Yes.

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1 me. I rejected the change. I didn't need an

2 alternative, I needed people to do their job, which is

3 what doctors went on to do, which was to treat everyone.

4 And my job was also to try to stop getting into

5 a position where you even have to choose. I did not

6 want the rationing of care, and that is what we

7 achieved.

8 **Q.** Well, you did need an alternative, you needed isolation

9 and testing and PPE and -- (overspeaking) --

10 **A.** Yes, and I went on to build all these things, exactly,

11 yes.

12 **Q.** Finally on Nimbus, there appears to have been discussion

13 about staff absence in the healthcare sector --

14 **A.** Yes.

15 **Q.** -- with respect to communication about it, but nothing,

16 no discussion about staff absences in the adult social

17 care sector. Why was that?

18 **A.** I don't know whether that's the case. As I say, it was

19 a Cabinet Office prepared paper, so the -- ultimately,

20 Exercise Nimbus was the -- in my view, the endpoint of

21 the approach of -- embodied in the 2011 strategy. If

22 you remember, a few weeks before this, I'd been calling

23 for COBRs, trying to get action, been blocked by the

24 Cabinet Secretary. They'd quite rude about me, and they

25 continued to be rude about me.

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1 **A.** I have a feeling -- I have a -- if you go up a page,

2 back a page. I'll have to read it because there is

3 a bit of --

4 **Q.** Well, I don't want to be unfair.

5 **A.** I suppose there's two points. The first is I rejected

6 it, and it's there in the minutes somewhere. But the

7 second point is that in real life -- this is the

8 exercise -- in real life, the BMA brought this proposal

9 to me and I rejected it, in the pandemic itself.

10 **Q.** That's not my point, Mr Hancock.

11 **A.** Okay.

12 **Q.** My point is: where is your alternative here? You've got

13 the exercise, you've got the proposal. You say you

14 rejected it.

15 **A.** Yes.

16 **Q.** But where is the alternative -- (overspeaking) --

17 **A.** The alternative is the status quo, which is that doctors

18 make decisions on the ground.

19 **Q.** -- at 12 February we need to realise that in order to

20 avoid this discriminatory proposal, we need to do X, Y

21 and Z; and it's not there, is it?

22 **A.** No, because it's the status quo that I was supporting,

23 and therefore I didn't need to set it out. It was that

24 we were not going to make such a change.

25 I was being -- the NHS was recommending a change to

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1 **Q.** Well, let's not worry about that.

2 **A.** No, no, it's important because what I'm trying to get

3 you to understand is that Exercise Nimbus was based on

4 the wrong doctrine it was the moment for me that I

5 thought, "We cannot let this happen", and then there was

6 a whole load of action that went from it. So that's my

7 explanation why certain things aren't in there that,

8 really, in a future exercise absolutely should be.

9 **Q.** Okay. I'm not going to take Nimbus any further with

10 you. The point I put to you is that the problem about

11 the proposal that was being put to you, you're chairing

12 it and --

13 **A.** Yes.

14 **Q.** -- these are the minutes, they're not the Cabinet Office

15 briefing documents, these are the minutes of it.

16 **A.** Yes.

17 **Q.** There's nothing in there about all the measures that you

18 say you agree should have been taken thereafter, and

19 this is 12 February.

20 **A.** Yes, and my response to that is that all you're doing is

21 reinforcing the point that I would make in response to

22 Nimbus, which is the exercise highlighted the wholly

23 inadequate attitude that was being taken by the Cabinet

24 Office to how to respond to a pandemic.

25 **LADY HALLETT:** Mr Weatherby, it's not your fault, you are

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1 over your allotted time, but we're going to take a break
2 now. And don't worry, if you could try to work out
3 during the break what you can do if I allow you another
4 ten minutes.

5 **MR WEATHERBY:** That's very kind, thank you.

6 **LADY HALLETT:** I shall return at 3.50.

7 (3.37 pm)

8 (A short break)

9 (3.51 pm)

10 **LADY HALLETT:** Mr Hancock, before we start again,
11 I appreciate how difficult it is for you and how you
12 wish to make sure that any criticisms that aren't fair
13 aren't made, but there's limited time left, the
14 stenographer has had an extraordinarily long day, and we
15 still have a number of other questions from other Core
16 Participants, so, please, if you could focus on the
17 questions and just answer the questions, I'd be really
18 grateful.

19 **THE WITNESS:** Absolutely. Could I just very quickly put on
20 the record a further -- a little addition to the
21 previous answer, though, to exactly this point, because
22 I was asked about this point about who took decisions
23 over prioritisation of care, and we could have
24 shortcut that whole section, because in paragraph 35
25 of that same paper it says:

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1 **A.** The problem here was that the PHE clinical advice said
2 that asymptomatic testing was not appropriate, and of
3 course there weren't enough tests. I had stated in
4 January that the policy should take -- would be: proceed
5 on a reasonable worst-based scenario. Noting that there
6 was evidence, even then, of asymptomatic transmission.
7 You'll have to ask PHE why it didn't update its advice
8 until April.

9 **Q.** Right. In terms of the self-isolation point, though,
10 the requirement for returning cruise ship passengers for
11 self-isolation for 14 days, why wasn't that something
12 that could be done with the discharges from care homes,
13 for example, by things that you've already discussed,
14 about holding accommodation or hotels --

15 **A.** Yes.

16 **Q.** -- where care homes didn't have the availability to do
17 it themselves?

18 **A.** Yes.

19 **Q.** Why was that not done?

20 **A.** You'll know from the discussions that we've had that
21 that is something that ministers were pushing for,
22 and -- but we weren't able to put that in place until
23 the middle of -- the middle of April. In fact, because
24 of my concerns about asymptomatic spread, I'd insisted
25 that people coming back from Wuhan were isolated, in

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1 "The chair stated that clinicians, as part of NEPP
2 [which is the national emergency planning procedure]
3 should be empowered to make decisions."

4 So it's stated there in the minutes, thank you.

5 **MR WEATHERBY:** Yes, well, thank you for that clarification.

6 That wasn't my point. My point was about the other
7 issues that should have come as a result of you
8 rejecting the proposal that was put.

9 Two topics to finish my questions and I'll deal with
10 them as briefly as I can.

11 Asymptomatic transmission. On 14 March of 2020,
12 your department and the Office of the Chief Medical
13 Officer received data on the Diamond Princess cruise
14 ship confirming that 696 people on board the Diamond
15 Princess had tested positive, 328 of which were
16 asymptomatic, and some of the cases appeared to be
17 superspreaders.

18 Just for the record the reference is INQ000048086.

19 Can you help us, those who had been repatriated from
20 cruise ships were required to self-isolate for 14 days
21 and tested within 24 hours of arrival, and that had
22 happened on the 10 March return of passengers on the
23 Grand Princess cruise ship.

24 Why were care home residents discharged from
25 hospital at around this time not treated similarly?

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1 February, as early as that.

