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

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.

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

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 --

A. Yes.
Q. -- there was in relation to adult social care. And you've made it clear that it's the department really, as I understand it, that sets the policy but it's the local authorities that commission the care that's provided, in a simple form; do you agree?
A. Oh, absolutely. That is the -- that is the settlement that's been with us since the foundation of the NHS, because, of course, before 1948, local authorities were also responsible for health provision.
Q. Okay.
A. And that -- this has a series of consequences. But the other thing I'd put right into the top of this, as an issue, is the lack of data and the lack of information. So it's not really just the lack of levers; it's also the lack of information that was a huge problem.
Q. All right. We'll come on to that, as well.
A. Sure.
Q. You said in your statement that the Department of [Health and] Social Care in fact has nominal responsibility. Why is it in name only?
A. Because the policy decisions that are taken by the national government with respect to care and policy towards care, have to be implemented through local government's contractual arrangements, or funding which

went through MHCLG, as the department was called at the time, whichever government department is responsible for local authority funding, where essentially the funding was supplied directly to MHCLG and, through them, to the councils by the Treasury.

So the department has policy decision making, if you like, that has to be cleared across government, but it doesn't then execute that policy. The policy is executed through other arms of the state.

This is a recipe for difficulty in decision making, especially in a crisis.

Q. Right. So when you say we lacked the levers, are you able to help those who are watching, who are perhaps not familiar with that term, what did you actually mean by the department lacking levers?
A. Well, I can give you one example relating to lack of data. We needed to know, as best as we could, for instance, how many people were actually getting tested in care homes once the -- enough tests were available. In order to get data like that and others, we had -- we put a requirement on the funding that -- the extra funding that was given in emergency funding -- that funding would only be available to a care home if they made the data available. That was an innovation in how we created a lever by giving extra funding and requiring

data in return for the funding.

But of course if a care home found it very difficult to get that data back to us, they therefore didn't get the funding. That was a necessary part of the lever, otherwise the lever wouldn't have any traction. But that itself is a difficult position to put a care home in, and often some of the care homes with the most challenges are the ones that also don't have that sort of data in-house.

So there's an example of action we took to try to create levers. If we simply said, from the Department of Health and Social Care, "We want data on [for instance] how many tests you're carrying out, and what the results of those tests are", then we may well get a good reply from a large chunk of the care homes but we wouldn't necessarily be able to -- wouldn't be able to insist or get all of the care homes, or other care providers, domiciliary care, for instance, to follow that requirement.

Q. When did you first realise that the department lacked the levers that you think are necessary?
A. I knew that before I became Secretary of State.
Q. Right. And are you able to answer this sort of rather global question: what would you recommend the government do in future to ensure that it does have the levers to

support care providers if there's a future pandemic?
A. Well, I think there are -- there's a whole series of things that need to happen now. In fact, they needed to happen several years ago. You know, we are three years into this Inquiry and I think the situation has got worse, not better, for when the next pandemic hits.

I would absolutely have a requirement baked into every contract for care provision that allows for requirements to be put in place by central government that are proportionate and medically recommended and so that, in extremis, new requirements that we can't think of now, may be able to be put in place.

Immediately there's a series of concrete things that should happen now. For instance, one of the major, major problems that I'm sure we'll come on to, was the lack of isolation facilities within care homes.
Q. Yes.
A. There should be no care home in the country today that doesn't have isolation facilities. It should be a requirement for the provision of care. Because we don't know when the next pandemic will hit, and when it does hit, it will hit fast, like this one did. And our problem was, the central problem with that, the discharge question, which I know we'll come on to, was that there wasn't isolation facilities in every care

home.

Likewise, every care home should have a legal requirement to have a stock of PPE. We got PPE to care homes, free PPE, pretty quickly in the grand scheme of things, but it was very, very difficult and challenging to do that.

There is -- there is a whole series of recommendations --

Q. -- (overspeaking) -- slightly --

A. -- that we can come to, but the levers question is an extremely good one.

LADY HALLETT: I'm sorry, I've not followed whether you've answered it, Mr Hancock.

THE WITNESS: Okay.

LADY HALLETT: You've talked about the contracts between local authorities and care providers and, as you appreciate, contracts have to be fairly carefully drawn so people know if they're in breach of it or not, and I wasn't quite following what you say should go into such contracts. Are you saying things like you must have isolation facilities and you must have PPE stocks? Is that what you were saying? I wasn't following whether your answer was all together or different factors.

A. My Lady, I apologise for not being clear enough.

Firstly, I think there are a series of requirements that we could set out now that you might consider for your report. That should happen immediately that we can specify, clearly: like isolation facilities, PPE stocks, data on communicable diseases. Personally I would ban staff movement between care homes in good times as well as in pandemics because communicable diseases kill people in care homes all of the time.

And then -- so there's a series of concrete recommendations of policies that can be specified now. But I would also put in place, if you like, an in extremis provision that subject to clinical advice, further measures could be brought in in the event of a pandemic. For instance, visitor restrictions, testing requirements. These are likely to be needed but we can't be certain they'd be needed, depending on the nature of the next novel pathogen, and therefore an ability of the centre to say to care homes "This is what is required" would be valuable, but you, of course, have to have a reasonableness consideration, because you would be not specifying concrete action; you'd be specifying future unknown action.

But that, in a way that second part is less important than the things that we know should be happening in care homes right now, like the universal

provision of isolation facilities and of PPE stock in every care home.

MS CAREY: So from your perspective, Mr Hancock, do you consider that that would require legislation to bring about those changes to contractual requirements? Or is that a regulatory matter? Can you help us as to who it would be in the event that we wanted to recommend that there were such changes to contracts?

A. It's a good question. There would be a number of different ways to do it. Probably the best would be to take a provision in legislation that such measures could be brought in by regulators. That would be, I think, the normal and the best way to do it.

Q. Thank you. All right.

Now, you've mentioned data in one of your early answers.

A. Yeah.

Q. And in your statement you say, "I was extremely concerned about the lack of data we had on social care" and, essentially, you considered some of the data that you had to be inadequate?

A. Absolutely, either inadequate or non-existent, yeah.

Q. Given that the data was inadequate and you were concerned about it, are you able to tell us what you did to try and improve the data that was available to the

Department of Health early on in the pandemic?

A. Yes, so in the first instance, we asked questions. So we simply asked for the information necessary. And we then brought in more and more sophisticated data requirements, both providing the technology for care homes easily to be able to provide data that was required, and then, as I mentioned earlier, to tie the provision of high-quality data to the emergency funding. Some of the emergency funding.

Q. Yes.

A. -- not all of it.

Q. No.

A. Very important that everybody got -- every care facility got some emergency funding, but to an element of the emergency funding. I mean, that was an innovation because we needed to know as much as possible what was going on. And then I suppose the third element was constructing surveys which weren't mandatory, but that almost every care provider leant into the -- providing data into.

Q. Right. I'd like to look at just one aspect of the data with you please.

And could we have up on screen INQ000274068_8. Thank you.

Mr Hancock, this is a WhatsApp exchange between you

and Ms Whately the Minister for Social Care, on 9 April.

Can we highlight, please, on the screen, thank you, from 21.20 down -- this is about data in relation to deaths in care homes.

A. Yeah.

Q. And the minister says:

"I'm afraid [I've] been sent [the] first proper data on care homes deaths just now and it's not good. Speaking to PHE, the CQC, Ros [that's Ros Roughton who was in the Department of Health and Social Care] tomorrow morning about it."

A. Yeah.

Q. You said, "Ok".

Ms Whately says:

[As read] "You're doing a press conference. Care home death data may come up. We expect official ONS data on Tuesday will show a big jump in deaths. Also we now have deaths of residents in care homes but there is some double counting because it includes some people who have died in hospital and non-Covid. It's not that we're not counting, it's that it's complicated. Changes to notifications will give us better data soon."

And she says:

[As read] "We're investigating how Covid outbreaks are occurring, how it's getting in and getting passed

on. PHE has launched research."

And at 3.36 you say:

"Thanks. Do you have a briefing on the deaths data?

"Great."

And she says she's "seen it and discussed it with Ros."

And then it looks like you were probably going to go and do a 5 pm conference that evening because there's a break in the messages.

A. Yeah. Huh!

Q. Can you help us, Mr Hancock, with -- clearly the death data took some time to become available, if we take March as the start of the pandemic, we are five or six weeks or so in. Do you accept that that type of data was essential earlier on to inform the response alongside data on the outbreaks?

A. March wasn't the start of the pandemic; January was the start of the pandemic.

Q. Well, January it started but by the time we were entering the phase when we're thinking about lockdowns, the numbers are rising.

A. Yeah.

Q. If we take March as a rough starting point.

A. We were thinking about -- (overspeaking) -- since the pandemic started in January, it is absolutely crucial

that we -- a point that is really important to recognise, crucial to recognise is that we knew from very early on, from January, that the greatest impact of this virus was on older people. We knew that from the deaths internationally.

Q. Yes.

A. So that is why this point about it didn't -- it just didn't start in March. I mean --

Q. All right. Put that to one side.

A. Yep.

Q. Whenever the pandemic started from your perspective, do you consider that the death data was essential and it would have been better to have had it earlier on?

A. The answer is yes, but I'm also going to unpack it slightly.

Q. Okay.

A. Because the point here in Helen's 3.34 message is really important. There are two problems with the data. One is the quality of data that's being received at the centre. The second is what is actually knowable, because when a lot of, or in a lot of -- when people -- how shall I put it? Working out whether a death was due to Covid-19 or not is not a trivial task, clinically. Chris Whitty is more eloquent on this than I'm being. And therefore, working out what was non-Covid, what was

Covid, and separating out also, you know, was -- if there was a care home resident who went into hospital and died, making sure that that doesn't double count, that's a sort of tractable administrative challenge, but then there's genuine deep clinical challenges which is when somebody who is very frail dies, what they died of is a difficult question.

And therefore there were both tractable and intractable problems with the data. Does that make sense?

Q. Yes, I understand that, and I think the answer to my question was: yes, you would have rather had it earlier on --

A. Yes, of course.

Q. -- but there are various practical reasons why it may not be possible to ascertain in the level of detail what is a death from Covid or a death of Covid. I understand.

A. Death with Covid.

Q. I see.

A. But the answer to your question would it have been better to have data earlier? Yes. The real question now, for the country now, is, will we be in a position to have this sort of data right from the start next time? And I just would also put a note on this in that

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

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

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

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

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

So, yes.

Q. You did have it, all right.

A. No, no, I asked for it.

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

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

You can see it in this exchange. I say:

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

And Helen says:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Q. Right.

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

A. Yes.

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

some detail about that visit or visits?
A. Well, firstly, if I just -- I visited hospitals many, many times over the course of the pandemic, when it was safe to do so, not just once in 2021.
Q. No, but that was the example you gave us in Module 3, which is why I alighted upon it.
A. Right.
Q. So just help us with the care homes, please, Mr Hancock.
A. Yes. Yes, I did.
Q. How many did you visit? Tell us what you saw, tell us how it helped inform your response to the pandemic.
A. So I visited care facilities both virtually and, when it was safe to do so, in person. Remember, visiting restrictions were strong during most of this period in order to protect residents. I visited, for instance, in my constituency engagements, where I had good relations with my -- many of my local care facilities. I'm very happy to provide a list, but you have the documentation that will set out when I did those visits.
I found it vitally important, in a leadership role, to listen to what I heard on the ground. For instance, the importance and the gratitude for the free PPE that we supplied was something that was always brought up with me on a visit to a care home after the first peak. And that's one of the reasons that informs my

recommendation that there should be PPE stocks.
You know, when suddenly there was a requirement for PPE -- and remember that since most care homes are private facilities, purchasing PPE was a private matter that the government didn't really have any input into before the pandemic -- suddenly, we had, we felt, a duty to get PPE to care homes, and we provided it for free.
So I got a lot of positive feedback about that element of what we did, and the other huge amount of support that we put into care homes.
Q. Free PPE I think was provided on 20 July, or that's certainly when you authorised that. Are you able to help with --
A. I'm not sure that's right.
Q. Well, we'll come to the detail when we look at PPE in due course.
A. Sure.
Q. What I wanted to ask was, prior to the rollout of free PPE, did you perform any visits to care homes in March, April, May 2020? Can you recall?
A. Not physically. That would have been totally inappropriate.
Q. No, I prefaced the first question with "[either] in person or virtually".
A. Yeah, I can't remember. I may well have done --

Q. Right, okay.
A. -- but I was also dealing with a national pandemic.
You have to remember the context. I'm also dealing with driving testing, lockdowns, I had Covid myself, obviously the vaccination programme. I was pretty busy.
LADY HALLETT: Mr Hancock, Ms Carey asked you about what you learnt from your visits, either in person or remotely, with care homes. And you mentioned two positive things: provision of free PPE and the support you say that was going into care homes.
Did you learn anything negative about what was going on in care homes?
A. Well, care homes were having a terrible time. I mean --
LADY HALLETT: So what did you learn?
A. I learnt that those on the ground in care homes were working unbelievably hard to try to support their -- those who were in their care, and they were having a torrid time with it. I take that as read. Sorry, I should have -- I absolutely should have -- should acknowledge that. Quite rightly.
I also -- one of the other things that I talked to the care homes I spoke to or visited about was this incredibly difficult challenge of visitor policy. So we knew that when there was spread of Covid in the community, visitors were likely to increase the risk to

care home residents, which could be a fatal risk, but at the same time lack of visiting is incredibly painful and can be damaging, especially to -- for instance, to those with dementia. And you couldn't fail to be moved by the impact of the visitor restrictions.
And there was one point during this period when I was being legally challenged both in favour of more visiting and against visiting at the same time. You know, in a way, visitor policy captures the fact that there were just no good choices in many areas, and it fell to us to try to strike the best balance. So visitor policy was often something I discussed.
As it happens, most care homes, in my recollection, strongly supported the restriction on visitors because they wanted to keep their residents safe, but at the same time, they acknowledged the emotional and potential medical impact of that restriction.
MS CAREY: We have jumped ahead but can I come back --
A. No, but I'm grateful for the opportunity to set that out more broadly than I did in my first answer.
Q. No, not at all, and we'll come back to visitor restrictions. All right?
Can I ask you, please, though to go back to February 2020, please, and the initial response to the pandemic. And you set out in your statement, at

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

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

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

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

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

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

tense, rather than the future tense. It was already clear that we were going to have a major pandemic. And that was -- to me, that was obvious. But what's even more frustrating is it was obvious to the team around me, as well, I mean this is -- this was late February. We were, you know, we'd switched into full pandemic planning mode from the end of January in the Department.
Q. Right. That was -- that can come down, thank you.
That was as at 25 February 2020. The two plans that we've just spoke about that were inadequate were sent to you on 3 March. Ms Whately told you in some WhatsApps that they were inadequate. She said to you that essentially the plans didn't really say very much --
A. Yes.
Q. -- as you've just acknowledged. And in a WhatsApp back to her you said this:
[As read] "Can you possibly put some serious drive into getting them to a credible position? CMO tells me there's guidance to social care being developed and published. It seems to me we need to do a lot of work here."
And she says:
[As read] "Absolutely right, it's taken a week even to get these two example plans in a meeting. You are right, it needs a rocket under it."

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

LADY HALLETT: Can I just ask, sorry if I don't really follow it, PHE was an independent agency but responsible to the Department of Health and Social Care?

A. Through the CMO, yes. And I spoke to the chief executive.

LADY HALLETT: So why doesn't the Secretary of State for Health and Social Care have any levers over PHE?

A. You may very well ask. Because of the behaviour of some of the senior officials. So for instance, when I said in January "I want the serum that we have to be made available to the private sector so they can expand testing", they didn't do it. Right? It's astonishing that we haven't got PHE senior officials at this Inquiry and they've essentially not been asked these questions. It was an enormous --

LADY HALLETT: I'm afraid we have had officials from Public Health England and UKHSA, Mr Hancock, so ...

A. No, the ... These questions have not really been aired. I got so frustrated with PHE I abolished them, right, because they were so poor in their responsiveness. I took responsibility for testing away from them. It is wholly unfathomable to me that they didn't change the advice on asymptomatic transmission even to acknowledge that asymptomatic transmission might happen until April, and as you can see from the -- my exchanges with Helen

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

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

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

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

A. Yes, so eventually --

LADY HALLETT: Couldn't you insist --

A. Yes.

LADY HALLETT: -- and call people in?

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

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

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

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

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

We can see you opened the meeting by stating that:

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

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

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

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

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

testing, vaccines, where we in the Department under my leadership with the CMO, decided to take the action that ought to have been happening or ought to have happened, and grip it.