2 So this was something that the clinical advice was
3 clear from PHE, Sharon Peacock led I think on that
4 advice. It's something you'll have to ask PHE.

5 **Q.** I'll come on to that in just one second.

6 Just on this point of the apparently different
7 treatment at returning cruise passengers and discharged
8 patients, and this position of discharges in the middle
9 of March, and then more testing becoming available with
10 the action plan on 15 April, why did you not stop
11 elective treatments, elective surgery, for example, at
12 the same time or before the discharges from hospital to
13 care homes?

14 **A.** The NHS were working on their policy of elective
15 discharge -- pausing electives at that point. That was
16 a decision for Simon Stevens, so you'll have to ask him
17 about that.

18 **Q.** That would have meant that the discharges could have
19 been delayed until you had proper testing and more
20 data --

21 **A.** Well, not necessarily because it depended on the spread
22 of the virus and how many people ended up in hospital,
23 but I mean I essentially agree with the thrust of your
24 point. People coming home from cruises, of course,
25 could self-isolate at home. For somebody in a care

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1 home, their home is the care home. So there is a -- it
 2 is more difficult --
 3 **Q.** Yes --
 4 **A.** -- because there isn't a place automatically to go.
 5 **Q.** -- I understand it's more difficult, that's why I put
 6 the point about holding centres.
 7 **A.** Yeah.
 8 **Q.** Finally, onto asymptomatic transmission more generally.
 9 You've said today and in your statement that the initial
 10 consensus that the virus could transmit asymptotically
 11 underpinned many decisions, including, for example, the
 12 Department's initial advice on the management of the
 13 virus in care homes and, to be fair to you, in your
 14 statement you set out your reservations about that.
 15 **A.** Yeah.
 16 **Q.** But does it follow that if you had worked on the
 17 precautionary assumption that the virus could transmit
 18 asymptotically you would not have supported the
 19 decision to discharge patients untested in March 2020?
 20 **A.** Oh, not necessarily. I think if we -- if there had been
 21 concrete evidence and clinical advice of asymptomatic
 22 transmission that would not necessarily have changed
 23 that policy because for instance, then we would have
 24 known that asymptomatic transfer in hospitals would have
 25 been more prevalent and therefore hospitals would have

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1 **Q.** Were you made aware of any evidence that that was based
 2 on?
 3 **A.** Oh, I was advised this repeatedly by my clinical
 4 advisers from early on. There was then a disagreement
 5 that we went through in a previous module between Chris
 6 Whitty and Patrick Vallance on this point. I asked for
 7 advice from the two of them, and a month later, Patrick
 8 Vallance finally came up with that advice. So we went
 9 through this in the previous module and --
 10 **Q.** Yes, and did you suggest or consider ordering, as
 11 Secretary of State, a trial of whole care home testing,
 12 for example, in one of the locations with an outbreak to
 13 test for --
 14 **A.** We did that when enough tests were available, when we'd
 15 expanded the testing capacity but, as you know from
 16 another module, that took longer than it should have
 17 done and I had to take personal responsibility for
 18 making that happen.
 19 **Q.** Bearing in mind the answers you've given, even if it was
 20 necessary to go ahead with the discharges without
 21 testing being available, was it something that you
 22 considered to only require care homes to accept patients
 23 if they had facilities to isolate them? Is that
 24 something that you --
 25 **A.** Yes, so we did consider that at the time, and the

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1 been even -- would have thought to have been even more
 2 dangerous settings than they were thought to be at the
 3 time. So I don't think it follows that an -- a policy
 4 assumption of asymptomatic transmission at that stage
 5 would have changed that policy. It's a difficult
 6 counterfactual question, but there is a case that in
 7 fact it would have made the policy as enacted --
 8 **Q.** Yes, I follow that. I follow that your case is that
 9 there weren't enough tests available, hospitals are
 10 dangerous places.
 11 **A.** Yes.
 12 **Q.** But the question is you would have stuck to the same
 13 policy decision --
 14 **A.** As I said --
 15 **Q.** -- (overspeaking) --
 16 **A.** -- it's a difficult counterfactual question --
 17 **Q.** Yes.
 18 **A.** -- but there is an argument that in fact knowing about
 19 asymptomatic testing categorically at that point might
 20 have made the policy choice that was made, more, rather
 21 than less strong.
 22 **Q.** Yes. Now, you say that -- finally this. You say that
 23 you'd received advice from PHE that tests didn't work
 24 reliably on asymptomatic individuals.
 25 **A.** Yes, yeah.

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1 problem was what you do with people who don't have that
 2 available. And the point about the danger of hospitals,
 3 you know, remains the same. So --
 4 **Q.** But you would have had a position where maybe half of
 5 the care homes or three-quarters of the care homes in
 6 a particular area had isolation facilities, so you would
 7 have had that capacity, and then you'd have been able to
 8 consider what to do with the others?
 9 **A.** Yes, but all of that presumes that people are safer in
 10 hospital than in a care home, and I don't think that was
 11 true at the time.
 12 **MR WEATHERBY:** Nothing further. Thank you.
 13 **LADY HALLETT:** Thank you very much, Mr Weatherby.
 14 Next I think it is Ms Beattie.
 15 Over that way, Mr Hancock.

Questions from MS BEATTIE

17 **MS BEATTIE:** Mr Hancock, I ask questions on behalf of
 18 Disabled People's Organisations. You gave evidence this
 19 morning that it was when you saw the two local authority
 20 plans that you realised that local plans were as good as
 21 useless, I think you said?
 22 **A.** Yeah.
 23 **Q.** Now in June 2018, which is just before you were
 24 appointed Secretary of State for Health and Social Care,
 25 a department briefing paper on pandemic influenza in

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1 adult social care and community healthcare had
2 highlighted that Exercise Cygnus in 2016 identified
3 "a knowledge gap in community services preparedness"?

4 **A.** Right, I didn't -- I don't think I knew that.

5 **Q.** Including for adult social care.

6 **A.** Mm.

7 **Q.** So do you agree that the adult social care sector's lack
8 of preparedness for a pandemic was well known prior to
9 Covid-19, including to your department?

10 **A.** I can't testify that because I haven't seen the evidence
11 you refer to. If that's what it says, I didn't know
12 that until you just said it.

13 **Q.** So you didn't have to see those two local authority
14 plans to know about the knowledge gap in community
15 services preparedness; is that right?

16 **A.** I can only testify what happened to me and what I did,
17 and it was when I saw those plans that I first realised
18 that that was a major problem.

19 **Q.** Had you made any investigations between becoming
20 Health Secretary and the outset of the pandemic into
21 that level of preparedness?

22 **A.** Yes, I was briefed when I became Health Secretary on our
23 pandemic preparedness plans, and I went back in some
24 detail with Clara Swinson, who was the lead official, on
25 this -- on this question.

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1 **A.** I do mean social care. Thank you for picking me up on
2 that. You're quite right.

3 **Q.** So having decided that at the beginning of March 2020,
4 why did it take until mid-June 2020, almost three and
5 a half months after you thought that there was
6 a complicated set of problems which needed to be gripped
7 as soon as possible, and what you've just told us, to
8 set up the social care sector support taskforce?

9 **A.** That's a misrepresentation of what happened. What
10 happened after the 6 March meeting was immediate action
11 on a whole series of fronts. We saw earlier the minutes
12 from that meeting saying that I'd set out ten different
13 areas in which we needed to take immediate action, and
14 a huge amount happened from that moment onwards. The
15 Social Care Taskforce was a way of bringing together
16 a disparate sector to -- and a way to have a formalised
17 engagement with the sector that, I, on recollection, was
18 led by the minister rather than me, largely, but that
19 was a -- you know, it comes back to the problem that we
20 were discussing with the -- with the Bereaved Families
21 Group, that there is no single leader of social care,
22 you know, at that -- I've looked at the minutes of the
23 exercise that we just talked about, Clara Swinson was
24 there as a departmental official leading on social care,
25 and as part of the -- was part of the discussion. So

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1 **Q.** But you weren't told what was in that June 2018 paper?

2 **A.** No. Not that I can remember.

3 **Q.** Now, at the beginning of March 2020 -- Counsel to the
4 Inquiry took you to the coronavirus and social care
5 meeting of 6 March this morning; do you remember that?

6 **A.** I do. I remember it very clearly.

7 **Q.** And at that meeting you said the impact of Covid posed
8 a complicated set of problems for the social care sector
9 which needed to be gripped as soon as possible.

10 **A.** Yes.

11 **Q.** You recall that?

12 **A.** That's right.

13 **Q.** And I think at the same meeting, the Minister of Care,
14 Helen Whately, said: We need to ramp up preparedness
15 around social care. Is that right?

16 **A.** Yes. The essence of this meeting was it was when the
17 department decided -- and it was my decision ultimately,
18 but it was a strong consensus in the department -- that
19 we needed to take responsibility for what was going on
20 in care homes, irrespective of the fact that the -- some
21 of the policy levers were not our formal responsibility.
22 We just decided that nobody else was doing it so we'd
23 better had.

24 **Q.** You say "care homes", I assume you mean social care
25 generally -- (overspeaking) --

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1 she was doing that job, so it was done, but there wasn't
2 a sector-wide formal grouping, in that sense, and so
3 I understand that's -- that's my recollection of why the
4 taskforce was set up.

5 It absolutely does not imply a lack of action.

6 **Q.** But are you telling us that it wasn't until
7 mid-June 2020 that it occurred to anyone that that
8 formalised engagement structure needed to be put in
9 place?

10 **A.** No, I'm not saying that. There was a huge amount of
11 engagement, largely led by Helen Whately and the Civil
12 Service team, Ros and the rest of the team. The -- it
13 was put into a taskforce form, so a reasonable thing
14 to do.

15 **Q.** One of the things that taskforce was set up to do was to
16 oversee the Social Care Action Plan; is that right?

17 **A.** I don't recall.

18 **Q.** Right. I think that's stated in the letter that you
19 sent to David Pearson in -- (overspeaking) --

20 **A.** At the time, right.

21 **Q.** -- (overspeaking) -- June setting up the taskforce.

22 **A.** Right, okay.

23 **Q.** And that Social Care Action Plan had been published in
24 mid-April 2020; is that correct?

25 **A.** Okay.

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1 Q. Sorry, you understand the action plan was published in
2 mid-April --
3 A. If that's what you're telling me. You mean the 15 April
4 document?
5 Q. Yes.
6 A. Yes.
7 Q. And would you agree that it's not very useful to set up
8 a taskforce to oversee delivery of an action plan that
9 had been published two months earlier?
10 A. No, I don't think that's true at all. I think we
11 published the plan, and we got on with delivering the
12 plan. The plan itself changed the advice in a way that
13 reflected the now agreed clinical recommendation of
14 assuming asymptomatic transmission, for instance, and
15 many, many other things. A huge amount of further work
16 was done, including the changes announced and the extra
17 money announced, for instance, on 15 May and many other
18 times.
19 Formalising that after this period of intense
20 activity into a group that could take it forward, led by
21 somebody from the sector, in David Pearson, was a good
22 next step. It was entirely reasonable to do it in that
23 timeframe.
24 Q. And you've given evidence already that it was -- your
25 department was overstretched and had no levers. So was
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1 discharge. A discharge to assess option was proposed,
2 which you agreed with?
3 A. Right.
4 Q. And just to put that in context, is it right that
5 discharge to assess essentially aims to discharge
6 patients from hospital as soon as possible, as soon as
7 they no longer need acute care, but they might still
8 need care services, and that would be assessed once
9 they're out of hospital? Is that right?
10 A. That is -- that's the definition of it more or less,
11 yes.
12 Q. And you were at that time trying to free up tens of
13 thousands of beds, and so discharge to assess was
14 accelerated; is that right?
15 A. Yes, and it's entirely reasonable if you don't
16 clinically need to be in hospital but do need continued
17 help, making sure that people -- that the assessment of
18 what continued help is needed is done after discharge is
19 an entirely reasonable way of going about things.
20 Q. So what safeguards did you understand existed, then, to
21 ensure that patients who were discharged to be assessed
22 did in fact receive full assessment of their support
23 needs once they were out of hospital?
24 A. Yes, it's incredibly important that they do. For
25 instance, we were putting in place at the same time the
215

1 it an overstretched department with no levers that had
2 been overseeing that action plan?
3 A. Of course we were all unbelievably busy responding to
4 the greatest civil emergency in 100 years. So yes, we
5 were busy, yes.
6 Q. The next March meeting which Counsel to the Inquiry took
7 you to was 11 March. Do you remember that? It's the
8 social care coronavirus meeting --
9 A. I don't remember that specifically. It wasn't as
10 momentous as the previous one.
11 Q. Right. Well, I'll ask the questions and you can tell me
12 if I need to be up the note of the meeting, but it is
13 a social care coronavirus meeting of 11 March at which
14 there was discussion of speeding up hospital discharge.
15 A. Right.
16 Q. Do you accept that?
17 A. I don't know. It was five and a bit years ago, so --
18 Q. Right, well, if it assists the witness, it is
19 INQ000328131.
20 LADY HALLETT: Can you get on and ask the question while it
21 comes up, Ms Beattie, please. You're running short of
22 time.
23 MS BEATTIE: Yes.
24 At the meeting there was discussion of whether
25 everything was being done to speed up hospital
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1 financial arrangements to make sure that the initial
2 period of care -- an initial period of care was paid for
3 in all instances, rather than having to be assessed for
4 payment. So removing the financial barrier to getting
5 that care was one of the steps that we took. It's --
6 because what you wouldn't want to do is to undertake
7 a discharge to assess without a care package in place.
8 And normally the care package is agreed in negotiation,
9 and it's based on the assessed care needs, but instead,
10 we simply put the care packages in place.
11 Q. Now you're aware, I presume, of Healthwatch England
12 survey material which showed that in fact in the first
13 six months of the pandemic, 82% of respondents did not
14 have their recovery and longer term support needs
15 assessed. Nearly one in five of these was reported as
16 having unmet needs. 45% of people with a disability,
17 and 20% of people with a long-term condition said they
18 had support needs that were not being met following
19 their discharge?
20 A. Yes, well, the -- you'd need to consider that evidence
21 alongside what is the normal reported level of unmet
22 need in that group, because some of those needs will be
23 significant in normal times as well. Because we're
24 generally talking about non-Covid needs, those who were
25 in hospital for non-Covid reasons.
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1 The one possible explanation for why the proportion
2 of those who didn't have assessments is so high is
3 because we were paying for the care irrespective of
4 a needs assessment, whereas normally the payment only
5 comes following a needs assessment, and therefore, the
6 needs assessment is critical to unlock the payment.