Q. Right.

A. That's what I --

Q. Yeah, but what did you actually do to grip it?

A. Well, shortly after this we put out further advice.

Q. Yes.

A. We increased the amount of money, and over the next two months we put £5.1 billion in the hands of care homes. We provided free PPE. Obviously, when tests became available, we made them very high in the priority order after hospitals, and made them available for tests -- for staff and residents. We took, for instance, responsibility for visiting policy which normally would have been a local question. We took those decisions at a national level.

Q. Right.

A. And then we got on to, once it became clear that staff movement was the primary issue, we got on to, firstly, advising against staff movement and then trying to get a legal ban on staff movement.

Q. I understand that, and there's number of things you subsequently did --

A. -- (overspeaking) --

Q. But as of 6 March, what I was trying to understand is what did you actually do there and then to grip the problem?

A. We gripped all of those issues in time. The central point about this, what I mean by "need to be gripped" is we need to take responsibility. I don't care that it's not our legal responsibility. And actually I don't care if people get upset about it. You know, one of the -- we've seen -- even from this very chair -- people who were upset about me taking action that was necessary. I ruffled some feathers, they were rude about me at the time, they've been rude about me since, but it saved lives, and that was my duty as Secretary of State.

Q. Can we come back to the document.

A. That's what it says.

Q. Can we come back to the document, please, and look at the fourth bullet point down:

"[Secretary of State] flagged the most contentious item in the Bill [which I assume is the Coronavirus Bill] is to raise the threshold for giving care. It's a very complicated set of problems."

Are you able to briefly explain to us today what it was that was being proposed --

A. Yes.

Q. -- in relation to raising the threshold for giving care?

A. Yes, so this a question about a measure in the Bill, the Coronavirus Bill, to say that care should not be given for those who are -- who there is a judgment that ...

It's a measure in the Bill that says -- essentially for rationing care. We did not execute this measure. It's very important to state that. And it was against policy to either -- have do not resuscitate orders without proper and due consent, and there was pressure, for instance from the BMA, to have national rules on restricting care and raising the threshold for giving care. So the doctors unions were pushing for that. I refused to do that. And Chris Whitty and I on this were absolutely as one, which is the best place to decide on the appropriate care is the doctor by the bedside, not a national policy, despite the significant pressure we came under to put that policy in place.

Q. All right, thank you.

Can we move down the page, please, to the entry beginning:

"DCMO [Jenny Harries] flagged that the majority of the people that we're talking about are receiving domiciliary care too. [Secretary of State] agreed that we would be thinking about this in the following hierarchy: residential home, nursing home, domiciliary

care."

Can I ask you, what did you mean when you said "in the following hierarchy"? Why was there a need for a hierarchy, Mr Hancock?

A. Well, the -- I don't know what the specifically what "this", the word "this" is referring to here. If it's, for instance, referring to provision of PPE, then it's reasonable that you might understand the order in which life saving support is needed, but I don't know specifically what it is, what this is -- which particular area of policy this is referring to.

Q. So I understand that, I want to be clear, you can't remember now, at this remove, what the "this" is referring to; is that correct?

A. No, I can't --

Q. It might be PPE --

A. It may be. I don't know.

Q. Right. But just thinking about the actual hierarchy itself, can you help now with why residential homes came before nursing homes?

A. No, I think -- any -- any hierarchy like that, I would take clinical advice on. So, for instance, the hierarchy of who got vaccines first, care homes were right at the top of that. Who got PPE first in the -- who got testing first. In the case of those two,

hospitals were at the top of the clinical hierarchy. But this would -- any question like that would be based on the evidence and I based it on clinical advice.

Q. All right.

On any view, given the number of people in receipt and indeed providing domiciliary care, can you help now with why domiciliary care is at the bottom of the hierarchy?

A. Well, it depends what we were talking about. So it's impossible to say with precision, but, for instance, if it is about the provision of PPE, then that may well have been my clinical advice, that the order in which PPE protects most may well be that order. But I can't -- but we don't know what "this" is referring to. It's certainly not that I thought of these three elements of care services in a rank order in that way. It depends specifically what the note is referring to.

Q. A little lower down the page:

"There was a discussion on workforce, with DCMO [Jenny Harries] flagging workforce shortages and noting the majority of nursing home staff are not clinical."

A. Yeah.

Q. And she "flagged the risk of double counting capacity". So she's putting out there on 6 March the problems with the workforce.

Then can I ask, please, that we go over the page to the bullet point, second bullet point:

"[Secretary of State] summarised there is work to be done and issues to solve on 10" --

A. Ten work areas.

Q. -- "10 different areas ..."

Workforce being one of them, financial support, excess deaths, data, support for non-Covid illnesses, equipment, local resilience forum readiness, collaboration, comms and the Bill.

"Noting the big question is if we have got enough of a team or a system in place to be able to do everything we can ..."

Were you concerned that, as at 6 March, there wasn't enough people dealing with the adult social care response within the Department of Health and Social Care?

A. Yes, of course. We were unbelievably stretched in all areas. And I'm summarising here work needed on -- in ten different areas, in many of which -- in many of which we would not have had, as a department, a locus on in normal times. You know, financial support is not something that the Department of Health and Social Care would lead on in normal times. And so yes, of course, it was enormous pressure. What you can see is me

driving the system, because we were essentially taking responsibility from around 50 local authorities that were nominally and formally and legally responsible for this area and we were taking it on our shoulders to try to fix these problems.

Q. Can you help me with why one of the areas that is not mentioned -- why isn't IPC mentioned in there, Mr Hancock?

A. I don't know.

Q. Was IPC on the radar at that stage as being a way of --

A. Yes, it is. It's -- PPE is mentioned.

Q. Well, PPE is a form of --

A. PPE is one element.

Q. Yeah.

A. Yes. I don't know. It may well have been, and it depends whether it was not -- it was definitely on the radar, absolute hundred per cent.

Q. So there we were as at 6 March 2020, and can I ask you, please, about a follow-up meeting on 11 March.

And can we go to INQ000328131.

This was a "Social Care/Coronavirus meeting".

Thank you very much.

Ros Roughton is flagging the importance of engagement with the sector. There are three pieces of guidance that in fact came out on 13 March, and clearly

they were being discussed.

And the bullet point starting just below that:

"[Secretary of State] asked about providers paying staff if they are ill ..."

A. Yes.

Q. "... and asked to self-isolate in order to disincentivise staff with milder conditions going to work with older people."

A. Yeah.

Q. I'd just like to have your explanation, please, of what it was you were worried about and why you were asking about disincentivising staff with milder conditions from going to work?

A. So in a way this is an early indication of what became the staff movement restriction issue. The -- it was clear to me that if staff are ill, then they shouldn't be going to work. However, in this country, sickness pay is absurdly low, and many people find it difficult not to go to work because of the ridiculously low levels of sick pay, and that leads to disease spreading in the workplace.

If you work in a care home, of course, that leads to disease spreading to some of the most vulnerable people in the country. This happens every winter with flu and people die unnecessarily because of it.

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

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

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

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

A. Yeah, that didn't get anywhere.

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

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

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

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

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

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

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

A. No.

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

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

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

insisted on the policy?

A. Yes.

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

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

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

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

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

decision that could have been taken at the time.

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

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

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

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

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

A. Yes.

Q. -- departmental meetings --

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

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

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

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

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

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

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

Q. Right.

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

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

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

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

A. Yes.

Q. Eye-watering numbers on any view?

A. Yes.

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

Can we have on screen INQ000325232.

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

A. Right.

Q. And the question is:

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

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

issue in any event.

A. Yeah.

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

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

A. Yeah.

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

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

A. No, no, it's not.

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

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

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

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

Q. Right.

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

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

adult social care staff.
Q. Right. So there is an acknowledgement by you that expedited discharges would increase the pressure on an already constrained workforce?
A. Yes, that's a very reasonable way of putting it.
Q. A number of options are set out there. There was extending free care to speed up the discharge. There was removing the continuing healthcare assessment. There was rolling out capacity trackers. Greater use of the independent sector and the use of live-in carers.
A. Yeah.
Q. So they were all options that were being considered around the time of the discharge decision.
A. Yeah.
Q. And I think in due course, can I invite us, please, to look at page 2 of the document. There's, under the section dealing with joint arrangements, Mr Hancock can you see the underlined section:

"To note: We need a clinical decision on whether this is the right thing to do. The policy implies that emptying the hospital is more important than protecting residential or domiciliary care capacity to support people currently in the community. We would need this to be taken on a clinical basis."

A. Yes.

Q. And did you see that comment on whether this was the right thing to do?
A. Of course. This was something that was, as you said earlier, it was a question of what is the least worst solution to this terrible problem. And the clinical advice was obviously a critical part of the policy making.
Q. Do you agree that the policy implies to some that it does look like that the emptying of hospitals and freeing up NHS capacity is more important than the impact that it had on the care sector?
A. What I care about here is the substance. The substance at the time is that I can't find a better least bad -- a less bad solution than the one we went ahead with. Then the consideration for the future is about the preparation that's needed now to avoid exactly this sort of impossible choice.
Q. And so we come to 17 March, when the NHS England letter goes out to health boards, trusts, et cetera, saying, "Please start the discharge."

As at 17 March 2020, do you agree that there was not enough testing capacity to test all patients being discharged?
A. Absolutely, yes.
Q. You've told us that you were worried about asymptomatic

transmission --
A. Yes.
Q. -- but there was no scientific agreement about the extent to which it was a problem?
A. That's correct.
Q. As at 17 March do you agree that there was not enough PPE in care homes at that stage?
A. It depends what you mean by "not enough". There were definitely -- we definitely would have wanted more, and we were pushing very hard to get more. And that was a major issue, yes.
Q. Do you agree that at 17 March IPC training had not yet been rolled out to the care homes to help them with donning and doffing, and the like?
A. That was needed, it was absolutely needed, yeah, as part of this package.
Q. And the guidance that accompanied the discharge did not advise the care home to isolate any patient being discharged from hospital, did it?
A. That was -- that is absolutely true, and that comes back to this clinical advice that -- on asymptomatic transmission that we've covered in other modules, and the emphatic advice from PHE, backed by the World Health Organization, until April that we should plan on the basis of no asymptomatic transmission. That was

a mistake. It was a mistake I challenged at the time, but as a non-clinician it was not a mistake I could overrule.
Q. Right, and as at this time, staff movement as between care homes is not banned or even advised against?
A. No, at this point, because of the lack of understanding around asymptomatic transmission, consideration had not yet been given to banning staff movement, and we came to that later.
Q. Right. So taking all of those factors into account can you help then, against that background, how people in care homes were to be protected as at 17 March?
A. Well, at that point, the best thing that could have happened to somebody leaving hospital would be to treat them as if they had Covid, and to isolate them as such. Those sorts of facilities were not universally available, though.
Q. Do you think it was an error now to not have directed that all untested patients should have been isolated when they were transferred to a care home?
A. With hindsight, that is absolutely right. At the time, with the clinical advice on asymptomatic transmission, that is not what was clinically recommended. But absolutely.
Q. We know that in due course you gave a daily press

conference, on 15 May, which included you saying:

"Right from the start we've tried to throw protective ring around our care homes. We set out our first advice in February, and as the virus grew, we strengthened it throughout."

And you went on to set out the measures that you say the government had taken, and you said again:

"From the start, we've worked incredibly hard to throw that protective ring around our care homes. Yes, it has been difficult. These viruses reserve their full cruelty for those who are physically weakest, the elderly, the frail, and the already sick."

Now I appreciate, Mr Hancock, that you've already acknowledged that, notwithstanding all the measures, there was no unbroken circle, to use the phrase that was put to you in Module 2.

A. Yeah.

Q. But can I ask you why, as at 15 March, was it suggested that there was a protective ring, given all of the absence of things that we've just looked at?

A. Well, we've also been looking at all of the things that we did do. So by 15 March, we'd brought in 88 separate measures, including over £5 billion of funding, and testing by that stage available to all staff and residents. We've discussed the free PPE. We had

brought in advice and support, we'd given a clinical lead for each care home. There were a whole series of measures that we had brought in.

I would stress, you know, in that piece of rhetoric, that what I said is that we had tried. It was not possible to protect as much as I would have wanted. And that is the central task of the Inquiry: to work out what we can do right now -- frankly, what should have already been happening in care homes -- because there has not been enough action to prepare for the unknown date, which could be tomorrow, when we will get the next deadly pathogen. And in fact the national debate on this has gone backwards, with prominent people saying that even the actions that we did take were a mistake. So it is a -- it is urgent now that this action is taken for the future, but I hope that's my explanation of why I used those particular words based on the substance at the time.

LADY HALLETT: Could we just rewind for a second.

Ms Carey very carefully asked you the question, focusing as at March, what was the protective ring, and you mentioned, for example, PPE. I thought Ms Carey told me earlier that that wasn't available until 20 July. So could --

A. No, that's not right. In March we made the first

actions to start to get free PPE at care homes.

MS CAREY: Yes, in March I think there was a drop that resulted in about 300 face masks going to each care home, Mr Hancock. So on any view that's not going to last particularly long, is it?

A. I don't think it's appropriate to belittle the efforts that started in March. There was a huge amount of work to get free PPE out to care homes, and it started in March, and it grew over time. But I don't think -- I don't think laughing at that is appropriate.

Q. I'm not belittling it --

A. Well --

LADY HALLETT: If anybody laughs at any evidence, Mr Hancock, I'll be the one to direct them, thank you very much.

MS CAREY: Her Ladyship's question though was, if you look at the position as at 17 March, what was the protection provided to care homes as at the date the letter went out saying to discharge anyone who is medically fit?

A. Well, at that point we were starting the work of getting the PPE out. Remember that PPE was the responsibility of care homes themselves before the pandemic. We come back to the 6 March meeting when I said we needed to grip this, ie the department needed to take responsibility. It was from then that we got going on

ensuring a supply of PPE, which started, I -- you know, you have -- which started with as much as we could get our hands on, and grew over time.

Q. So it may be me. I'm just trying to understand, if we don't have testing, there is an inadequacy of PPE, you can't isolate, and the advice doesn't say isolate, you're not banning staff, what was the protection for the care homes, Mr Hancock?

A. The question we faced was what is the best policy --

Q. That's not what I asked you.

A. It may not be what you asked but it was the question that was valid at the time. You see, if you take these questions out of the context then you are not asking the real question that we faced. The protection at the time was clearly not as much as we would have liked. But the alternatives were even worse.

Q. Now, you say it was not as much as we would have liked, but what was it? That's what I'm trying to understand.

A. Well, we started the flow of free PPE. We were testing those with symptoms, we were not testing asymptomatically because of the clinical advice and the shortage of tests, the expansion of testing, which we were in the middle of, which we expanded rapidly in the days following that announcement. And in particular, over the month of April. We were -- these were all the

protections that we were putting in place.

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

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

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

situation was at the time.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

homes reporting an outbreak.
A. Yeah.
Q. Were you aware of this data at the time you said in the press conference that there was the protective ring?
A. Of course I was aware of it. Of course I was aware of it. I was the Secretary -- are you -- it's very strange, this questioning. I was the Secretary of State. I had taken personal responsibility for this area, despite not having the formal accountability for it. At the same time, on the same day, we had the announcement of a further funding allocation. So yes, of course I was aware of it. And the action that I and the team were taking, and Helen Whately and Ros and everybody else in the department, was to try to save as many lives as possible.

And perfectly reasonable for you to question the exact words that I used, but what I care about is the substance of what we did, the protections that we put in place, and most importantly, what we can do in the future to ensure that the options available are better than they were last time.
Q. All right. Finally this, please, on this topic: do you think a member of the public or indeed people running care homes would interpret what you said as a piece of rhetoric?

A. Yes, I think largely people in -- running care homes would understand that what I was trying to say was that we have put in -- we have tried to put in a huge amount of support. That was the -- that's the lived experience I have from talking to people in care homes.

You know, there may be campaign groups and politically-motivated bodies that say other things. What I care about, though, is the substance. And frankly, that's what this Inquiry should care about after all the millions of pounds that have been spent on it.
LADY HALLETT: And I can assure you, Mr Hancock, it is what I care about.

On that note, we'll come back at 11.45.
MS CAREY: Thank you, my Lady.
(11.28 am)

(A short break)

(11.47 am)
LADY HALLETT: Ms Carey.
MS CAREY: Thank you, my Lady.

Mr Hancock, I'd like to finish with a few questions more about the hospital discharge policy and then I'd like to move on to staff movement and attempts to restrict staff movement, all right?
A. Yeah.

Q. So can we just look at perhaps some of the guidance that touched on the discharge policy. Clearly there was the policy that came out on 17 March. There was guidance on 19 March. There was updated and admissions guidance on 2 April.

And can I have up on screen, please, INQ000325255_0005.

This was the admissions guidance as at 2 April. Again, as with the PHE guidance that we looked at from 25 February, you can see, when it's dealing with admissions of residents, reference there to:

"The care sector looks after many of the most vulnerable people in our society ... As part of the national effort, the care sector also plays a vital role in accepting patients as they are discharged from hospital -- both because recuperation is better in non-acute settings, and because hospitals need to have enough beds to treat acutely sick patients. Residents may also be admitted to a care home from a home setting. Some of these patients may have [Covid], whether symptomatic or asymptomatic. All of these patients can be safely cared for in a care home if this guidance is followed."

Now, do you remember seeing this piece of guidance, Mr Hancock?

A. I was not closely involved in writing it, but it was signed off by the department.
Q. Right. Did you think, as at 2 April, all patients discharged, whether symptomatic or asymptomatic, could safely be cared for in a care home if the guidance was followed?
A. Well, that was based on the best clinical advice. I can't recall exactly how I felt about it at that time, whilst this was -- this was developed, this guidance, whilst I myself was at home with Covid.
Q. Right. It was before, so that you recall, a change in testing pre-discharge which came on 15 April?
A. That's right, and it was published, I think, on the 2nd. I think it was published the day before the CDC changed the international advice on asymptomatic testing and when -- and the changes, and that finally got PHE to change on that position.
Q. Right. What I wanted to ask you about was some questions about some developments between 2 April guidance that we've got on screen and the 15 April action plan when there was the change to the testing --
A. Correct.
Q. -- at pre-discharge. All right, so can we just think about that period of time, please.
A. Yeah.

Q. And if it may help you, Mr Hancock, if we have up on screen, please, some WhatsApps that you had with Helen Whately.

And if we have up INQ000475068 on screen and there are number of different topics that are in this WhatsApp but I just want to try to look at the ones that impinge on the discharge policy.

And at 10.16 can we see there a message from Helen Whately?

A. Yeah.

Q. "The discharge policy [is] my biggest concern."

She says:

"That's an argument with Simon ..."

Presumably Simon Stevens?

A. Yeah.

Q. "... clearly.

"Dom's [Dom Cummings] asks for some more detail on testing and PPE" --

A. Not necessarily. That may be Dom Raab.

Q. Right, thank you. Either one of them --

A. I think it will have been Dom Raab, because I think Dom Cummings was away at this point.

Q. All right. So possibly Mr Raab asks -- his asks are:

"... for more detail on testing and PPE ..."

They are:

"... the same as [hers] have been for the last few days."

A. Yes.

Q. "No one sems able to give it!"

Then the thread picks up again, in fact, later that evening, at 21.56.

So could we go to page 2, please.

A. Right.

Q. And it's not that I'm deliberately skipping over something, but different topics crop up in the WhatsApp.

A. Yeah.

Q. But to return to the discharge policy, there we are now at 9.45 in the evening.

A. Yeah.

Q. You saying to Helen Whately:

"Have you agreed a discharge policy with NHSE?"

And Helen says:

"Nhs won't keep them in an Nhs setting if fit for discharge. We can't force care homes to take them if covid infection risk -- however, some may have isolation/covid positive zone so can...and if not, we advise local authorities to secure appropriate 'alternative care arrangements', eg an [local authority]-commissioned isolation facility."

And a little bit -- you say:

"That sounds messy."

Now, are you able just to give us an overview of what is the argument or disagreement or concern, as at 13 April, in the run-up to the publication of the action plan?

A. Well, at this point, of course, the assumption, the clinical assumption around asymptomatic transmission had changed, and therefore I am concerned that advising local authorities to secure appropriate alternative care arrangements is going to be complicated. My recollection is that Helen was pushing for the NHS setting aside certain NHS settings, because by now the numbers in hospital, we'd got some further -- we'd got the Nightingales up and running so there was more capacity, I think.

The -- Helen was driving for the NHS to keep people in an NHS setting and the NHS were not accepting that. And so clearly, a policy compromise had been made, which is advising local authorities to secure appropriate alternative care -- (overspeaking) --

Q. So can I see if I've understood this correctly. The argument really is before discharge should they be quarantined in the NHS, in a hospital estate, or should they be quarantined post-discharge in a care home? Is that the two competing sides?

A. Well, really the question is where to quarantine people.

Q. Yes, where?

A. Yes.

Q. In hospital or --

A. Nobody thought that it was a good idea to keep them in a standard general hospital setting. Right?

Q. Right. I follow you.

A. But would there be NHS, other NHS settings? For instance, earlier in the pandemic we'd used NHS nurses' facilities.

Q. Right.

A. But, you know, the question is: where do you isolate people?

Q. Right.

A. Hence my recommendation now that every care home needs to have isolation facilities.

Q. Right. We'll come back to that.

A. So this is the policy row that's going on between Helen, essentially between Helen and Simon Stevens, and you'll have to ask Helen about the details of it. Because Helen is so competent and such a good minister, I was -- I delegated a lot of responsibility to her because she was highly competent.

Q. All right. Thank you.

Now, if we just go on, that helps us contextualise

the two sides of the debate, if you like.
A. Yeah.
Q. Can we go to 14 April and page 3 of --
A. Hold on, hold on, can we just stick on this one because, actually, the remainder of this page is also extremely important in this context.
Q. Yes.
A. Firstly:
"Who is speaking for NHSE here?"
Answer, Ian Dodge, and Ian Dodge, in my experience, never did anything without Simon Stevens' sign off. And then I say:
"Can you please write your preferred language into the document taking into account genuine NHS concerns and we will take that forward."
So my instruction was that Helen should take into account genuine NHS concerns, but obviously I knew she was also deeply concerned about the care sector because that was her primary responsibility, and then I said, "And we will take that forward."
I also know that at the same time, that evening, I was having a text exchange with Simon Stevens when he came to me at said, "This isn't agreed, I'd agreed some policies with Ros, and Ros said she would handle Helen Whately."

And that implies that they thought they could present an answer to Helen, she's clearly unhappy with the answer, and I am backing Helen.
Q. Right.
A. And then there was a -- I was also working on a whole load of other things, and when we came back to it in the end, we did not have the text that Helen had signed off. It was a messy battle.
Q. Right. So there is Helen at this stage, as I understand it, advocating for the quarantining to take place perhaps not in a hospital but under the umbrella of the NHS, and --
A. Correct.
Q. -- the NHS are saying that they don't want that, there are the machinations behind the scenes that you've just spoken of.
A. Yeah.
Q. Can I turn to 14 April, please, to round off this exchange.
A. Yeah.
Q. Because by 10 o'clock the next morning, if we see there the message at 10:10:07 from Helen Whately, she says:
"For discharges -- I concluded last night it does make sense for [local authorities] to have responsibility for people who don't need to be in

hospital but do need to be in -- do need to be quarantined."
A. Yeah.
Q. "My understanding is [that the] LGA and ADASS agree (& NHS clearly). Can be funded out of the £1.3 billion that went to NHS for discharges. The question is one of how they do it, eg by commissioning a specific care home for the area, or hotel accommodation ... Some are already doing this."
She says:
"I realise you may disagree and want to revert to NHS."
And then you say at 11.27:
"I'm very happy for it to be via [the local authorities]."
A. And then I say, I obviously consider it for seven and a half minutes, and then say:
"Best to include in the wording on discharge: 'as agreed locally between the NHS and local authorities'."
Q. Yes.
A. Ie, I'm trying to get to a joint position.
Q. Right, so --
A. But in the -- anybody who has worked in this area knows that the communication and the co-working between the NHS and local authorities, in terms of discharge, in all

normal times, it is extremely difficult. In some areas it works well; in other areas it works badly. It is a very, very complicated intersection. And anybody who has had a family member, maybe a parent who has had to go from hospital into a local authority setting, knows that getting the funding package for that is a real nightmare. So this is a standard problem in a much, much, much worse context.
Q. All right. But what I wanted to ask you, Mr Hancock, was when you said, "I'm very happy for it to be via the local authorities", why did you plump for that side of the coin as opposed for it to be being quarantining on the NHS side of the coin?
A. Because I'm taking Helen's advice. So my two key people here are Helen and Simon Stevens, and Helen obviously advised by Ros. Helen has overnight, essentially, considered the NHS option further, as I'd asked her to do on the previous page. I'd said, "Write into the document what you want, taking into account the NHS's real world concerns." She had then -- she has then come back to me the next morning to say, she says, "I've concluded last night that it does make sense for local authorities."
So in my view, if she's come to that view, essentially representing internally the view of the care

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

Q. All right, okay.

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

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

A. Yes.

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

A. Right.

Q. So that's where we get to.

A. Yes.

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

A. If that had been available, yes.

Q. Right.

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

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

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

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

A. Yes.

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

A. Yes, that's correct, yes.

Q. All right.

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

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

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

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

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

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

A. Yes.

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

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

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

Q. Right.

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

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

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

A. Yeah.

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

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

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

back in March 2020 was to buy capacity from the independent sector?
A. Yes.
Q. The private hospitals?
A. Yes.
Q. And, indeed, you will know from Module 3 and your experience, there was the three-month pause on elective surgery --
A. Yes.
Q. -- to free up bed capacity?
A. Yes.
Q. I think somewhere around 20,000 to 30,000 beds potentially freed up.

Do you think it was possible to have delayed the expedited discharges until such time as 15 April, when testing was available, by using the spare beds that had come from cessation of elective care or the spare beds that had been bought from the private sector?
A. No. It would have been better if that had been a credible option but it wasn't.
Q. Can you help us with why?
A. Yes, the reason is very straightforward, unfortunately, and clear in the data, which is that we ran out of NHS capacity. We used -- if we hadn't built the Nightingales, we would have had hundreds of people

without the ability to be treated. The -- or the Nightingale, the ExCeL London Nightingale Hospital.

We -- the -- even having taken the policy of discharge, we still didn't have enough NHS capacity. So it's just a matter of fact that the NHS became full, and thankfully we had the Nightingale capacity. Not nearly all of the Nightingale capacity was used but some was, and that -- which demonstrates that there wasn't -- there wasn't that spare capacity, even having done the discharges.
Q. Right. Of course, a number of people discharged from hospital were discharged back to their own homes?
A. Yes, in fact far more than went to care homes, yes.
Q. Yes. Did you consider the impact on the reduction of access to care, and the early discharge of patients on those and their family carers who were doing their best to try to look after their loved ones?
A. Yes.
Q. Can you help us, please, with what was done to provide support to the unpaid carers that were looking after people that went back to their own homes?
A. Yes, so the primary response to that problem was the shielding programme.
Q. Right.
A. And we've considered that in other modules. I regard it

as one of the big successes. It was designed by -- essentially by Jenny Harries at a clinical level, and it was a -- and then others, including from the private sector, came in to make it work.
Q. You've set out in your statement your overall reflections on the appropriateness of the discharge policy. And does it come to this, Mr Hancock: there was no good decision from your perspective, and you consider that the hospital discharge policy to be the least worst decision?
A. Yes.
Q. All right.

You say in your statement -- can I have up on screen, please, 0030 of Mr Hancock's statement, and paragraph 129. Yes, thank you very much.

I want to look at the practical effect or otherwise of the discharge policy, and you say in your statement there:

"A widespread concern was that patients who were being discharged from hospital were the main source of infection in care homes. I understand why many held this view, however we now know this was not the case."
A. Yeah.
Q. "We learned in the summer of 2020 that staff movement between care homes was the main source of transmission.

As I will later discuss, we acted on this and [we] asked for urgent work to be undertaken to restrict such movements."

We're going to look at staff movement in a moment, but your reference there to learning in the summer 2020, can you help us now with what study or research or report it was that that sentence is based on?
A. Well, as we've seen in discussion this morning so far, we were worried about issues relating to staff from March, and the -- a number of different pieces of evidence were brought to bear. And ultimately, it was a PHE -- it came from PHE that staff movement was likely the main source of transmission.

Once you have taken the position that asymptomatic transmission is significant, then it becomes more intuitive that staff movement, and indeed visitors, are likely to be the main source of infection, simply because there are far, far more entries into a care home by members of staff than by residents.

You know, residents --
Q. So your recollection is it was a PHE study that is essentially being referred to when you say, "We learned in the summer of 2020"?
A. Yes, the reason I've phrased it like that is because I don't know the precise source of where that became --

where that insight came from.
Q. Right.
A. I know that it wasn't my insight. What I know is that once I saw that that was -- once I saw that evidence, I seized on it and tried to change policy on the basis of it, and that carried on for the next year --
Q. Were you --
A. -- the rest of the year.
But, you know, sometimes -- anyway, I don't know where it came from exactly, but somebody spotted this issue.
Q. All right, let me see if this helps you at all, and please say if it doesn't. Were you aware of the findings of the Vivaldi Study that started to emerge in June of 2020?
A. Well, Vivaldi was one source of this, but I wouldn't stress the Vivaldi Study. SAGE, for instance, considered a very wide range of scientific advice in this space and -- including but not limited to Vivaldi.
Q. If given some time, would you be able to find the PHE study that you're referring to in the summer of 2020?
A. I'm very happy to write to the Inquiry with more detail if I can find it.
Q. Please do. I ask you that because we're aware of

a study that they did in July 2021 --
A. Oh sure, yeah.
Q. -- which is a long time after this --
A. Yeah, I know the 2021 study, and -- but that is obviously an -- analytical and backward looking. What I can't remember is who came up with the idea -- the point that staff movement is likely to be a problem and therefore we needed to do something about it. What I remember is that, you know, once that penny dropped we got onto it.
Q. Can I ask you this: you say there that "We learned in the summer of 2020 staff movement was the main source of transmission" --
A. Yes.
Q. -- Vivaldi says it was a source of transmission, not the main source of transmission. Are you able to help us now with what it was that led you to believe it was "the main source" of transmission as opposed to "a source"?
A. Well, the -- as I said, I'll have to write to you with that exactly. We know it's the main source from all the scientific work that's been done since. I would not put the stress on Vivaldi as a sole source of truth on this. It was helpful but not the only piece of scientific work in this space.
Q. All right. There have been subsequently a number of

studies, a PHE report from July 2021.
A. Yeah.
Q. A consensus statement in May 2022, but can I just, before we have to descend to the detail, if we do, I take it you are not suggesting that the discharges did not cause some infections in care homes?
A. Of course. The word "main", it's critical here. You know, the 2021 PHE study suggests that the percentage is under 2%.
Q. Yes.
A. You know, it -- you want that down to zero, right?
Q. -- (overspeaking) --
A. You want to get it down zero. The aim here is to -- as much protection as possible.
Q. Of course. Let me call up the PHE study so that everyone else knows what we are talking about, INQ000234332, page 3. This is a PHE report dated July 2021. I think, in fact, you had resigned on 26 June 2021, but here's the published report. And as you say, PHE set out there that in fact it was 1.6% of outbreaks of the tests that they had conducted that were identified as potentially seeded from hospital-associated Covid-19 infection, with 804 care homes -- sorry, 804 care home residents with confirmed infection associated with these outbreaks.

"The majority of these potentially hospital-seeded outbreaks were identified in March to mid-April 2020, with none identified from the end of July until September where a few recent cases have emerged."
So you're right, the PHE data is suggesting a small proportion of patients discharged from hospital accounted for care home outbreaks, but do we not have to factor into that, Mr Hancock, that there was limited testing up until 15 April?
A. Yes, but there was also limited testing from everywhere, so that applied -- the limited testing applied across the board so it doesn't invalidate this finding. My point here is not -- I don't have any additional scientific input into this question. It's an important question. I have -- what I'm stating in my -- in my witness statement is based on the best scientific evident available. What is the assessment here? In a way, my policy point, and that what matters now, is that staff movement is a major issue for a novel pathogen, especially one where there's asymptomatic transmission.
And indeed, some say that since care home workers sometimes are also bank workers in hospitals, then you should take that into consideration, because there's potential spread there too, as well, in the ban on

working in multiple places that I recommended. So, you know, it's a -- that's the point.

Q. Can I just ask you, before we leave this page, clearly the conclusion in the exec summary is:

"The findings of this report suggest hospital associated seeding accounted for a small proportion of all care home outbreaks. Policies on systematic testing prior to hospital discharge for patients discharged to care homes, and where a test result was still awaiting, the patient would be discharged and pending the result, isolated ... were introduced on 15 April ... This may have supported the decline seen in these ... outbreaks contributing to an overall reduction in care home cases."