7 So ironically the generosity of the support for the
8 care sector, and the £5.1 billion that I outlined, may
9 have led to fewer assessments being done, along with the
10 fact that this was in the middle of a pandemic, so there
11 would have been -- people would have had other
12 priorities as well.

13 **Q.** Right. So that's the formal aspect of -- you're talking
14 about the procedural aspect of the assessment, but are
15 you aware of any auditing of discharge to assess cases
16 to ensure that patients have not remained,
17 post-discharge, in unsuitable placements and without
18 adequate support and needs being met?

19 **A.** I'm not aware of whether there was or there wasn't.
20 It's a level of detail that you'll have to ask
21 Helen Whately or maybe even -- or maybe one of the
22 officials. It wouldn't have come to my desk.

23 **LADY HALLETT:** I'm afraid you're going to have to wrap it
24 up, thank you, Ms Beattie. I'm sorry we're in such
25 a rush this afternoon. Thank you.

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1 you would work with those representing care workers to
2 ensure there's a way that staff can flag if they're not
3 getting that support through.

4 **A.** Yes.

5 **Q.** Then if we cross-reference that with INQ00088629, which
6 is the minutes of the Covid-O meeting at which that
7 draft strategy was discussed --

8 **A.** Right.

9 **Q.** -- page 4, it explains the reasoning for rejecting that
10 Statutory Sick Pay proposal as follows:

11 [As read] "The commitment in paragraph 2.27 [which
12 is the one I've just taken you to] might cause
13 difficulty for the government as it would be the first
14 time that the government acknowledged that Statutory
15 Sick Pay was not appropriate ..."

16 **A.** Yeah.

17 **Q.** "... and clarification would be needed ..."

18 **A.** Yes.

19 **Q.** "... about why the policy wouldn't apply to all key
20 workers who had been declared as essential."

21 **A.** Absolutely.

22 **Q.** So my question is this: do you accept that it was well
23 understood at an early stage that an increase in
24 Statutory Sick Pay was needed to protect care workers
25 and service users alike, but that it wasn't immediately

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1 Ms Weston.

2 **Questions from MS WESTON KC**

3 **MS WESTON:** Good afternoon, Mr Hancock. I am asking
4 questions on behalf of the Frontline Migrant Healthcare
5 Workers Group. We represent care workers who were at
6 the sharp edge of the pandemic.

7 **A.** Yeah.

8 **Q.** Our questions concern how the employment conditions for
9 workers in the adult social care sector, impacted on the
10 spread of the virus.

11 **A.** Yes.

12 **Q.** Can I ask that we turn up INQ000088388, which is the
13 early draft of the Adult Social Care Strategy Document,
14 if I can ask you to look at 0020, which is
15 paragraph 2.27.

16 So in that paragraph, we can see that the proposal
17 was for paying workers their full wages for up to so
18 many weeks of sickness or isolation during the pandemic.

19 **A.** Yeah.

20 **Q.** And that:

21 "Where local authorities face particularly
22 disproportionate costs ... Government [to] meet the
23 costs, (policy not agreed with ministers)."

24 **A.** Yes.

25 **Q.** Then, if it wasn't happening, you'd want to know, and

218

1 adopted for ring-fenced?

2 **A.** Yes, it's safe to say that I campaigned in favour of
3 that. I was strongly in favour of the language that you
4 highlighted in yellow in 2.27 of the previous document
5 and I would have made the case for that in this meeting
6 but clearly didn't get my way.

7 **Q.** Well, wasn't the reason to save the government the
8 embarrassment of admitting that Statutory Sick Pay was
9 inadequate across the board?

10 **A.** No, I thought that Statutory Sick Pay was inadequate and
11 I still think it's inadequate and I made that case
12 firmly.

13 **Q.** So how would you describe, then, could you explain what
14 was the nature of the difficulty that such a policy
15 would present for the government that's referred to --

16 **LADY HALLETT:** Ms Weston wasn't suggesting that was your
17 attitude.

18 **A.** No, no, I know, but all I can do is tell you what
19 I think. I think Statutory Sick Pay should be higher,
20 I don't think there's a difficulty, that point would
21 have been made by somebody else. I lost the argument.

22 **MS WESTON:** Yes, but presumably you were at meetings where
23 that was discussed --

24 **A.** Yes.

25 **Q.** -- and what the objections were were discussed. Can you

220

1 help us with that?

2 **A.** No, because I don't recognise them. I don't think there

3 are any.

4 **Q.** So you didn't hear anybody talk about any objections?

5 **A.** Well, I can't remember but lots of people make rubbish

6 points that you forget, don't they?

7 I mean, I can't -- the implication of the question

8 is that there should be better Statutory Sick Pay.

9 I strongly agree. I can't think of reasons not to,

10 other than the direct cost of it. The direct cost, in

11 my mind, is massively outweighed, in normal times, let

12 alone in a pandemic, by the benefits of such a policy.

13 I apologise that I can't remember what the people who,

14 unfortunately, won the argument at that time said in

15 doing so.

16 I regret that they won the argument and I think that

17 the government should sort out Statutory Sick Pay now,

18 and I would recommend that to the Inquiry.

19 **Q.** Just moving on --

20 **A.** Yes, sorry.

21 **Q.** Dame Jenny Harries has noted in her witness statement --

22 for my Lady's note it is paragraph 9.13:

23 [As read] "The financial position of the carer also

24 served to encourage them to return prematurely to work

25 when staff in other sectors would have isolated,

221

1 **Q.** And they are also undocumented workers who have come to

2 the UK legally but whose visas have expired?

3 **A.** I haven't seen evidence of that myself.

4 **Q.** These were important aspects of the sector, the

5 significance of which I suggest was overlooked by

6 government when looking at the impact of working

7 conditions on the spread of the virus; do you agree?