A. Yeah.

Q. So that essentially is supporting the need for pre-discharge testing, would you agree?

A. Absolutely, but you've got to remember there were no tests.

Q. No.

A. Yeah.

Q. No. The absence of tests, though, in March to mid-April, do you agree does make it difficult to reliably assess the extent to which the discharges caused infections in care homes?

A. It makes -- yes, absolutely. It makes it difficult to assess all of these things. You know, we were working in an environment of low and unreliable data. Of course we were. Hence why the acceleration of testing capacity was so important, which, you know, we were doing at the same time. So yes, that -- all these things were true.

You know, in fact, even in this study, 1.6 is what was measured in this report, but that is -- it does seem to me, you know, a spurious level of accuracy, the .6, but, you know, what it's saying is it's relatively low in this report. What -- the policy consequence of this is to ask where is the 98% coming from? But also at a human level, 1.6 is still too high, right? It may only still be 1.6% but if the impact of that is that one of your relatives dies in a care home, as one of mine did, it matters.

Q. That's why I want to come on to staff movement between care homes, please.

A number of the documents that we have looked at, indeed, that you will have seen, Mr Hancock, comment on the unintentional infections caused by staff movement and indeed, the CMO's technical report, as I think you are aware, and indeed you quoted it in your statement, makes the point that:

[As read] "The majority of outbreaks were introduced

unintentionally by staff members living in the wider community. Interventions to mitigate this through asymptomatic testing and the avoidance of cross-deployment were only partially successful at times of high community prevalence."

A. Yes.

Q. That's what the four CMOs wrote up.

A. Yes.

Q. Do you agree that in reality, the three main routes of transmission into the care homes were either staff, the visitors, or the admissions themselves?

A. Yes.

Q. And I want to just look at the staff transmission route.

Could we have up on screen, please, a Covid strategy meeting on 6 May, INQ000146701.

Now, Mr Hancock, this was a -- I think what is sometimes called a deep dive?

A. Yes. Could you remind me of the date of this?

Q. Yes, 6 May. Now, you are not present.

A. Okay.

Q. Helen Whately is. The meeting was about care home delivery plan, and for what it's worth, nosocomial infection rates, all right?

A. Yes.

Q. But I just want to ask you about some of the things that

are said in the deep dive.

At that strategy meeting:

"The Director General [so Ros Roughton at the time] said that DHSC had worked with care providers to identify several measures aimed at reducing the spread of infections in care homes. One measure proposed would be to restrict the movement of staff between care homes. However, this had presented some key implementation challenges for care providers."

A. Yeah.

Q. "She said that care providers needed a larger workforce pool to ensure they had the capacity to restrict intra-care home movement. She said that some staff were concerned about the financial consequences of restricting shifts to one care home and many staff would not be willing to work in this way. She said further work was needed to understand the funding consequences and the resource requirements to implement the proposal."

And so she has made the attendees of the deep dive aware of the challenges here with limiting staff movement.

A. Yeah.

Q. Do you -- although you weren't in that meeting, you're familiar with those challenges, no doubt, Mr Hancock?

A. Yeah, of course, yeah.
Q. And do you think it was therefore known at an early stage that mandating restrictions on staff was not really going to work without either a larger workforce pool, and/or financial consequences, to try and compensate those who were now having to limit the way in which they worked?
A. Yes, and I think I articulated this at the time. I've seen that in the paperwork. The conclusion we came to, which I announced on 15 May, was strongly to recommend, but then -- and that did reduce the infections in care homes and in the second wave the problems in care homes were much, much lower. What I would say, though, was that having brought that -- I think we ended up with about a 90% reduction in staff movement, ie, number of -- the number of staff in the system working in more than one care setting.

I then, over the autumn, tried to drive that to zero with the mandated solution and couldn't get that through.
Q. We're going to look at that.
A. Okay.
Q. There's one thing I want to ask you before we come to the autumn efforts.
A. Yeah.

consideration" and as we'll see when we go through the autumn, the legal considerations were significant.
Q. Now, I don't want you or anyone else to be confused. There were clearly, when you were thinking about mandating restrictions on staff movement, legal considerations --
A. Yeah.
Q. -- but were you aware whether there was a reason why the pilot didn't go ahead?
A. No.
Q. Right. Following, I think, that meeting, I think you were considering banning staff -- and indeed you wrote to the Prime Minister.
A. Yeah.
Q. And I'd just like to have a look at the letter, please, INQ000292617.
A. Do we have a date for this?
Q. Yes, it was 8 May.
A. Right, okay.
Q. So just a couple of days after the deep dive.

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

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

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

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

"The First Secretary of State, Mr Raab, said that care homes were a decentralised system and a recommendation should go to the Prime Minister on the Government mandating the restrictions of movement of care home workers in between care homes for one month, subject to legal consideration."
A. Right.
Q. Now, bearing in mind you weren't it, though, were you aware that there was a potential for a one-month trial period, or pilot, call it what you will, to restrict movement.
A. Yes, I would have been -- I expect that I would have been debriefed on this meeting by Helen, as you could see, our relationship was very good, and also, I would have seen these minutes.
Q. Minutes, yeah.
A. I would have just not been able to go to the meeting because I would have been doing something else.
Q. We're not aware that the one-month pilot or trial, call it what you will, in fact happened.
A. Right.
Q. Are you aware of whether there was such a pilot?
A. No, I don't recall it being -- getting anywhere, not least because it says here "subject to legal

the Department's plans.
A. Yes.
Q. You've got there reference to the latest Public Health England evidence showing that:

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

And you set out the five steps.

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

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

As we touched on this morning.

"This makes delivery of sensible policy proposals -- like reducing staff movements between providers -- very difficult. We need to change this through legislation."
A. That has not yet happened.
Q. No. Just bear with me because we will get there.
A. Yeah.
Q. "But in the mean time, the most effective way we can drive specific policy directly is to tie adherence to funding: to give funding to those providers who act in the correct way."
A. Right.

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

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

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

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

Q. All right.

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

to the PM.

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

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

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

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

A. Yeah.

Q. But help us with the section that says:

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

A. Yeah.

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

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

A. DHSC had no levers over that.

Q. Right.

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

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

A. Mm.

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

A. Yeah.

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

A. Yes.

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

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

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

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

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

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

A. Yes.

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

of the things that you did over the autumn of 2020 to try to bring in the legislation.

A. Yeah.

Q. Can I just have a look at a few documents with you, please, Mr Hancock.

Can we have up on screen, please, INQ000233987.

This is 14 September. And there's a paper -- there are a number of papers over that autumn on this topic, but you say:

"... the paper is not strong enough ...

"• We need to propose the rule that working in more than one social care setting is illegal under public health law.

"• Likewise we need to mandate self-isolation for social care staff, and make the care home responsible for that."

Were you taking legal advice at this stage about bringing in a new law or amending an old law? Can you help?

A. I think that the reference to "under public health law" means my goal here is to use the existing legislation to find a legislative hook, if you like, that could be used based on -- because there's a number of very strong powers in the 1984 Act that allow a wide degree of discretion for policy, if it is based on the advice of

clinical advisers, and that is -- this is where I've got to in terms of legislation. Instead of new legislation, I'm trying to use the existing legislation.

I would have thought it would be a -- it would require a statutory instrument under the 1984 Act.

Q. Yes. And I think in due course you received advice about amending various regulations that were in place as a potential way of bringing in this law.

A. Right.

Q. I don't want to get into a legal --

A. Sure. It's second order.

Q. Yes. Can I ask you about this though:

"• Likewise we need to mandate self-isolation for social care staff and make the care home responsible for that."

What did you mean when you said you wanted to make the care home responsible for mandating self-isolation?

A. I am not exactly sure.

Q. All right.

A. As in I can't remember now the mechanism that was in mind my mind when I wrote this.

Q. Putting the mechanism aside, can you help us with why you wanted it to be the care home's responsibility?

A. Because they're on the ground, they'll know who does and doesn't need to self-isolate. You can't decide

individually who is ill and who is not from -- or who has got a positive test, from Whitehall. That has to be an on-the-ground decision.

Q. I want to jump. There was a -- various Covid-O meetings about this topic. Can I ask you, please, about just one of them.

Can we have up on screen, please, INQ000090180, at page 4, please. You were present at this meeting, Mr Hancock, which was on 15 September. And a little bit lower down that page, please, can we see the sentence that begins:

"More could be demanded of the sector."

Let's just pause there. I'll just wait for it to be highlighted, Mr Hancock.

But there's a sentence, I hope you've got it?

A. Yes.

Q. "Some of the recommendations would be uncomfortable for the social care sector. More could be demanded of the sector. The measures included a strengthened CQC inspection regime, and legal powers to: prevent staff movement ... require full payment of wages ... when isolating; to stop visiting; ... comply with PPE [and a number of things]. The government should consider going stronger on staff movement restrictions and sick pay in particular, and legal powers to enforce these

would not face the same backlash that had been seen earlier in the year due to the existing guidance."

Can you help me with that guidance? What was the backlash that was being referred to there?

A. I don't know. You'll have to ask Helen.

Q. All right.

She said:

"... this was a 'stick', that needed to be accompanied by an incentivising 'carrot' of additional funding through the Infection Control Fund. A further 'stick' to consider was a move to greater transparency through publishing care home test rates."

A. Yeah.

Q. Can I go to page 7 of that document, because it then sets out a number of things that were discussed in the meeting and I wonder if you could help us with (j) there. In the course of the discussion, there was reference to "the sector had not done enough to protect those in its care, nor its staff".

A. So I -- maybe I --

Q. Can I ask the question?

A. Yes, of course.

Q. Thank you.

Can you help us, please, with what that was a reference to?

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

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

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

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

Q. Yes.

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

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

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

A. No, it --

Q. -- considering --

A. It is definitely not either of us.

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

A. Yeah.

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

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

Q. Right.

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

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

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

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

A. Yes.

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

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

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

A. Yes.

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

A. Yes.

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

A. Yes.

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

A. No.

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

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

Q. Ah.

A. It was perfectly possible.

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

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

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

launch it if we compensated people and I could secure funding from the Treasury. But since the Treasury are the unilateral decision makers on funding and they said no, that was effectively a killer blocker.

I still, to this day, don't know who stopped this policy from happening. But as you know from earlier modules, there are number of people who were prepared to use all sorts of tactics to try to stop things that I thought were necessary to save lives, and, you know, sometimes that boils up, and sometimes it's done quietly.

Q. You obviously -- and it's set out in your statement and I'm not going to go through it all -- made a number of efforts to try to bring this legislation in if at all possible --

A. Yes.

Q. -- or at the very least to find some way of restricting staff movement. And do I take it that you think that is something that should happen in non-pandemic times?

A. Yes, I do because of the number of deaths in care homes from flu and other infectious diseases, yes.

Q. Do you think it is a matter that should be bought in via legislation?

A. Yes, and I think in normal times, you could do it in a very considered way, thinking about the exemptions

that you might need, the levers that you'd use, and the enforcement mechanisms that you'd put in place.

LADY HALLETT: Is it possible -- forgive me for interrupting. Is it possible when you have a very limited workforce?

A. Well, we don't have a limited workforce. There's 2.5 million people and we managed to bring this in with 90% effectiveness without causing a -- there was more pressure, but not a disruptive negative consequence on the workforce. So it's absolutely doable. And it comes down, in a way, it comes down to the cost of looking after people in care homes. Do we think that it's right that we allow people to go to work in a care home with the flu, knowing that that may well spread the flu to people in care homes who might then die.

LADY HALLETT: I am not questioning the wisdom of the policy, I am just questing whether it's practical. I thought it had 100,000 vacancies?

MS CAREY: Yes, can I -- may I can pick up on that, my Lady, and to help you, Mr Hancock. There was a DHSC briefing in November that estimated that 22,500 staff in residential care held a second job in social care.

A. Yes.

Q. And the majority are understood to hold two jobs: perhaps one in residential care and one in a domiciliary

care setting, for example?

A. Yeah.

Q. There are also, I think, about over a million and a half jobs on zero-hours contracts.

A. Yeah.

Q. And so to pick up on her Ladyship's questioning, how feasible or realistic is it to ban staff movement when people are relying on having two jobs?

A. It's a perfectly reasonable question but I think that it's entirely feasible because you could --

Q. Help us.

A. You could easily re-jig the employment arrangements so that, if two care homes each employed people part-time, and then each of them could take a fewer number of people full time. It would lead to a decrease in flexibility, that's absolutely true, but you could still work in one care home on a zero-hours contract and do something else when there weren't any hours coming from that care home for instance.

But why should we have care home workers on zero-hours contracts anyway? Don't people in care homes deserve highly professional, highly organised support with the staff who are in reliable employment? I think it's a sort of -- you know, we should have been more ambitious for the care we give to the most vulnerable in

society.

Q. Same topic from a slightly different angle. Were there ever any plans to try and restrict staff movement in domiciliary care?

A. No. I don't recall that. Domiciliary care is different because you are, by your nature, in the community all the time. So it doesn't, in a way, if you worked for two different employers in domiciliary care you'd still be visiting dozens of different houses to look after the clients, no matter who was paying the bill.

Q. It brings me on to -- I want to ask you about domiciliary care because clearly there would be real practical difficulties with restricting staff movement in domiciliary care for the reasons you've just given.

A. But also it would be less important. Because, you know, if you're --

Q. Why would it be less important?

A. Well, say, you're a domiciliary care worker who looks after 15 people and you go into their home. If you did that for one company, you'd still be visiting the 15 people in their homes. If you did it for two companies, you'd be visiting 15 people, just being paid through two different companies. It wouldn't make a difference to the spread, to the clinical outcome. So it's less important. Whereas a care home is a physical setting

that -- where infection can occur within the setting.
Q. Yes. Although a domiciliary care worker going from house to house to house providing close contact is equally providing a care in a closed getting?
A. Yes, but -- yes, what you'd have to -- to make it work, you'd have to say that domiciliary care workers could only work with one person or a smaller number of people, and that would probably have been impractical.
Q. In relation to domiciliary care, though, given that on any view, workers had to move from house to house to house --
A. Yeah.
Q. -- and acknowledging, as you do, that you can't restrict their movement, and you can't isolate the person in the house because the carer has to provide the care, the washing, and the like.
A. Yes.
Q. Can you help us then, please, with what was done in relation to PPE for people providing domiciliary care?
A. Yes, well, we provided PPE to domiciliary care workers, but we ... and again, in non-pandemic times, that is the duty of the company involved. They're not all companies, but nearly all domiciliary care is provided by the private sector. And we provided free PPE. It is a less defined sector, by its nature. And so it's

harder to be absolute about how many people -- what proportion of people benefited from that.
Q. I want to look at some of the efforts to provide free PPE that were taken up during the course of the pandemic, particularly at the beginning.
Now, you've made the point, obviously, that formal responsibility for PPE distribution rests with the individual institutions, and care homes. And prior to the pandemic, the NHS Supply Chain would only supply the main hospitals --
A. Yeah.
Q. -- whereas, of course, in social care they provided PPE for themselves.
A. Yeah.
Q. Just to provide the context for everyone.
And on 13 March, there were 7.5 million masks delivered to the 25,000-odd care homes in England. All right? That amounted to about 300 face masks per CQC-registered provider, and I think you chastised me earlier for laughing at you, and I certainly wasn't, but I'm asked to ask you why so little PPE was provided to that number of care homes when it amounts to, Mr Hancock, 300 face masks per care home, which would be gone through in no time.
A. Well, that was just the start of it. And obviously we

built up that PPE supply, but PPE was in incredibly short supply globally. We've had a whole module on it. So the answer, the substantive answer to the substantive question, is that we did everything that we could, and went the extra mile to get as much PPE as we possibly could in the circumstances.
Q. Was that -- does it come to this: that that's all you could afford to give at the time?
A. It wasn't about affordability, no.
Q. No, but that's all that was available --
A. That's all the resources that were available at the time, given the clinical prioritisation of PPE into hospitals.
Q. Now, there was a further drop of PPE to the local resilience fora in April.
A. Yeah.
Q. And I think you were informed of a plan by way of submission.
And can we have a look at that, please, at INQ000551555.
This went to you on 4 April. It was an emergency PPE drop to the 38 local resilience fora. Are you able to help us with the background as to why there was this need for an emergency drop at the beginning of April 2020?

A. Because there was a shortage of PPE. I mean, we knew that from March. The challenge was getting as much PPE as possible. And we also were trying to invent a distribution system as well, because the -- in some cases the private sector distribution system worked, in other cases it didn't.
Q. All right. You've arranged -- you can see there:
"DHSC have ... [arranged] a one-off drop of PPE to each [local resilience forum] in England to help respond to local spikes in need and blockages in the supply chain ..."
A. Yeah. So, you know, in some of the many criticisms about what happened with PPE, sometimes people say, you know, "We had to go outside the government system and got PPE."
Well, we regarded that as a good thing. If you could get your hands on PPE thorough private procurement or through your own efforts, then of course that's good. It's all -- you know, it was all shoulders to the wheel.
This was the additional PPE that we could direct from the centre to go into this space.
Q. All right. But this PPE was not solely for the adult social care sector, was it? It included prisons and any other enclosed setting that the local authority felt there was a need for PPE?

A. Yes, that was a matter for the LRF to decide the --
Q. Okay, but I don't want anyone to misunderstand this was a solely social care-related emergency drop?
A. No, I think I'd describe it as a primarily social care-related emergency drop, yeah.
Q. The highlighted section there says, in the final sentence:

"We do not expect that NHS Acute Trusts or Ambulance Trusts will need to draw from this supply given they are already being supplied via the NHS."

A. Correct.
Q. Were you aware that the PPE supplies for NHS were being prioritised at the expense of the adult social care sector?
A. That was not my assessment of it. There was a clinical prioritisation, and that was based on advice. It wasn't something I would interfere with.

I am absolutely aware that people, for instance some people in LRFs, felt there was a prioritisation, and that the NHS hoarded PPE. I didn't ever find evidence of that happening. What I found evidence of was, in a situation of desperately short supply, everyone was trying to get their hands on PPE, and if they got their hands on PPE then they would tend to hold on to it.

So I don't ascribe any negative intent on some of

these behaviours and accusations that we've seen in this space. I totally understand why people complain about it, but at the same time, this was a desperate situation in terms of PPE supply.
Q. All right. Can I ask you about an email chain that has been provided to you, please.

Can we have up on screen INQ000572355.

You are not copied into it, but I want to know if issues like this came to your attention.

This is an email chain between the National Care Forum and people at the Department of Health.

And could we go to page 4, please.

The National Care Forum are setting out to the department a number of concerns they've got, but they, in the course of the email, make reference to "NHS Requisitioning Stock". This is, to help you, 1 April, Mr Hancock --

A. Yeah, I suppose this is an example -- I didn't know you were going to bring this up, but this is an example of what I was saying, which is that, you know -- "requisitioning" is the wrong word. Requisitioning means mandating taking something.

What was happening was the NHS were also buying, and in some cases they would be bidding against each other, outwith the government effort to provide PPE.

Q. I take your point. There was never any directive, was there, from DHSC to say that the NHS should get PPE first?
A. Or should be able to buy, you know --
Q. Yes.
A. -- and others not allowed to buy it. That wasn't how it worked.
Q. No.
A. But having said that, I'm -- all I'm doing -- I'm not defending the system, I'm describing the system. And what I'm -- you know, the truth is, a lot of people felt like this.
Q. Right. Forget the use of the word "requisitioning".
A. Okay.
Q. Can we just look at the examples that are given by the NCF. They told the Department that:

"Many of [their] members report[ed] that their suppliers have stopped delivering PPE to them or have had their deliveries diverted to the NHS."

Then there's some quotes.
A. Yes, I understand that.
Q. "When we tried to place [our] orders with our usual suppliers for sanitiser (and some other products) we were told they weren't taking orders because everything has been requisitioned for the NHS."

A. Yes.
Q. Next quote:

"Our suppliers have told us that all four major manufacturers/wholesalers have been barred from supplying to anyone but the NHS."

And indeed, at the bottom there:

"A number of items, eg thermometers are completely unavailable. These are crucial pieces of equipment for services which remain open and have potential drop in services. The bottom line is Google has become our procurement source."

A. Yes, so this is absolutely the lived experience.
Q. Right.
A. And what I'd say about it is, on the last point, "The bottom line is that Google has become our procurement source", if Google can provide you a thermometer and you need a thermometer, in a crisis, that's okay. You know, it's less bad than not getting a thermometer. But it's obviously not the best situation. It's not how you'd want it to be.

My role in this, if you like, was in trying to ensure that there wasn't overall a national shortage of it. And, you know, we've been through that. But this is a totally fair representation, that -- we were aware of this concern at the time.

Q. Right. So notwithstanding you're not copied in on this particular email, this does echo and resonate with concerns that you were being made aware of?
A. Yes, mostly by Helen. I mean, Helen would come to me and tell me these sorts of things.
Q. Right.
A. Yes.
Q. So there are -- before the emergency drop to the LRF, there is clearly concern within the sector about their ability to get their hands on PPE?
A. Absolutely.
Q. All right.
A. As there was, by the way, across the NHS as well. So, you know, care felt like this, some parts of the care system felt like this. The NHS also felt like there were challenges in PPE availability. So it was just that the world suddenly started using PPE at a radically faster rate.
Q. Okay. So back to the LRF emergency drop, please.
A. Yeah.
Q. The plan was to make, I think, over about 30 million items of PPE available to the local resilience fora. And I'd like to ask you, please, about an email chain, at INQ000325261.
And could we go to the final page first, it's on

page 3, and then work back to the front of the e-mail.
Just to help you, Mr Hancock, there was a submission on the PPE and an explanation about the drop.
And then can we go to page 2. This says:
"... our comms handling on this drop is below."
And can you see the section there says "Media handling":
"Given the uncertainty about how this drop will fulfil local demand and the possibility of criticism at a local level we would not recommend a proactive media approach for this drop and MHCLG and DHSC will liaise on developing strong reactive Q&A."
Can I ask, was there concern that this was going to a drop in the ocean, effectively, Mr Hancock?
A. I've no idea. I can't recall seeing this.
Q. All right.
A. I'm not copied into it. But it's a totally -- you know, it seems -- given the concerns that we were hearing from stakeholders, it's not an unreasonable judgment for a comms official to have made.
Q. Right, but you're going to make an announcement that: here we are, we're going to give you 30 million pieces of PPE. But equally, are you acknowledging that that might not be sufficient to help out the sector? Is that how the announcement went?

A. I've no recollection.
Q. Over the page, please, then to emails that you are copied in on, and we can see you at the top:
"Hi all,
"Linking in Private Office subs list. DHSC ministers approve the sub and have the following comments ..."
You asked for an annex to be sent. And the ministers said:
"• [We] Would like to be stronger than saying we don't 'expect' acute trusts to [supply this], there [was] already a ... line for [the] NHS ...
"• Thinks [that] the letter should include a stipulation that the LRFs do a stocktake of their available PPE to give better data to inform future drops.
"• [They] Questioned why there are so many FFP3 masks ..."
I don't need to ask you about this. But you, there at the bottom:
"... agrees with the following feedback ...
"• This needs to be pitched that this is a significant drop; LRFs are to use it judiciously as we cannot guarantee when the next drop will be."
How does that tally, Mr Hancock, with the comms

media handling that we need to be careful, because there may be criticism about how --
A. If you read the next bullet:
"• However, we should not overblow the volumes or over pitch it."
So it seems totally reasonable. I'm saying: be honest about where we're up to.
Q. Right. But --
A. You know, 30 million is a significant number, but "we [shouldn't] overblow the volumes or over pitch it" seems totally ...
Q. All right. And did it seem to you to be an acknowledgement that this wasn't really going to be sufficient to help out the adult social care sector, this drop?
A. I think, you're -- if I may say so, you're focusing a little too much on the comms handling of this. Here it says:
"SofS agrees with the following agreement from MHCLG ..."
Q. Yes.
A. So what will have happened here is Rob Jenrick will have said "This is my feedback", and I will have read it and just put a tick next to it and moved on to the next thing. This is the comms handling. For me it was

second order. You know, this was as much as we could get our hands on and get out to the system. Of course it wasn't enough, because the world didn't have enough PPE. We didn't have enough PPE. We were out there buying it, and the PPE module has gone into great detail about the lengths we went to buy it. And indeed, you know, a bit like visitor policy, I've been criticised for buying too much and criticised for not buying enough. You know, c'est la vie.

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

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

A. Yes.

Q. -- and visitors should wear face coverings.

A. Yeah.

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

A. Yeah.

Q. -- in the adult social care sector.

A. Yeah.

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

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

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

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

Q. Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. No, I -- sorry, that's a non sequitur. If the clinical advice is this is more important in hospitals, I can't just say that's not the clinical advice. That was the clinical advice, first. Secondly, I've tried to explain, I'm happy to go through it again, that in government, policy making over social care is harder than policy making over the NHS because of the way it's set up. Because of the fact that local authorities have the contracts, MHCLG has the relationship with the local authorities, formally. Treasury has the money and the Department of Health has the policy accountability, albeit not the levers. This is exactly what I was talking about, this is an example from when we were talking at the start about the lack of levers. That -- I'm not defending that. I think that's a mistake. I think it's an error. I think it needs to change. I wish it had changed already. I was working on changing it when I was in office.

It's wrong, okay? But it's the truth.

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

A. No, it's not.

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

I presume that's a reference to Dido Harding?

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

Q. Is the press conference. And Natasha Price says:

"Jenny Harries is concerned about this ..."

A. Yes.

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

A. Yeah.

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

A. And the Mr Pearson as well.

Q. Yes -- but -- over the page, sorry, to page 2, one of your, I think, advisers says:

"Why are we not saying it for social care? Can't we say that when social care visitations are relaxed, face coverings will be required? Or just have some language that shows some ..."

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

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

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

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

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

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

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

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

A. Can I just add one little thing? I'll try to be quick.

I totally understand why, if you're in social care, it looks like you're getting things afterwards. I'm trying to explain why, if you care just as much about each of them, it is still harder to deliver in one space than the other.

Q. I follow that. All right. Let's just look at this exchange and then break for lunch.

Here you are on 5 June which is the day you announced the mask wearing in hospitals, and you say:

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

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

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

Q. Right. She says:

[As read] "Jenny's view is that because we haven't spoken to care home stakeholders are all -- [that should probably be "at all"] -- they are likely to be unaware of this and be critical of this rapid expectation, so would advise against announcing today, could speak to her."

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

Q. Yes, because you haven't spoken to the care home stakeholders to prepare them for the announcement?
A. Yes, because there's a whole series of things you have to do in that sector that you don't have to do in the NHS.
Q. Why weren't they done by 5 June?
A. What? Because we're moving incredibly quickly. The clinical advice on face coverings only changed just before this, and the decision essentially -- that question implies that I should have waited within the NHS and done it with social care, because of comms concerns. I cared about savings lives. I appreciated that this might cause some criticism, but I cared about the substance and saving lives. And over and over again, in the pandemic I faced this dilemma. I might get criticised for a decision, but it might save lives, and my decision always was to save lives.

It's why I can -- you know, I can explain all these decisions that I took, even when there have been broad criticisms of them, and some of them more acute than others, but there are reasons behind them based on the substance. And that is why -- that's why I get so frustrated when we -- when at other points we have moved off the substance.

Here, this is a classic example. I could have

delayed, but I thought it was better to keep people alive.
Q. All right. Doesn't it imply you should have brought home -- brought forward the care sector announcement rather than delay the NHS England announcement?
A. No, it doesn't. Jenny Harries is advising against announcing for care homes.
Q. Yes, yes, and the reason she is, is because you haven't warmed up the care home stakeholders by this stage?
A. No, because the policy -- the clinical advice on wearing face masks was only just changed. So this absolutely supports the decision that I made, because it's -- because the only alternative -- it comes back to this question of when you don't have good alternatives, right, when there aren't good options. It comes back to that.

The only alternative that you've suggested is that we delay the NHS announcement. Now, I wasn't prepared to do that.

And if you say, "Well, should you have brought forward the care home announcement", well, I've got Jenny Harries saying, "Don't do that because we were not ready for it, essentially", and I hadn't got cross government clearance either, so I wouldn't be able to do it. So there you are.

LADY HALLETT: I think that's as far as we're going to go.
MS CAREY: Thank you, my Lady.
LADY HALLETT: Otherwise I'll have a stenographer on strike. 2.10, please.
MS CAREY: Thank you, my Lady.
(1.10 pm)
(The Short Adjournment)
(2.10 pm)
LADY HALLETT: Ms Carey.
MS CAREY: Thank you, my Lady.

Mr Hancock can we stick with a few questions, please, about PPE, then I've a number of other topics to cover with you this afternoon.

At paragraph 199 of your statement, I don't need it called up on screen, but you've set out there that you've received a submission from the PPE demand team at the department on 15 July proposing free distribution of PPE to frontline, primary, and social care services, initially until March 2021; is that right?
A. I'm sure it is.
Q. I'm taking it from your statement.
A. Yes, of course.
Q. And you thereafter extended the free PPE to March 2022?
A. Right.
Q. All right. Obviously that post-dates the end date,

post-dates your leaving the department, but can I ask you about unpaid carers please and PPE for them?
A. Yes.
Q. And can I call up on screen, please, INQ000328012_4. Now this is a submission in fact to the minister.
A. Right.
Q. But I'd like to ask you about a few things in it, if I may. If I ask you something and you can't answer, please will you let me know. All right?

It was a submission to Helen Whately in November of 2020 asking her to amend guidance to advise PPE should be worn by unpaid carers when providing personal care to someone who they do not live with. All right? Just to help you. Okay?
A. Okay.
Q. And can I ask, if a submission goes to the minister, do I take it that it doesn't come to you?
A. Correct.
Q. Would you expect, though, a submission like this, for her to speak to you about it or to ask your views on it?
A. No.
Q. All right.
A. If it's just to her, as opposed to her copying my private office or copying -- or to her, then me, I'd see it, otherwise -- and especially with a minister who

I delegated a lot to.
Q. All right, fine.
A. Essentially in government the civil servants work out which junior ministers the secretary of state trusts, and which one he or she doesn't, and in this case they will know that I would have agreed with whatever decision she -- (overspeaking) --
Q. And we shouldn't take this as signifying that you weren't interested in unpaid carers, this was just one of many tasks that you no doubt delegated to Helen Whately?
A. That's right.
Q. All right.
And we've seen the recommendation there that she amends the guidance, and I'd just like your help, please. On page 2 we have a summary of the position as it was, and then what the plan was.
"The DHSC guidance for unpaid carers in England does not currently [so as at November] recommend that unpaid carers need to wear ... (PPE) when providing care, unless advised to do so by a healthcare professional. In May 2020 ... (PHE) advised that ... carers [who didn't live with the person they were caring for] should wear PPE if providing personal care. [And] ... that co-resident carers ... should wear PPE if the cared-for

individual [has Covid symptoms]."
So that was the position with the guidance. You were obviously aware that there were many millions of unpaid carers.
A. Of course.
Q. Estimates vary between about 5.5 million and, I think, about 7.7 million.
A. Well, it all depends how you define it, so yes.
Q. Quite. And it's obvious, isn't it, Mr Hancock, that there was not going to be PPE necessarily for all 5-7 million unpaid carers providing personal care?
A. Well, that's a perfectly legitimate decision for an elected government to make, to make PPE available for free to everybody if they wanted to, but there is a limit on the public purse.
Q. It's not a criticism --
A. No, no, no, indeed.
Q. -- it's just a fact here that if we wanted to provide PPE for those many millions of people providing unpaid care, it would obviously place significant demands on the availability of PPE?
A. Yes, and the cost to taxpayers, yes.
Q. Yes, all right.
Can I look, please, at page 5, and paragraph 7. The data on unpaid carers -- sorry, it's my fault, I just

jumped to the paragraph above to give some context:
"[The] Data on unpaid carers, including how many there are, the types of activities they do and whether they are extra-resident/co-resident, is limited."
Does that accord with your understanding of the data available on unpaid carers?
A. Yes, I'd say it's -- it's not only that it's limited; it's also a definitional question. So I would have taken -- if I'd taken -- had a piece of advice like this, our best estimates suggest there could be as many as 7.7 million, I would have said: well what does that mean? What about an elderly couple where one of them is in slightly greater disrepair than the other? Does that count? You know, it's really hard to define what an unpaid carer is and isn't.
Q. Understood. But did the lack of a definition in any way impede or hamper the pandemic response to unpaid carers?
A. The way that we handled this primarily was through the shielding where there was a definition of the risk to an individual, and then that individual's carers would be brought into the programme, either directly or indirectly. But it does mean that the whole subject of policy around unpaid carers is complicated by these boundary definitional issues.
Some people are obviously unpaid carers and nobody

would dispute it. Others, it's just, you know, people caring for each other. What does that mean in a formal policy sense? It's quite hard to define.
Q. No, so that was -- to ask the question again: did the lack of definition, though, in your mind, hamper the way that you approached the pandemic response to unpaid carers?
A. Well, the word "hamper" has a --
Q. Impede --
A. -- pejorative sense to it --
Q. Well, I don't mean it pejoratively.
A. No, well, my answer isn't a yes/no because it's not really a yes/no thing. It's not a legalistic thing. It's just a piece of context you have to take into account when making policy in this area.
Q. Right. The paragraph says:
"Clearly providing all of these carers with PPE would be unfeasible from a stock, supply and distribution perspective."
A. Yes, and I would add taxpayer, as well. I mean, you know, we spent a lot of money but there was still a consideration of the taxpayer.
Q. Then the next paragraph says:
"It is unclear how many unpaid carers would take up an offer of PPE."