8 **A.** I agree that the decision by the government that I had

9 argued against by its nature, therefore, didn't take

10 into account this important factor.

11 **Q.** For example, whistleblowing for a care sector in such

12 a precarious position would be impossible, even in, to

13 use your language of a short while ago, the worst

14 extremes, wouldn't it?

15 **A.** Yes, it would. Well, it depends on the exact

16 circumstances of the worker.

17 I mean, I strongly support those who are in the

18 sector and I absolutely recognise, and we all should,

19 the huge contribution of migrant workers in this sector.

20 I do not endorse the continued employment beyond the

21 period of their visa of workers in that situation, and

22 I think that the policy that I proposed, some of which

23 became policy and some of which didn't, reflects that

24 balance, and I think it's a reasonable position to take.

25 **Q.** Mr Hancock, do you accept that the government's pandemic

223

1 supported by adequate sick pay."

2 **A.** Yes.

3 **Q.** And that's because of the nature of the peripatetic

4 workforce?

5 **A.** Absolutely. Yes.

6 **Q.** So given that subsequent scientific evidence -- I'm

7 thinking particularly of the Vivaldi Study -- did

8 confirm the link between inadequate sick pay and the

9 spread of the virus --

10 **A.** Yes.

11 **Q.** -- firstly, understanding that it wasn't your decision

12 to take, but do you regret the decision?

13 **A.** Of course. I disagreed with it at the time. I'm sorry

14 I can't be more use to you other than to say that you're

15 completely right.

16 **Q.** Mr Hancock, I'm going to move on to the position of

17 domiciliary care workers.

18 **A.** Right, yes.

19 **Q.** So you accept, I think, and you've already recognised

20 today, that workers in domiciliary care are frequently

21 on zero-hours contracts working multiple jobs?

22 **A.** Yes.

23 **Q.** Do you accept that they're also frequently migrant

24 workers on tied visas?

25 **A.** Yes, frequently and disproportionately, yes.

222

1 strategy suffered from a lack of understanding of the

2 realities for this cohort of workers who were already at

3 the bottom of the hierarchy?

4 **A.** No, I don't think that we in the department failed to

5 understand the situation; I think that the situation was

6 exceptionally different because of the nature of the

7 virus.

8 You know, the question is a very reasonable one.

9 You're saying, was there a lack of understanding? There

10 wasn't a lack of understanding, it was just really hard.

11 **LADY HALLETT:** Thank you, Ms Weston.

12 **MS WESTON:** Those are my questions, my Lady.

13 **LADY HALLETT:** Mr Straw.

14 Mr Straw is over there.

15 **Questions from MR STRAW KC**

16 **MR STRAW:** Thank you.

17 Mr Hancock, I represent John's Campaign, The

18 Patients Association and Care Rights UK.

19 In January 2021, Helen Whately pushed to have

20 visitor restrictions relaxed.

21 **A.** Yes.

22 **Q.** You refused and you said that this was because we needed

23 to save lives.

24 **A.** Yes.

25 **Q.** Could we have on screen, please, a document

224

1 INQ000492343. Thank you.
 2 You can see, this is a letter here from -- we can
 3 see from the bottom of the page -- John's Campaign,
 4 Dementia UK and others --
 5 **A.** Yes.
 6 **Q.** -- addressed to you, dated 2 July 2020.
 7 **A.** Right.
 8 **Q.** I'm just going to refer to a couple of aspects of it and
 9 then ask you the question, please.
 10 So it refers there to the "hidden catastrophe ...
 11 taking place in care homes". A little further down:
 12 "... much suffering and a deterioration in mental
 13 and physical health among many of the residents because
 14 of the ban on all visitors.
 15 "This enforced separation has had particularly
 16 damaging consequences for those living with dementia
 17 (who make up over seventy per cent of the population in
 18 care homes) ..."
 19 And then a couple of paragraphs down:
 20 "What's more, without these essential family carers,
 21 the cognitive abilities of a person with dementia can
 22 deteriorate rapidly ... this enforced isolation from
 23 family and friends can be fatal."
 24 There's been:
 25 "... a significant rise, 52%, in
 225

1 I understood these considerations. I also had a duty to
 2 ensure that as few people died as possible overall, and
 3 this was, as I said, a difficult balance to strike.
 4 I'm sure that the policy, over time, can be improved
 5 by consideration now about how you can better -- have
 6 better options, essentially, but ultimately, visitors
 7 were one source of bringing the disease into care homes,
 8 which we had to take seriously.
 9 **Q.** Well, looking at that side of the picture, were you
 10 aware of evidence that permitting visitors by an
 11 essential care supporter with appropriate safeguards,
 12 and so for example, a negative test, PPE, limited
 13 contact with others, didn't greatly raise the risk of
 14 harm from Covid? And to give you one example of that
 15 evidence, the Department of Health and Social Care's
 16 paper on the winter plan, dated 15 September 2020, said:
 17 There is currently little evidence that visits are
 18 a source of outbreaks.
 19 **A.** Yes. So, firstly, I was absolutely aware of that sort
 20 of evidence, and it was duly considered, as your
 21 question implies. The second thing is that the case
 22 rate in September 2020, whilst rising, was still
 23 relatively low. So that might explain that statement.
 24 **Q.** Looking --
 25 **A.** Whereas by January, the case rate was absolutely off the
 227

1 non-coronavirus-related deaths for people with
 2 dementia."
 3 At that time, were you aware of this type of
 4 evidence that restrictions on visitors themselves caused
 5 many deaths as well as other widespread harm?
 6 **A.** I was aware of the difficulties caused by the
 7 restriction on visits, yes.
 8 **Q.** Was this is an area of data lack, where you didn't have
 9 enough information as to the seriousness of the harms
 10 including deaths and other illnesses caused by visitor
 11 restrictions?
 12 **A.** It's true that the data on this improved over time and
 13 was weak at first. It is something that we considered
 14 in making the difficult balanced decision about
 15 visiting.
 16 **Q.** In terms of recommendations for a future pandemic, in
 17 order to ensure that the data on this very important
 18 area is better, can you recommend any changes? For
 19 example, the better involvement of stakeholders
 20 representing those with lived experience in information
 21 coming to government?
 22 **A.** Well, the -- I largely left it to -- delegated to Helen
 23 Whately the discussions with stakeholders in this space.
 24 I, as you've seen from the earlier discussions,
 25 I essentially took her advice in this -- at this time.
 226

1 charts and extremely high. So the level of background
 2 prevalence of the disease is a very important
 3 consideration, which is why the rules around visiting
 4 changed over time.
 5 **Q.** But even in January 2021, in terms of an essential care
 6 supporter, would you accept that the balance of harm, so
 7 the harms that would be caused by refusing access to
 8 essential care supporter, clearly outweighed the risks
 9 of harm through Covid of allowing them in?
 10 **A.** No, that wasn't my judgement. On the contrary, by -- in
 11 January 2020, the disease -- sorry, January 2021, the
 12 prevalence of the disease was at the highest point that
 13 it had been throughout the entirety of the pandemic,
 14 higher than in the first wave, and it was when the
 15 vaccine programme was only just getting going. If you
 16 recall, the rates shot up over that Christmas period,
 17 and it was extremely serious, and so my guiding
 18 principle, then, as throughout, was to save lives, and
 19 that's why I took the decision that I did. I think the
 20 balance actually was pretty clear.
 21 **Q.** Would you accept that in decisions like this, the harms
 22 due to Covid were prioritised over the harms from other
 23 causes?
 24 **A.** No. That isn't how we operated. Right from early on,
 25 Chris Whitty set out the direct Covid harms, the
 228

1 indirect harms due to Covid, the non-Covid harms, and we
 2 took all of these into account. That was a really
 3 important principle of how we did things.
 4 **Q.** A linked but slightly different question. So going back
 5 to CQC suspending its routine inspection and a question
 6 linked to that. Do you accept that the vacuum of
 7 oversight that was caused by that could and should have
 8 been mitigated by giving a right to visit from an
 9 essential care supporter to each person who was living
 10 a care home?
 11 **A.** I think that is -- when prevalence of the disease was
 12 low, that would be a reasonable option to consider. But
 13 I think the challenge with all of these policy proposals
 14 is you have to set them against the cost of increasing
 15 the likelihood of people dying, and that's what we did.
 16 **Q.** A different issue now about PPE. You covered this
 17 earlier but there's a slightly different question you
 18 haven't been asked. So guidance dated 16 March 2020
 19 advised that the provision of care within the home
 20 should continue as normal essential care. However, you
 21 didn't decide to provide free PPE for extra resident
 22 unpaid carers nationally until 20 January 2021.
 23 **A.** Yeah.
 24 **Q.** Would you accept that the needs of unpaid carers for PPE
 25 should have been met well before this, particularly when
 229

1 Right. Mr Payter.
 2 **Questions from MR PAYTER**
 3 **MR PAYTER:** Mr Hancock, I represent the National Association
 4 of Care and Support Workers, and the topic for you is
 5 the vaccination as a condition of deployment --
 6 **A.** Yes.
 7 **Q.** -- in CQC-registered care homes.
 8 And at paragraph 247 of your Module 6 witness
 9 statement you said that the concerns about the mandatory
 10 vaccination policy raised during the consultation period
 11 "especially about staff leaving these caring professions
 12 did not materialise"?
 13 **A.** Yes.
 14 **Q.** And, indeed, you repeated that evidence in response to
 15 a question from Ms Carey this afternoon.
 16 **A.** Yes.
 17 **Q.** Item 56 on your evidence proposal is a record of a
 18 meeting of the Covid-19 Operations Committee on
 19 31 January 2022.
 20 Could we have INQ000091577, page 6, on the screen
 21 please.
 22 Just while that's being brought up, Mr Hancock, at
 23 that time the government was considering revoking the
 24 policy and associated legislation, which had been in
 25 effect for about two and a half months. And as we'll
 231

1 their essential role in the home was noted as early as
 2 March 2020?
 3 **A.** Well, that is a very, very good question. There were
 4 a number of challenges there. The first is that we
 5 didn't have enough PPE, and you'll know from the whole
 6 PPE module, the extraordinary lengths that we went to to
 7 buy more PPE, and the challenges that that in turn threw
 8 up. So that's the first thing to say.
 9 The second thing is, as per the previous discussion,
 10 defining who is an unpaid carer is hard. I think this
 11 is an area where we could seek recommendations from the
 12 Inquiry for the future because there should be more PPE
 13 more widely available in a future pandemic, and the
 14 concept of a definition of an unpaid carer has been --
 15 is improved. There's been a lot of work done on that
 16 including during the pandemic.
 17 So I think it was a reasonable judgement at the time
 18 but it is an area where we should be better prepared in
 19 future.
 20 **MR STRAW:** And so, if I -- may I do one final question,
 21 my Lady, or is that my time?
 22 **LADY HALLETT:** I think you have had your time, I am sorry,
 23 Mr Straw.
 24 **MR STRAW:** No problem at all.
 25 **LADY HALLETT:** I'm really sorry. Thank you.
 230

1 see on page 6, your successor as Secretary of State, the
 2 Right Honourable Sajid Javid, was recorded as having
 3 said that there was "an estimated 19,000 people who had
 4 lost their jobs as a result of the policy."
 5 And you will know from your own time as Secretary
 6 of State that 19,000 job losses was well within the
 7 predicted estimated range as set out in the legislative
 8 impact assessment. So Mr Hancock, in view of all of
 9 that, do you accept that the concern about the reduction
 10 in workforce capacity as a result of the policy did in
 11 fact materialise as predicted?
 12 **A.** No. This was at the lower end of estimates, and you've
 13 got to put this in the context of around 2.5 million
 14 people who work in the sector. The turnover in the
 15 sector is significantly higher than 19,000. It didn't
 16 have a material impact no.
 17 **Q.** Well, Mr Hancock, the 19,300 figure was the net
 18 reduction in the size of the workforce in the relevant
 19 period and takes into account both normal turnover and
 20 new staff joining and staff leaving. And in
 21 December '21, a survey, undertaken by your former
 22 department, of workers gave the second most likely
 23 reason to leave as the policy. So again, in view of
 24 that evidence, do you accept that it did in fact lead to
 25 a reduction in workforce capacity?
 232

1 **A.** No. The number isn't material in the context of the
 2 normal turnover of a workforce of 2.5 million people,
 3 and you're modelling up gross and net numbers to say
 4 that people left because they chose not to be protected
 5 against harming people in their care, is -- they will
 6 have been -- they will have been hiring to replace them.
 7 So no, it didn't reduce capacity, and the actual number
 8 of people who chose to go down that route was lower than
 9 the central estimate in the impact assessment.

10 So I absolutely stand by the position. In fact,
 11 my -- the lesson from this is that vaccination of
 12 a condition of deployment has a lower impact than we had
 13 feared before bringing it in, and therefore, the
 14 balancing item, the only argument you can make against
 15 it -- the only moral argument, in my view -- is weaker
 16 than we thought at the time.

17 The logical case in favour of vaccination of
 18 a condition of deployment for people in caring
 19 professions is absolutely categorical, stronger than
 20 when I brought that policy in, and is a deeply ethical
 21 and moral policy.

22 **LADY HALLETT:** Thank you, Mr Payter.