A. Yeah.
Q. "Currently, in Liverpool -- Liverpool regularly provides approximately 8 unpaid carers with PPE out of an estimated 52,000 ..."
A. Right.
Q. Now, I know you said the minister wouldn't necessarily bring this to your attention but were you asked at all for any of your views about the feasibility or otherwise of providing PPE for unpaid carers?
A. Oh, it was an item that we discussed. I don't precisely remember when, but unpaid -- essentially, you know, in the continuum of concern, unpaid carers are there, but less than, you know, less concerned that those in hospital for instance. And, you know, so there's a -- of course it's a consideration, but I would say that mostly, I left policy towards unpaid carers largely to -- delegated it largely to Helen.
Q. All right, but you -- that can come down, thank you.
You did in fact, though, if I can remind you by reference to your statement, I think you agreed to a proposal of a trial of free PPE for unpaid carers in November 2020 and in fact, in due course, then you approved a national rollout in January 2021.
A. Right.
Q. Can you help us with why it was that you agreed both the

trial and, in due course, the national rollout?
A. I imagine because they were proposed to me with Helen's support and I backed her judgement.
Q. Right. It may be suggested to you that the trial in November and the rollout in January 2021, to some might look that unpaid carers are an afterthought given that there was PPE provided to both care homes and the domiciliary care sector before that. Are you able to help with whether there was an afterthought here to unpaid care?
A. No. The word "afterthought", which you've used a few times is a rhetorical device to imply there was less consideration given, which is false and wrong. However, the context means that the acuity of concern was less, by the nature of the group. That is an appropriate and reasonable position to take, when you've got to deal with a huge number of things and you therefore have to prioritise.
Q. From your perspective, was there anything else you think now, upon reflection, you could have done earlier in the pandemic to provide additional support to unpaid carers?
A. I'm sure it's worthy of consideration. It's not an area that I was particularly close to, and I'm sure it's a question worth asking Helen and I'm sure she'd come up with some sensible suggestions. It's just not something

I'm particularly close to.
Q. All right. Finally on the topic of PPE, I said earlier this morning that you were in favour of all health and social care facilities keeping PPE, a PPE supply themselves for use in an emergency.
A. Yeah.
Q. Can I ask you, how practical do you consider that to be for perhaps smaller care homes with less buying power, less space, limited shelf life of PPE?
A. Well, if they're smaller, they need less PPE in their stockpile. So a stockpile will be proportionate. You wouldn't have the same size for a big care home as a small one. Everybody's got a cupboard, and so it's totally reasonable to require a degree of PPE, say a month's supply, you know, you can pull any time period out of a hat but a month would seem reasonable. That would take, you know, in a small care home, that would take a -- you would need obviously a storage facility for that but it would be relatively modest. And -- but the impact of it will be really great because it will give you a month to sort out all these problems that, you know, it took us more than that to really get the system going.
Q. Right. What about domiciliary care? Would you make the same recommendation that providers of domiciliary care

have their own supply --
A. Yes.
Q. -- of PPE?
A. Yes.
Q. I presume not, though, for the reasons you've just alluded to, you wouldn't be in a position to make a recommendation about that in relation to unpaid care?
A. No, I think unpaid care is different in its nature.
Q. Right, understood.
A. And also, again, there's no levers, no contract. There's no -- you know, you can make a recommendation but you couldn't enforce it in any way.
Q. All right.
A topic that you have also referred to this morning was that of visiting restrictions.
A. Yes.
Q. Can I come back to that, please, just to get your overall views. Clearly there is the protection of the residents versus the impact on them and their loved ones and you mentioned this morning trying to strike the best balance, to use your words, in this difficult area. Did you ever consider asking for studies to be done about the extent to which visitors brought in Covid-19 into care homes?
A. Yes, that was part of the understanding, and as I think

you put it well earlier, when you said broadly that the disease got into care homes through residents, visitors, and staff. I mean essentially, through people. You know, that's how the disease spread.

Q. And you are aware of the real upset, and you've mentioned it yourself a couple of times in evidence, that the visiting restrictions caused on a number of people who could not be with their loved ones when they died --

A. Of course.

Q. No -- it is not a criticism --

A. No, no, no, I didn't take it as a criticism, I just think it's awful. I mean, some of the things that people went through were truly ghastly and it was an awful virus.

Q. I wanted just to pick up on one contributor to Every Story Matters, who said, perhaps not in context of elderly people or those with dementia but a resident -- a loved one of a resident in a care home said this:

[As read] "My son has severe autism and learning difficulties, has no speech and limited understanding. He was in a residential care home. I was unable visit him for 24 weeks. I couldn't visit through a window or Facetime as he would not understand, and so became upset. It was a choice between keeping him calm or

upsetting us all by seeing through a window."

A. Yeah.

Q. So clearly a number of people impacted in different ways.

A. Yeah.

Q. Five years on, do you think it had to be either no visitors or allowing visitors? Did I have to be either or?

A. Well, that is a very, very good question. I'm glad you brought that example up, because the care home question often ends up considering older-aged care homes more because actually, for those of working age or, you know, people like the example you've raised, the impact of visiting would be lower because the impact of the virus would be lower, and so that sort of consideration should be taken into account.

We also, we got to a position over time that was more nuanced, for instance when vaccinations were rolled out, having a difference between those who'd been vaccinated and those who hadn't. When PPE was more widely available, allowing visiting when -- with PPE. You know, for instance, with hindsight, we know that Covid-19 spreads much less outdoors, so visiting outdoors, and at a distance, would have -- would be safer than visiting indoors. So the more nuance and

consideration you can bring into this, the better.

You know, it's -- there are -- so it isn't just a binary of visiting or not visiting. It's how to do the least risky visiting. Like visiting and seeing people through a window, you know, is very low risk, for instance, but obviously as this example shows, doesn't work in all cases.

Q. No. Do I take it that had there been enough PPE, that might have enabled some visiting to take place sooner than it did?

A. Well, it took some time to work to know how the disease spread.

Q. Yes.

A. So as visiting restrictions were lifted, then at that point PPE was more widely available. And as you saw in the discussion that we had when we required face masks in hospital settings, one suggestion from one of my advisers was to have the PPE available when visiting was -- when restrictions were eased. So this is in fact an area of work, again, like so many others, that consideration and thought should be put into it now so that more nuanced versions of policy can be put in place, rather than, you know, having to invent it on the fly.

Q. Yes, and do I take it that if there'd been enough

testing, that might have enabled at least some visiting -- (overspeaking) --

A. Yes, and I think in fact once testing was available to the general public, that was used as a, you know, if you have a negative test then visiting is more highly recommended.

Again, you know, you've got to have policy and sometimes policy isn't rolled out on the ground exactly as you -- as intended, not least because of the issues of accountability and authority that we talked about just before the break. So all these things should be considered, yes.

Q. All right. Can I -- I just would like to ask you about one document that impinges on visiting restrictions and indeed the lifting of them.

Can I ask to have on screen, please, INQ000327939_0001, this is a submission that went to both you and the minister --

A. Yes.

Q. -- in July of 2020.

There was a proposal to application updated guidance on visiting policy and clearly it says there in the timing, it was urgent.

"Visits remains a source of concern for many families and friends of care home residents."

And they were keen to publish the guidance as soon as possible.

Can I just look at the rationale for change with you, please, Mr Hancock. Clearly, as we all acknowledge, there was -- making changes involves an increased risk of transmission, it must be balanced against the significant impact on the care home residents and being isolated. ONS data, as at 3 July, shows that between March 2 and June 12 of 2020, only 29% of deaths in care home residents were Covid related. The deterioration of the physical and mental health of vulnerable people is likely to have been impacted by loneliness. One only needs to look at the final line, reference there to carers representatives of --

A. Yeah.

Q. -- residents who are, to quote "fading away".

Over the page you received -- or annexed to it, I should say, was some SAGE advice that highlighted, as at July, there was:

"... medium evidence to suggest that visits of short duration, where appropriate social distancing and infection control measures are adhered to, are likely to pose a lower risk to residents than risk of infection by care home staff."

And then there was good evidence about the benefits

of the residents seeing their visitors and their loved ones and the detrimental impact on them of not having visitors for an extended period.

And in due course you were content for the guidance to be published in July.

When we move forward to the winter of 2020 into 2021 and rising transmission rates again --

A. Yes.

Q. -- you say in your statement that you took a hard line on loosening visiting restrictions. Can you just explain to everyone, please, why it was you considered in the winter of 2020 into '21 that that hard line was required?

A. Because transmission rates were high and even higher than they had been in the first wave. Certainly measured rates were higher than in the first wave.

And if you look at the analysis of who had had Covid, it's highly likely than the real world rates of Covid were higher in the second wave, and, therefore, visiting was a significant risk, again, in a way that it hadn't been by July.

You know, in the middle of July 2020, the number of infections measured was only in the hundreds, as opposed to the tens of thousands by December 2020.

So that's the reason.

But I also -- I'd just say that on the previous piece of advice that you've showed, that shows the degree of thought and consideration that went into this question.

Q. I don't think anyone is suggesting that there wasn't a degree, and there's no easy answer here --

A. Exactly, yeah.

Q. -- but what I did want to come to ultimately, though, was your reflections on what we should do in the event of a future pandemic, vis à vis visiting restrictions, when perhaps there isn't testing and there isn't a mass of PPE available. Would you still propose and advocate for an outright ban at the outset?

A. Well, I'd propose having a testing system that could be expanded quickly, and having stockpiles of PPE that can be picked. So let's try to avoid being in that position in the first place next time round, please.

But taking the question at face value, visiting restrictions are a reasonable measure. The more that you can introduce nuance into them, the better, taking into account the infection risk and the risk -- and the impact of not having visiting, exactly as this piece of advice did.

Technology is probably now more ubiquitous than it was, and people, especially older people, might be more

used to using it, and that helps relieve some of the lack of connection and the loneliness, but of course it's not the same as face to face, and face to face isn't the same as physical touch. We all know that.

I think it would be a very useful piece of work to think through in advance what is the best way to have the least worst outcome in this space.

Q. You mentioned there testing. Just one aspect of testing I'd like to ask you about, please, and it's testing for domiciliary care workers.

A. Mm.

Q. Obviously, there was some access in April 2020 for symptomatic testing of domiciliary care workers, but in fact asymptomatic testing for domiciliary care workers was not introduced until November 2020 and in fact may not have been rolled out until January 2021.

Can you tell help with why asymptomatic testing of domiciliary care workers was not rolled out until November 2020?

A. Well, this was about the access to tests. So it's not quite right exactly the way you put it, because of course asymptomatic testing was available to the general public by then, and so domiciliary care workers would have had access to tests, just because they're members of the general public, should they have wanted to, and

therefore I don't think the problem is quite as acute as set out.

I can't remember the exact timescales around then of when the huge quantities of lateral flow tests became available but that was essentially the breaking open of testing from a controlled to a widely dispersed issue, if you like.

And that was in the autumn of 2020, wasn't it, when we got the first --

Q. Yeah.

A. -- mass, hundreds of millions of lateral flows through, and made the whole issue easier.

Q. New topic, please. And I'd like to ask you about changes to the regulatory inspection regime.

A. Right.

Q. Did you agree with the decision to suspend routine regulatory inspections?

A. Yes.

Q. How were you assured of the safety and quality of care homes in the absence of those inspections?

A. I thought two things on that. The first is that whistleblowing was still possible in the worst extremes, and the second is that it was a necessary short-term measure, given the -- everything else that was going on and the risk of bringing Covid into care homes through

inspections. But also, that many, many inspectors are themselves medically trained and were needed on the front line.

Q. In your statement you said:

"I supported the CQC's decision to suspend ... because I wanted hospital and healthcare workers' primary focus to be treating patients, rather than complying with inspection requirements, and to free up inspectors to work directly on the front line."

A. Yeah.

Q. The reference there to "rather than complying with inspection requirements" may to some sound dismissive of the importance of inspections.

Why did you phrase it that way, Mr Hancock?

A. So I'm a supporter of inspections, but the reason I phrase it that way is that these were extraordinary times. Care settings and hospitals were doing unusual and extraordinary things, and sometimes -- one of the reasonable criticisms of most inspection regimes, including the CQC's, is that they can get box-ticky, and the last thing you want is somebody making a decision based on a worry about a future imminent CQC box-ticking exercise when there is life-saving work to be done.

It comes back to my overall -- the way that I led the health system was to presume that everybody would be

doing their level best to do the right thing, and part of my job was to give them the tools to do that but then get out of the way of their ability to do that, and that was the overall approach that I took within the health system, and this is just one example of that.

You know, there are times for CQC inspections. The middle of a pandemic is not one of them.

Q. Right. Can I ask you about reference to box ticking because -- can we have up on screen, please, a text message or WhatsApp exchange you had with Peter Wyman the chair of the CQC.

INQ000419147_002. Thank you. I don't know if we can expand it?

It's from 16 March, Mr Hancock, which is the day of the announcement of the --

A. There you go.

Q. -- regulations -- sorry, the routine inspections being stopped.

A. Yeah.

Q. And you say:

"In return, I need CQC to pull back more than they after currently planning on inspections & data collection. We are likely going to have people in hotels & it's important" --

Should that be "hospitals"?

A. I don't think so. What date is this?

Q. 16 March.

A. Yes, so this is --

Q. Who was going to hotels?

A. Hmm?

Q. Who was going into hotels?

A. People who couldn't fit in the NHS.

Q. All right.

A. This is before the Nightingales have been built.

Q. Yeah.

A. You can see that I am worried about -- this is after -- this is before we have got the legal lockdown in place. It's when rates are still climbing very quickly. So I think that we are going to have people in -- end up with people in hotels.

Q. Right, understood.

A. Remember the Italian experience a few weeks earlier --

Q. Okay.

A. -- had been that people were -- their health system was completely -- (overspeaking) --

Q. Okay, so you're worried that their -- that's the position we're going to end up in, and people are going to have to be going into hotels.

"... it's important people do their best without worrying about box ticking."

A. Yes.
Q. And that may, to some, sound like you think inspections are just honoured more in the form rather than in the substance.
A. No, it's that inspections do have an element of box ticking.

And "box ticking" is a pejorative term but what I mean by that, and there's a reason that there is some of this, is that in order to make inspections consistent between different inspections, there are structures and frameworks which naturally have to get written down, which can then become box-ticking exercises. It's a sort of -- it's the nature of the system that you end up with box ticking. I don't like it but it's true.

Anybody who has had a child go through GCSEs knows that to get the points, you have to do a load of exam technique which is essentially box ticking. That's because they have to be able to compare exams from one person to another.

I use that analogy because it can also apply in hospital inspections, and I wanted the CQC to basically completely pull back from this sort of activity, except where they thought there was serious harm going on.
Q. Yes, a safeguarding concern, or neglect or abuse, I understand.

A. Exactly. And Peter Wyman, who is a very great public servant, understood that. He naturally would have been concerned to ensure that the CQC did its job, so I was pretty firm in my request to him, remember CQC is independent, rightly so, so I couldn't direct him, but I was asking him, and he is coming back saying, "We've pulled back on inspections; only where we think there's abuse or serious harm", and that's fair enough.
Q. All right. So given that you were supportive of the decision to suspend routine inspections, did you ask for any information or assurances from the CQC as to how residents would be protected and the quality of care maintained?
A. I considered that a matter for the CQC, and I am sure I would have discussed it with them, but I also wouldn't have worried about my need to insist on that to them, because that would -- that is their natural purpose.
Q. Right. So were you aware of what was planned to replace the routine inspections once they were suspended or did you leave that to the CQC?
A. Absolutely a matter for the CQC.
Q. Right.
A. It wouldn't have been appropriate for me to have done that. I was basically giving a directional steer which is, you know, you've got my cover, if you can go as far

as you can, feel you are able to, in this direction.
Q. Given that at this time there is now inspectors not going in routinely to care homes, there aren't visitors now going in routinely to care homes, there is an increased use of remote consultation by GPs and the like, do you consider that perhaps there was now a lack of the checks and balances that would normally be in the place, normally be in place in the care sector?
A. Absolutely there was a lack of the checks and balances that are normally in place but I don't think that was a mistake. But it was, of course, a downside consequence.
Q. In your statement at paragraph 260 you state:

"At a weekly ASC [adult social care] meeting on 17 April ..."

So about after a month after the inspections have stop, you specifically ask for an update on whether care homes could easily flag quickly to the CQC if they were facing serious issues.
A. Right.
Q. What prompted you to ask for that update, Mr Hancock?
A. I've no idea. It seems like a reasonable question to ask.
Q. Do you remember now what response you got to -- no?
A. No.

Q. Concerns, however, were raised with you about the lack of inspections. I'd like to show you just one example of a letter that you were copied into.

Could we have on screen, please, INQ000231915. Thank you very much.

Although it's to the then chief executive Ian Trenholm, at the bottom of it you're copied in, I just want to look at some of the concerns that are being raised about the lack of inspections.

We can see there in the second paragraph that the Relatives and Residents Association say:

"It was clear from the outset that care services would be in peril ..."

We looked at that Public Health England --
A. Yeah, we did, yeah.
Q. -- February 2020 guidance earlier.

"... CQC failed to speak out immediately to refute that. CQC announced that routine inspections of care homes would be suspended. With family visits banned in most care homes, many residents felt totally abandoned."

Then they go on to talk about the CQC producing an emergency framework which doesn't include detailed policy or practice guidance, and concern there about the lack of oversight and scrutiny that has been compounded by easements and various other measures that were put in

place.
Do you remember, perhaps not this particular letter, but having those concerns raised with you by family members of people who were resident in care homes?
A. I remember considering this as a balance, and that's the challenge. You see, often in policy, especially in these terrible times, we were taking actions in order to preserve life. Those actions had some negative consequences. We all know that. And a letter like this is an entirely reasonable expression of one side of the argument. And of course you see letters like this, I don't know whether I saw this one or not. You have considerations like this brought to you. You have considerations brought on the other side and you have to make a judgement. That's the nature of governing.
So, you know, you could read out any number of totally reasonable reports of people who found it deeply upsetting not to visit, not to be visited, and not to have a CQC inspection. The challenge is that on the other side, there were, in my view, greater risks of having taken the other decision so it's just a question of balance.
Q. Were you concerned at all about the lack of oversight?
A. I was concerned about it but I just think in this one, in the scales of the -- this decision, the balance was

so far down on the vital importance of protecting people in care homes and of getting everybody who could to work on the frontline in a national catastrophe, that in my view this was not a balanced decision; it was a very clear decision.
Q. Okay. You go on in your statement to say you met with the CQC on 1 July and, in fact, Helen Whately was also meeting with the CQC on the same day. And I'd just like to look at some documents in relation to 1 July.
Can we start with, please, INQ000609960.
This is a summary of the meeting that Helen Whately was having on that day. She met with the CQC, and towards the bottom of page 2, if I may. Can we see the bottom two notes there:
"[The minister] asked KT [who was a member of the CQC] whether KT [was] confident that right and timely steps were taken to ensure people weren't neglected."
And:
"KT noted cautiously that whilst the right measures were taken (giving example of care home ... [that was] closed due to lacking basic in safety for residents), it is likely we will see an increase in the [number] of services that haven't been able to cope during [the] pandemic and therefore a spike of these cases being unveiled in the next few weeks.

"KT stood by their decision to stop routine inspections. [The minister agreed] but still unlikely to uncover bad cases in [the] next few weeks."
And:
"[The minister] asked if we can get more insight into [the] CQC findings in terms of latest and live intelligence -- especially where there are known alarming cases."
A. Yeah.
Q. Now, were you made aware that there was a potential concern that there was going to be inspections that did start to uncover bad cases of care in care homes?
A. I can't specifically remember that. I may have been. It might have been brought to my attention. But it's also -- it's also obvious. If you're stopping infections you're then -- you may find that you'll find more things out later that have gone wrong. In a system which hundreds of thousands of people reside, there are going to -- there are always problems.
Again, I come back -- you know, you've got to remember that the flip side of this is a very high amount of death that was happening in care homes. So that's the balance that we had to strike.
Q. Can I go to page 1 of that email chain, please.
You're not in it, but the minister, Helen Whately

says:
"Thanks Ros ..."
For the e-mail -- sorry, it's being relayed to the minister.
"... I have flagged with [the minister], but on the call Kate [who is the lady from the CQC] suggested a level of detail that [the minister] does not recognise.
"Given [the minister's] real concern by Kate's admission we should expect cases to emerge in the coming weeks of potential neglect/abuse/poor standards of care, she has asked:
"- Is there a way we can get them to expedite inspections?
"- Can we get more formal information ...
"- Do we internally have a sense of what the scale of the issue is that may be about to erupt?
"She was ... clear that whilst she agreed with the CQC decision to stop routine inspections ... she did not agree that this was done at the risk of neglect/abuse to residents and Kate's [the lady from the CQC] comments today did not assure her on this point."
So clearly the minister has got real concerns about what's going on. Does that help you remember whether this was brought to your attention?

A. No, I'm afraid it doesn't. This level of detail is exactly what I would expect the minister to do. She's doing her job exactly as she should.

The key, to me, reading this -- obviously this is the first time I've seen this and I wasn't involved -- the -- but the first sentence, "on the call Kate suggested a level of detail that [the minister] does not recognise", ie -- you know, you'll have to ask Helen about it, but my interpretation of that is that she's being given reassurance that everything's fine and she's challenging and not getting -- and finding out that, you know, the level of detail behind the reassurance is not adequate.

That is my reading of it, but obviously I wasn't -- I wasn't involved. This is one level of detail, more detail than I would have got into.

Q. Right. You --

A. The key point is here: she was clear that whilst she agreed with the CQC decision to stop routine inspections. Right?

So that's where I would have got involved. This is essentially about: okay, where's the boundary of routine inspections? Where do you need to go in? What's the limitation of and implementation of that policy?

If there had been -- if there'd been

a recommendation from Helen in response to this to say, "We must go back to having routine inspections", that's when it would have been brought to me.

Q. Right. Would you not expect, though, concerns that they are going to find potential cases of neglect, abuse, poor standards of care, to come to you as Secretary of State?

A. No, I wouldn't have been -- I'm not sure whether we did see that eventuality occur. You can't bring everything to the Secretary of State. I think we would have -- but we would have anticipated that there would be problems from not having inspections. That's why you have inspections.

But again, I come to the balance, which is you can look at all of these different things that we had to do to save lives, and many of them had downsides. I'm acutely aware of that. They needed to be managed, and what this is doing is managing that decision to suspend routine inspections, and -- but without -- but with a consensus on the core policy, because the alternative is more people dying.

And I know I return to that over and over, but it was our lodestar. It was the thing we were concerned about more than anything. We didn't care about the -- you know, the personal brickbats, the comms, except in

as much as it affected people's behaviour. You know, we cared about reducing the number of people who were dying in their thousands, and we took decisions accordingly.

Q. Can I just ask you a bit more about this, please. Because at the deep dive that we looked at earlier, and if we can have back up on the screen, please, INQ000090302_007 -- sorry, not the deep dive, the Covid-O operations meetings on 23 October, there is reference during the course of the discussion to there being 696 breaches. We can see it there at point (i), I hope, Mr Hancock, you can see it:

"... 696 breaches of regulations identified since the start of the pandemic."

The most common of the breaches were in relation to regulation 12, which was the regulation around the provision of safe care and preventing avoidable harm or risk of harm.

I know you've said to us that it was really a matter for the CQC as to how they assured themselves that residents would be protected, but you've had letters of concern, Helen Whately is receiving alarming messages from the CQC about what might be uncovered. By October now, there's nearly 700 breaches of regulations.

Do you think in fact you should have asked more questions for assurances about how people were going to

be cared for and protected?

A. I did ask for those assurances, and you saw right at the start my text exchange included considerations around this, even in the initial response from the chair of the CQC. So this was clearly at front of mind from the very start of this policy.

696 breaches of regulations in a sector that cares for hundreds of thousands of people over a what, by now, was a six-month period, needs to be put in that context. And in the context of thousands of people in care homes who were -- who'd died. So I think it's -- I think it's entirely -- an entirely reasonable set of decisions.

Q. Right.

There is a contrary view, I suppose, from some that given the level of transmission, the outbreaks, the death data that we've looked at, and the vulnerability of the people in the workforce, and the fact that perhaps training and use of IPC, and in particular PPE, was not as good as it was, in fact that was all the more reason to have inspections. What do you say to that counterargument?

A. I don't think it's correct. I think it's -- I think it is a -- you know, there's many cases when people put policy ideas or suggestions of different ways of doing things that don't -- didn't take into account the fact

that if you drive up contact between people, then you drive up the infection rate.

And it sometimes isn't a popular view, but actually the life-saving thing to do sometimes is to be firm on these things. Add to that, in this case, the fact that CQC inspectors were also incredibly important on the front line, and that's their -- that's the balance that you've got to put to reach an objective decision, given those considerations.

You know, to me, the question that is really important in this discussion is: were these things considered when a balanced decision was taken? And they very evidently were. And then a decision taken in the round.

Q. Two final topics, please, before, perhaps, some overarching observations from you.

You have previously given evidence to her Ladyship on a number of occasions about the case for vaccinations as a condition of deployment?

A. Yes.

Q. And clearly it was applicable to the consultation, indeed in due course the rollout, in the social care sector of that policy?

A. Yeah.

Q. Do I take it that you stand by the observations you've

previously made about the case for why you consider vaccination was necessary as a condition of deployment?

A. Yes, I absolutely do, and I think that we should have vaccination against flu and Covid as a condition of deployment in social care and in the NHS at all times, because I think that, given that these diseases can pass on without the person who has it knowing, it is a dereliction of duty to fail to take up the most straightforward and proven of scientific defences.

And in fact, you know, I -- again, it's something that people can make unpleasant personal criticisms of me for taking such a strong view of backing the science in this space. When we did bring in the vaccination condition of deployment, again, lots of people said that there'd be thousands of people leave social care and there'd be a huge gap in the workforce, and there just wasn't.

And, you know, just before one of the breaks, you read out a bit of vitriol against me. I've been and looked into it, it turns out it was -- it's somebody who was -- is arguing against vaccination as a condition of deployment. I mean, vaccination does, for some reason, cause people to feel very strongly against it, for some reasons, and we can see in America that that can have very negative consequences, and measle rates are going

up as a result. It's a real social problem in our modern society post the pandemic.

But none of that means that I change my view that we have this amazing scientific device called a vaccination. We have incredibly well thought-through logical processes to know when it is safe and effective, and since it is safe and effective and cost effective to vaccinate against flu and Covid, I can't for the life of me see why, if you're a care worker, and therefore care about people, you should allow yourself, or if you're an employer in that space, allow the people who work for you, to take this totally unnecessary risk.

So in short, yes, I agree with the view that I expressed earlier.

Q. Thank you.

Different topic, please. You set out in your statement that at a Downing Street press briefing on 15 April, so the same day as the action plan was announced, you made this statement:

"And we are making it crystal clear that it is unacceptable for advance care plans, including do not attempt resuscitate orders, to be applied in a blanket fashion to any group of people."

A. Yes.

Q. "This must always be a personalised process as it has

always been."

A. Yes.

Q. And we know in due course that there was the CQC report, both interim report and, indeed, final report -- but can I just ask you, when you stand back and look at the pandemic and how it developed, do you have any observations or insights as to why it might have been that people felt necessary either to apply a blanket policy or an inappropriate policy of DNACPRs?

A. I only saw this happen once, and we jumped on it, and I talked about it in public at the time. It is totally unacceptable to have blanket DNRs. There is a concern amongst a small number of people who focus heavily on this that this was more widespread. If it was, it didn't come to my attention, and if it did happen, it's totally unacceptable.

My own reading of it is that this is a one of a number of narrow conspiracy theories that have grown up in this space, but if I'm wrong, then it absolutely must be addressed and the Inquiry should uncover that. So you're quite right to ask the question.

I suppose the reason that it comes up as a question is similar to those people who demanded that we, at a ministerial level, or Chris Whitty at a senior clinical level, should make policy according to who gets

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.
Q. -- 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

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?

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

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

to go through that with you now. So could we have it up on screen, please.

It's INQ000274068, and it's page 19.

Have you got that?

So it's the entry, 13 July, 18.20, Helen Whately:

"We have received a PHE update on the new care home outbreaks -- some were not reported before, some are from blanket testing and some are 'suspected but not confirmed'. I find their report frustratingly vague and dismissive about new outbreaks. I have asked for a proper breakdown of how many fit into each of the categories above, going down to named individual care homes, and want to adopt a 'zero tolerance' approach to covid in care homes. Every single outbreak should be treated as a problem requiring immediate action and investigation."

A. Yeah.

Q. You replied:

"Totally agree. We should have zero tolerance for both covid and crap data. Remember: PHE described Leicester to me as 'progressing positively' 4 days before lockdown. It was only because I blew up ... that imprecision" --

A. "I blew up at that imposition", yeah.

Q. Yes.

"... that they acted."

So can you help us. You'd been Secretary of State since July 2018. Had you had concerns about PHE and the data they produced prior to the pandemic?

A. Well, prior to the pandemic, the -- PHE's focus was almost entirely on non-communicable diseases, and that is part of the reason that they needed to be abolished to replace them with an agency that concentrates only on infectious communicable diseases.

Of course I'd seen some data, but we'd discussed earlier, the data from the care sector was terrible before the pandemic.

Q. Yes, well, I'm going to come on to that. But just very short order, had you had concerns before the pandemic about PHE data?

A. Not specifically about PHE data, no, before the pandemic, but I did very early in the pandemic, yes.

Q. Yes, okay. So very early in the pandemic you start to realise that the data that PHE are producing is poor. You get --

A. Well, not all of it. I mean PHE's early scientific work was excellent. On the tests, for instance.

Q. Right.

A. And you've got to remember that the lack of data here, it's not fair -- I've been quite critical of PHE -- it's

not fair to criticise them for the fact that we -- many of the facts that we didn't know early in the crisis because it was a novel disease, and so --

Q. Okay.

A. -- getting the data sorted was really important.

Q. Well, okay, that's really the question I'm coming to. First of all, when did you realise it was a problem and what did you do about it?

A. Right. So we knew that there was a huge problem of lack of data on the spread of the disease very early. The chair's point earlier today on the difference between measured tests and actual numbers of cases is a vital question that we asked ourselves very early. For instance, we didn't know how many people had had contact with Covid and therefore had got antibodies --

Q. Yes.

A. -- until we got the ONS survey going. So this was a major issue at the start of the crisis.

Q. Yes. So what did you do about it?

A. We improved the amount of data radically over the period of the pandemic. And what you can see here is that, by July, I have a zero tolerance approach to crap data. By then, we were getting better and better data in certain spaces --

Q. Yes.

A. -- but clearly not good enough --

Q. Not here?

A. -- in this space, yeah.

Q. So by July what you're expressing is not only concern about this data that's being discussed but also the general quality of PHE data?

A. Well, by July, a lot of the data had got better. It still wasn't as good as it was in the autumn. You know, I'm -- I come from a tech background, I understand data.

Q. Yes.

A. I found it deeply frustrating, for instance, that early on, when we needed to know how many people had been infected by PHE -- infected by the virus, the first attempt to get that survey, PHE had gone to blood donors to get the blood to do the test. But of course to be a blood donor you have to declare that you haven't been ill for the last two weeks.

Q. Yes.

A. So it was effectively useless. So we got the ONS in to do that survey instead, and they came out with the answer, so that's --

Q. Sorry to cut across you, but we've got to crack on timewise. But do you think more should have been done by you in terms of sorting data out earlier on, and recognising the shortcomings that PHE and others had in

their ability to gather the data in quick time at that point?

A. We did absolutely everything we could, and coming from a technical background in this space, it was an area that I leaned into incredibly strongly.

Q. Should this have been something that had been fully considered in preparedness for a pandemic?

A. Well, it absolutely needs to be sorted for next time, yes, and I think it will. You know, the quality of the data now available is significantly better, and there are, you know, there are programmes across the NHS and UKHSA to improve on this.