23 Mr Burton.

24 Mr Burton is over there.

Questions from MR BURTON KC

233

1 **A.** Yes.
 2 **Q.** And the way the fund worked is that 75% of the grant
 3 that would go to care providers had to be allocated to
 4 specific measures, including paying staff full wages if
 5 they were off work because of self-isolation?
 6 **A.** Yes.
 7 **Q.** But also to ensure that they could employ more staff if
 8 necessary, and indeed limit the use of public transport
 9 by staff, and indeed, if necessary, provide them with
 10 accommodation. That's right, isn't it?
 11 **A.** I will take as read the points of detail, but broadly,
 12 yes.
 13 **Q.** Now, those objectives were discretionary on the part of
 14 the providers, and as early as June 2020, a month after
 15 the fund was set up, UNISON warned the department that
 16 they were worried that providers wouldn't actually use
 17 the fund to pay staff who were self-isolating.
 18 **A.** Yes.
 19 **Q.** Were you aware of that warning?
 20 **A.** Yes, I was aware of both that concern and the concern
 21 that some of the fund hadn't yet reached the providers
 22 from the councils. So the flow-through of the fund from
 23 Treasury to MHCLG, to the councils, then to the
 24 providers, and then to staff, had, frankly, drop-off at
 25 every point.

235

1 **MR BURTON:** Thank you, my Lady.

2 Good afternoon, Mr Hancock. I ask questions on
 3 behalf of the TUC.

4 **A.** Yes.

5 **Q.** The first topic I want to ask you about is financial
 6 support --

7 **A.** Yes.

8 **Q.** -- for people working in the care sector, and in
 9 particular the Adult Social Care Infection Support Fund.

10 **A.** Yes.

11 **Q.** Now I'm going to refer to that as "the fund" if you --

12 **A.** Okay.

13 **Q.** It's true, isn't it, that as a consequence of the
 14 paucity of Statutory Sick Pay and the general insecurity
 15 in low wages in the sector, that a particular problem
 16 was that employees in the care sector stood to lose out
 17 very significantly if they were required to
 18 self-isolate?

19 **A.** Yes.

20 **Q.** And as a consequence, that posed a risk for care workers
 21 properly being tested because of fear they would have to
 22 self-isolate?

23 **A.** A risk. That's a reasonable way of putting it, yes.

24 **Q.** And that was one of reasons the fund was set up, wasn't
 25 it, to address that risk?

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1 **Q.** So there were problems with the flow, but the specific
 2 problem of reluctance on the part of care providers to
 3 use this money to pay individual care workers who
 4 couldn't work because they were self-isolating, were you
 5 aware of that discrete problem?

6 **A.** Well, I didn't personally see evidence that I can recall
 7 now, but I wouldn't be surprised at all.

8 Certainly, you know, in a sector of 2.5 million
 9 people, with tens of thousands of providers, I wouldn't
 10 be surprised at all if some of that flow-through didn't
 11 happen.

12 **Q.** Well, Mr Hancock, the evidence is that by October,
 13 six months -- sorry, four months after that warning,
 14 only 25% of employers were using that money in that
 15 specific way, ie to compensate workers who were
 16 self-isolating. Were you aware of that problem?

17 **A.** I am surprised that the figure was that low.

18 **Q.** You were surprised it was that low?

19 **A.** Yes.

20 **Q.** As in you would have imagined a higher number of
 21 employers to have been doing what they were asked to do
 22 in accordance with the fund?

23 **A.** Yes. Are you saying that only 25% were doing what they
 24 were asked to do -- (overspeaking) --

25 **Q.** Yes, only one in four were using the fund for that

236

1 purpose.

2 **A.** Yeah, not good enough --

3 **Q.** Were you ever made aware of that?

4 **A.** Hmm?

5 **Q.** Were you aware made aware of that?

6 **A.** I may well have been but I don't specifically recall --

7 **Q.** Do you ever remember taking any specific steps to

8 address that?

9 **A.** Well, this comes to the point of levers that we have

10 been talking about all the time. It was not within my

11 direct bailiwick to be able to put those -- put

12 requirements on these funds, because that was a matter

13 for MHCLG in agreement with Treasury. So it all comes

14 back to this problem of -- this problem of governance

15 again.

16 **Q.** Can I just ask you one further question on that, then?

17 Did you ever invite either of those two other

18 departments to stipulate that that money should only

19 ever be made available to a care provider if they did

20 indeed use it to mitigate infection control by ensuring

21 they paid employees their full wages if they had to

22 self-isolate?

23 **A.** I can see where you're going with this. I essentially

24 agree with the thrust of the question. I wouldn't be

25 surprised if I had asked for that to happen. The

237

1 properly, we didn't have to rely on dragging in

2 employees from other departments or other agencies like

3 the CQC, in those circumstances, would you have taken

4 a different view? Would you have recommended that

5 inspections carried on if at all possible?

6 **A.** Well, we still may have needed an adjustment to

7 inspections, because of the fact that the frontline

8 workforce would have been doing unusual -- an unusual

9 array of things. So I'm not categoric about it. But

10 your broader point I agree with, which is that if we

11 hadn't been at fear -- had a fear of the NHS being

12 overwhelmed, then we wouldn't have had to take such

13 drastic decisions.

14 But that of course applies to a number of areas, and

15 it comes the back to the doctrine point at the start,

16 which I've agreed with the TUC representative on before,

17 which is: when a pandemic strikes, you don't have

18 a choice about whether to lock down or not. You have a

19 choice about whether to lock down at a low prevalence,

20 where some of these negative consequences could be

21 mitigated, or at a high prevalence, when you have to act

22 in a way that we had to in this instance. You don't

23 have a choice of not locking down, so you should get on

24 and lock down early.

25 That is the single-most important thing that the

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1 decision would have been outside my departmental

2 purview. It would be a more -- if we had paperwork,

3 I would be happy to go through it, but I -- it was

4 a long time ago now.

5 **Q.** Can I just ask you one final question on a different

6 topic then, which is just about the suspension of

7 routine inspections by the CQC?

8 **A.** Mm-hm.

9 **Q.** You gave effectively, I think, two reasons, in broad

10 terms, for your agreement that those inspections should

11 be suspended.

12 **A.** Yeah.

13 **Q.** One was that there was a risk of tick-box exercises

14 getting in the way of fighting the pandemic, if I can

15 put it that way.

16 **A.** Yeah.

17 **Q.** But the second one was perhaps more important, which was

18 that you wanted to ensure that any medically qualified

19 inspectors were available to be redirected towards, as

20 it were --

21 **A.** The front line.

22 **Q.** -- the front line?

23 **A.** Yes.

24 **Q.** Now if that second reason wasn't necessary, let's

25 imagine a future pandemic where we were prepared

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1 Inquiry and the nation can learn.

2 I fear currently the nation's learning on that is

3 going backwards, and -- but I'm in total agreement with

4 you that the -- the impact on things like CQC

5 inspections, which overall are a good thing, would be

6 lesser if the response was early and robust.

7 **Q.** So in other words, the inspections could have still

8 happened with some modifications if it wasn't necessary

9 to redeploy the staff who would otherwise be carrying

10 them out?

11 **A.** I think it's better to answer that question in the

12 future. In the future I would wish the action at the

13 macro level to happen sooner, and therefore fewer

14 mitigations like pulling staff from CQC to put them into

15 frontline situations would be more avoidable.

16 **LADY HALLETT:** Thank you, Mr Burton.

17 **MR BURTON:** Thank you very much.

18 **LADY HALLETT:** And lastly we have Ms Wilkinson.

19 I appreciate there are a number of matters that the CQC

20 wanted to correct, but don't worry, we don't have to

21 have oral evidence, we can do that another time. So we

22 just have the one last question.

23 Thank you, Ms Wilkinson.

24 **Questions from MS WILKINSON KC**

25 **MS WILKINSON:** Mr Hancock, I ask questions on behalf of the

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1 Care Quality Commission, the independent regulator of
2 health and social care in England, and I'd just like to
3 clarify the one matter in relation to a number of --
4 something you have said on a number of occasions, and
5 most recently at paragraph 39 of your statement for this
6 module, regarding the absence of a list of care home
7 providers.

8 **A.** Yes.

9 **Q.** You understand now, and understood at the time in 2020,
10 that what underpinned CQC's ability to regulate care
11 home providers in England or, to use your phrase earlier
12 this afternoon, what gives it its teeth, is that it is
13 a criminal offence to provide care home services without
14 being registered with CQC, isn't it?

15 **A.** I have looked into this, because the CQC wrote to me,
16 made the letter public, and said that I'd got this
17 wrong. In the letter, they say that there are care
18 settings that aren't regulated by the CQC. That proves
19 my point. I think we're dancing on the head of a pin.
20 There are care settings not regulated by the CQC. Our
21 problem, which I was being -- which I was making clear,
22 and I stand by, is that there was not a list of all
23 these settings. It isn't a criticism of the CQC, but it
24 is a matter of fact.

25 **Q.** I'm going to be precise about the language you used,
241

1 Right, one more time, Ms Wilkinson.
2 Please listen to the question.

3 **MS WILKINSON:** Can you now acknowledge that whatever you
4 were told, by whomever in your department -- and I'm
5 referring to your paragraph 39 -- that it is not correct
6 to say that nobody knew how many care homes were in
7 operation across England, because CQC did know that? It
8 has been publicly available on their website to download
9 since 2012. And indeed CQC took steps to check that
10 your department knew fully of that list as early as
11 25 March 2020. Can you now acknowledge that?

12 **A.** I can tell the Inquiry what I was told. I put it in my
13 statement. I stand by that that is what I was told.

14 There are other points where I've been challenged in
15 terms of the veracity of my evidence and I take it
16 exceptionally seriously, and I take quite a lot of
17 offence at being -- the implication that I haven't
18 stated the facts as I was told them. And that is all
19 I can say.

20 And the CQC have acknowledged, in their letter, the
21 complication around language, and it may be that that's
22 what we're getting caught up on. But all I can do is
23 faithfully and honestly tell you what I was told.

24 **LADY HALLETT:** That was your understanding. Thank you.

25 Thank you, Ms Wilkinson.
243

1 actually, Mr Hancock, because the language you used was
2 "care homes", care home providers and care homes. Not
3 care settings, not unpaid carers, not domiciliary care
4 settings, but care homes and you used that language
5 a number of times, including most recently in your
6 statement for this module, and it's in relation to care
7 home providers that I draw your attention.

8 **A.** Thank you.

9 **Q.** Because it is a criminal offence to provide care home
10 services without being registered with CQC. That is
11 a criminal offence contrary to section 10 of the Health
12 and Social Care Act, and it's in that context in which
13 I point out to you that that must obviously mean that
14 the CQC holds a complete list of all those registered to
15 provide care home services in England.

16 **A.** You see, the challenge I've got is that I have sworn an
17 oath, and I take my oath extremely seriously. And
18 I only will say things that I believe to be true. And
19 this has been true in all the modules --

20 **LADY HALLETT:** I think the fact that Ms Wilkinson is putting
21 to you, if you just forgive me, could you just repeat
22 the question -- (overspeaking) --

23 **MS WILKINSON:** Yes.

24 **A.** No, no, I'm answering the question, my Lady, because --

25 **LADY HALLETT:** Please don't interrupt me, Mr Hancock.
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1 That completes the questions we have for you,
2 Mr Hancock, except one more from me, I'm sorry.

3 **Questions from THE CHAIR**

4 **LADY HALLETT:** It's just going back to one of the first
5 questions Ms Carey asked you and it was -- I was
6 thinking back to the decision to discharge patients from
7 hospital to care homes. You mentioned that there was
8 pressure from NHS England, I think you said, that it was
9 a joint decision, members of the cabinet,
10 Prime Minister, everyone involved. That I totally
11 understand. But I was looking earlier at the decision
12 of the divisional court in Gardner & Harris against you
13 and others -- and that was you as Secretary of State
14 for --

15 **A.** Yes, it wasn't me personally, it was my office, if you
16 like.

17 **LADY HALLETT:** Yes, but it was taken against you as to one
18 of the decisions, which was the discharge decision.
19 Were you involved in that litigation at all?

20 **A.** No.

21 **LADY HALLETT:** It took place after you'd left --

22 **A.** So it was very frustrating, because --

23 **LADY HALLETT:** Just please answer the question. Were you
24 involved in it?

25 **A.** No.

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1 **LADY HALLETT:** You weren't? So you didn't provide
 2 instructions or anything -- (overspeaking) --
 3 **A.** I didn't provide instructions --
 4 **LADY HALLETT:** I don't want to know what they were.
 5 **A.** No, no, but I wasn't given the opportunity to state what
 6 I easily could have stated and I think would have
 7 changed the outcome of that case which is of course
 8 I considered asymptomatic transmission, I was worried
 9 about it from January and if I -- I could have sworn an
 10 affidavit or appeared in court and said that. Nobody
 11 asked me. The finding was that I didn't consider it.
 12 I couldn't believe it when the finding came out, I was
 13 like, "Well, hold on, I was worried about that from
 14 a long time before."
 15 **LADY HALLETT:** I just wanted to give you a chance to answer
 16 it, because obviously it's a decision of the High Court
 17 and I just wanted you to say. So now at least I know.
 18 **THE WITNESS:** Thank you very much for that opportunity.
 19 **LADY HALLETT:** Thank you very much indeed, Mr Hancock.
 20 I expect that is the last time which we'll call you
 21 to give oral evidence. Apparently I'm not allowed to
 22 say it is the last time but I --
 23 **THE WITNESS:** Thank you.
 24 **LADY HALLETT:** -- am feeling pretty confident that it is.
 25 So thank you very much for your help to the Inquiry.

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1 I appreciate it's been a long session today and indeed
 2 long sessions on other occasions, so thank you.
 3 I shall now retire and I shall be back at 10.00
 4 tomorrow morning.
 5 **(4.47 pm)**
 6 **(The hearing adjourned until 10.00 am the following day)**

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