Q. On 3 April 2020, you received a briefing ahead of a Healthcare Ministerial Implementation Group, from the healthcare secretariat signed off by Simon Ridley. And it included this:

[As read] "We have not focused on social care to date, given immediate priorities for the NHS. However, we recommend turning to this, given the large-scale discharge from NHS that has been required, of the risks in this sector, and the need to for a strategy to manage Covid in care homes. This will assess the overall social care strategy including discharging capacity and functioning workforce and resilience and guidance to care homes."

In Module 2 --

A. Could you just tell me what date that was that you've read out?

Q. That was 3 April.

A. Okay.

Q. In Module 2, Ben Warner, a special adviser, to Number 10, told the Inquiry:

[As read] "From the start of Covid it was obvious that care homes were hugely vulnerable and I was constantly worried that there was not sufficient attention being paid to them."

And Professor John Edmunds told the Inquiry, from SAGE:

[As read] "That hospitals and care homes were potential high-risk environments was not a surprise. It's clear that not enough was done in February/March 2020 to reduce this risk."

So question to you: taking those three passages into account, do you accept that not enough was done in February and March 2020 to reduce the known risk to this highly vulnerable population in care homes?

A. Absolutely not, in the areas I was responsible for. So, if we go through those three in turn: the first is from Simon Ridley in the Cabinet Office. It's important to mention that when you read out his statement. Simon

Ridley is a fine official, but his statement there is that by 3 April the Cabinet Office had not considered care homes enough. It doesn't mean that we hadn't in the Department; we'd been working on it since January.

Ben Warner is an exceptionally intelligent and capable individual and he is saying at that point that Number 10 had not engaged enough on care homes.

We know from Module 2 that Cabinet Office and Number 10 were making all sorts of complaints. We were getting on with trying to fix the problem. So we were engaged in trying to solve this as well as possible from January 2020, as you can see in all of the paperwork.

Q. Yes, well, I mean, the purpose of putting those three pieces to you is that it is from the Cabinet Office, from Number 10, and from SAGE. So it's three different sources. And another way of looking --

A. But hold on, that's not right. Because the Cabinet Office statement is that they have not turned their attention to care homes. It isn't that the Department hasn't. So it's -- the fact that you read it out without mentioning that it was from the Cabinet Office kind of demonstrates the point, that we were working to solve this problem; we had, in some areas, the Cabinet Office had been blocking the work that was needed. In other areas, they were -- Number 10 were going slow, for

instance on some of the publications that I wanted to make. But we, in the Department, were working as hard as we possibly could.

Q. Okay, well, I'm certainly not trying to hide that it was from the Cabinet Office in the way that I read it out --

A. Right.

Q. -- but one way of looking at those three pieces of information or evidence that I've read out to you is that the "we" refers to the whole government. This was a briefing sent to you about a ministerial group meeting and the professor is talking about not enough generally being done across government, isn't he?

A. I'm so sorry, the Cabinet Office saying that they have not considered this yet, as in the healthcare interministerial group, is not in any sense saying that there hasn't been attention paid to this. It is saying that the Healthcare Ministerial Group from the Cabinet Office, of which I was chair, had not itself considered it. That's a piece of -- it's a piece of bureaucracy which in fact came and went because it wasn't seen to be effective.

Q. I'm not going to fence with you. The Inquiry has the material, the Inquiry can make its own mind up about the question.

A. I am merely responding to the fact that you are

misinterpreting a piece of information and in your opening statement didn't even say who said it, and then you're putting a quite serious accusation that's wholly false based on a misreading so -- (overspeaking) --
Q. -- (overspeaking) -- which I think you've answered.
A. Yes, thank you.
Q. I'll put it again just for clarity: do you accept that not enough was done in February and March 2020 to reduce the known risk to a highly vulnerable population in care homes?
A. No, I do not.
Q. It appears your answer is no, you don't.
A. No.
Q. In a readout of a social care Covid meeting from your private secretary, it records that Ros Roughton asserts that domiciliary care is, in effect, an emergency service. Do you agree with that statement that domiciliary care is, in effect, an emergency service?
A. That isn't how I'd put it. It is a vital service to those who need it, but an emergency service implies both that it might be short lived, and it might be needed in an unexpected way. Both of those may be true occasionally, but generally not; generally, it is planned rather than emergency, and generally, it is long term rather than short term.

Q. Let me move on to levers and you've given a bit of evidence about this already so I'll be quick about this.
You've repeatedly referred back to the fact that as the Secretary of State you didn't have the levers to act when it came to adult social care and that you led on policy and guidance only, for the sector. Is it right that that was something you knew before the pandemic?
A. Yes.
Q. And certainly early on in the pandemic?
A. Yes, I knew, as I said earlier, I knew that before I became Secretary of State, yes.
Q. So why did you not do something about that to increase the levers that you had, certainly to be available in an emergency?
A. Because that would have required a change to the 1948 settlement that set up the NHS and I wouldn't have been able to get cross-government agreement for such a radical change.
Q. Right.
A. Effectively, that is the way -- the only way to solve that is to bring in what would effectively be a National Care Service, which was not something that the government was considering.
Q. Right. But is that something that should be done now, that levers should be available for the Secretary of

State for Health and Social Care --
A. Well, the -- my recommendation --
Q. -- (overspeaking) --
A. -- is that there do need to be levers available. We invented them, in fact, in the early part of the pandemic, as we've discussed, with the linking of emergency payments to action, and so I've made some recommendation in that space, yes.
Q. Yes, so would it be right to say, then, that your view is that it would have been preferable had those levers been available prior to the pandemic, so you could have used them straight away?
A. Yes.
Q. Given that they weren't, why did you not put levers into the Coronavirus Act or some other convenient legislation in the early part of the pandemic, if it was such a problem that you have -- (overspeaking) --
A. Yes, it's a good question. We did bring some measures with respect to adult social care in the Coronavirus Act, and selected the measures that were available in the preparation.
So in the legislation that had been prepared in response to Operation Cygnus. So that had been part of the preparation. To a degree it was used, but I think that there's more to do.

Q. Right. So the fact that you refer back to the absence of levers to act --
A. Yeah.
Q. -- is that then an excuse for things when they went wrong? They weren't your fault? Because if you were putting these levers into place with the Coronavirus Act, or other convenient legislation, then you could use them.
A. That is a very easy thing to say with hindsight. The reality of the situation is that I had to act with the tools that I had, and that's what I did, and drove the life-saving effort to make sure things weren't even worse than they were.
Q. You brought levers in quite early on with the Coronavirus Act. That gave you the ability to -- (overspeaking) --
A. Right, well, in this space, really the most effective things we brought in were the requirements in return for the emergency funding. That's what really brought the -- meant that we could bring to bear policy that we had not foreseen the need for before the pandemic.
Q. Yes. Okay.
Let me move quickly on. I want to ask you some questions about Operation Nimbus.
And I think we're going to need the document for

this, so it's INQ000195891.

So Nimbus, you chaired it, and it was a tabletop exercise conducted on 12 February?

A. Yes.

Q. And therefore very much with the pandemic in mind, even though it was an exercise of itself. No doubt you've had a chance to review the notes of Nimbus.

Can you help us just -- from the notes it appears that there wasn't any discussion about how the government was going to ensure that people discharged from hospitals could be discharged safely, and the right time, given the known problems with the adult social care sector?

A. I've discussed the problems about Exercise Nimbus before. So these exercises are put to -- are developed by the Cabinet Office and put to ministers, and they are best done -- exercised as if real. And the main thing that came out of Exercise Nimbus was the fundamental problem of the wrong doctrine that underpinned it. And the problem with Nimbus, it went -- it was much, much worse than what you imply in your question. The problem with Exercise Nimbus is that it was -- we spent however long we spent, an hour and a half I think, dealing with -- talking about body bags, dealing with how we solve the problems that are a consequence of an

unmitigated pandemic where we don't take action to save lives.

And I came out of Nimbus, and this was the real penny drop moment when I realised that the doctrine that had underpinned the pandemic planning, both in the care sector but also across the board, was fundamentally flawed. And this is well expressed in Module 1 -- the Module 1 interim report of the Inquiry.

Q. Yes.

A. Hold on, let me just explain this point, because it's critical to answering your question.

From 12 February, when I walked out of this meeting and thought "I am not going to preside over this pandemic just ripping through the population", I had to change the -- not just the policy but the underlying attitude across the board, in a whole series of areas, and it took me the work of the next few weeks to do it.

The concept of lockdown was not considered in Nimbus, and we had to get that going, and the publication on 1 March was vital to it.

Q. Yes.

A. The testing was stopped, because that was part of the underlying wrong doctrine by -- from PHE, as was contact tracing. And I had to get testing going again and rebuild contact tracing --

Q. Can I ask the question --

A. No, I'm going to answer your question.

LADY HALLETT: The trouble is that Mr Weatherby has an allotted time, and to be fair to his lay clients, which he's trying to do, they have number of issues they want put to you and he has permission to ask, so if you could just listen to the question, please, to be fair to the people, the bereaved that Mr Weatherby represents.

MR WEATHERBY: Thank you very much.

So I'm not asking you about the underlying doctrine. If you look at paragraph 17, you yourself, as chair, asked for an update on adult social care and the problems are set out there.

So not only have you got the pandemic well over the horizon coming towards us, so well in mind, but you've also got in mind the adult social care sector's inability to cope. So my question was: why wasn't there any discussion of how the government was going to ensure that people discharged from hospitals would be discharged safely and at the right time, given those known and acknowledged problems?

A. There was endless discussion of that. There was endless discussion. And we've been through some of it this morning.

Q. Okay.

A. The point in Nimbus itself is that the whole exercise was based on the wrong doctrine with respect to your question very specifically. And the point I was rather at length going -- you know, explaining, is that was true right across the board. And changing the attitude in PHE and amongst the assumptions underpinning the response in social care, and in this module and on your question, was just one part of having to change that attitude right across the board.

Q. Yes. Well, I've been through the note, if I've missed it someone will point it out.

A. No, it's not in the note here; it's in the notes of what we were actually doing in response to the actual pandemic that was coming.

Q. Right. So there's been a discussion, has there, about discharging patients safely to residential homes?

A. There were endless discussions about it around the time, yes.

Q. It's just -- it's just not recorded?

A. No, it's in loads of the notes about real world discussions we were having about the real pandemic.

Q. Can you help us as to why no one was apparently invited to Nimbus on behalf of the social care sector?

A. I was invited to Nimbus on behalf of the social care sector.

Q. Yes, well, you're the minister.
A. Yes, that's right.
Q. But looking at the participants in Nimbus further up, there's nobody there, as far as I can see, from the social care sector. Why is that?
A. Well, because this was a ministerial meeting, so I was there as the Secretary of State for Health and Social Care. That's the technical answer. But there is a wider point that you make that's important, which is that whereas the NHS has a chief executive who can represent them, there is no such figure.
Q. Yes.
A. The closest we got was David Pearson who did a fantastic job, but he did that job --
Q. Okay --
A. But it's not the same as having executive authority over a whole sector. It comes back to the accountability point we were making right at the start.
Q. Okay, well, you say it was a ministerial meeting but you've got people from the NHS there --
A. Exactly.
Q. -- but you've got nobody from adult social care. I fully understand what you're saying, you've got a chief executive for NHS, but you're not looking for people to express responsibility in an operation, are

you? You're looking for people who can put impact into how those sectors or those organisations would react, given what's going on in the exercise. That's what you really want in an exercise, isn't it?
A. No. This is not a stakeholder exercise; this is a ministerial exercise for decision making, so you need the people with decision-making authority, and there isn't anybody beneath ministerial level with that sort of decision-making authority in social care. It's one of the problems that we talked about earlier.
If you could possibly go on to page 2, you see Helen Whately is there.
Q. Yes, a minister.
A. The minister, yes. But ministers have responsibility for this in social care. That's right.
Q. Before I move on, would it have been improved, as an exercise, had there been somebody from the adult social care sector involved in it?
A. But who? That's the problem. Who? There isn't a chief executive. There isn't a Simon Stevens or Keith Willett counter party. That's one of the problems.
Q. Staying with Nimbus but moving to a different topic, older people. So the minutes record that you, paragraph 8 of the minutes, asked what were the key decisions to make, and NHS England clarified that the

committee needed to decide whether to expand the intensive care capacity at the consequence of stopping treatment to others, and following that decision, the doctors' regulations are updated to reflect treating by likelihood of survival by years of life left.
Now, am I right that that means that older people were less likely to be prioritised for treatment?
A. This was a recommendation by Simon Stevens that I rejected. I rejected it here in the exercise and then I rejected it when the BMA later made it on behalf of their doctors union later in real life.
Q. Right. So the answer to my question is that yes, this does reflect a view of prioritising -- less likely that treatment would be prioritised for older people?
A. It reflects that proposal that was put forward and rejected.
Q. Yes, I see.
And again, in those minutes, can you help us with what alternatives were actually put forward by you or by anybody else and minuted?
A. Alternatives for what?
Q. Well, this proposal is put forward; you say you rejected it.
A. Yes.
Q. But what is the rejection that's recorded in those

minutes? What is it that -- the alternative that you say, "No, no, no, I'm not having that" --
A. No. That's right.
Q. -- "So the way we'll prioritise treatment or the way we'll do it differently is this"; where's that?
A. Rejection of a change to this approach left us with exactly the same and normal approach, which is that the doctor on the ground makes the decision as to the appropriate --
Q. Yes --
A. -- please let me finish my answer because it's quite important.
Q. All right.
A. It's that the doctor on the ground should make that decision. That was my and -- my view, strongly supported by Chris Whitty, as CMO.
But it was exactly this sort of discussion that made me determined to ensure that we would stop the pandemic rather than just let it wash through, and that made me realise that the doctrine that had been underpinning the planning was wrong. And it is a deep irony that it was the Department of Health team who spotted that --
Q. Yes.
A. -- with me at the helm, and went on to solve all of these problems, as much as we possibly could in the

circumstances.
Q. Right.
A. That is what I did. And representing some of the bereaved families as you do, that is the work that we had to do from this point onwards.
Q. Right, okay. So this is what is thrown up in the exercise: that you realise here that what's being said to you is that we need to prioritise in a way that just basically discriminates against older people. And you reject that?
A. Correct.
Q. So where is it in the minutes about what you're going to do in the alternative?
A. Well, the alternative was -- what this led to, ultimately, was the policy of lockdown.
Q. Yes.
A. Because lockdown wasn't discussed in these minutes either, because it wasn't proposed as part of the plan.
Q. Exactly, there's nothing in this minute of Operation Nimbus which says: Secretary of State's rejected this view that was put forward, horrified at the idea of discrimination.
A. Can you go on to the conclusions? Because the chair was -- the chair asked what key decisions to make.
Q. Yes.

A. I have a feeling -- I have a -- if you go up a page, back a page. I'll have to read it because there is a bit of --
Q. Well, I don't want to be unfair.
A. I suppose there's two points. The first is I rejected it, and it's there in the minutes somewhere. But the second point is that in real life -- this is the exercise -- in real life, the BMA brought this proposal to me and I rejected it, in the pandemic itself.
Q. That's not my point, Mr Hancock.
A. Okay.
Q. My point is: where is your alternative here? You've got the exercise, you've got the proposal. You say you rejected it.
A. Yes.
Q. But where is the alternative -- (overspeaking) --
A. The alternative is the status quo, which is that doctors make decisions on the ground.
Q. -- at 12 February we need to realise that in order to avoid this discriminatory proposal, we need to do X, Y and Z; and it's not there, is it?
A. No, because it's the status quo that I was supporting, and therefore I didn't need to set it out. It was that we were not going to make such a change.
I was being -- the NHS was recommending a change to

me. I rejected the change. I didn't need an alternative, I needed people to do their job, which is what doctors went on to do, which was to treat everyone.
And my job was also to try to stop getting into a position where you even have to choose. I did not want the rationing of care, and that is what we achieved.
Q. Well, you did need an alternative, you needed isolation and testing and PPE and -- (overspeaking) --
A. Yes, and I went on to build all these things, exactly, yes.
Q. Finally on Nimbus, there appears to have been discussion about staff absence in the healthcare sector --
A. Yes.
Q. -- with respect to communication about it, but nothing, no discussion about staff absences in the adult social care sector. Why was that?
A. I don't know whether that's the case. As I say, it was a Cabinet Office prepared paper, so the -- ultimately, Exercise Nimbus was the -- in my view, the endpoint of the approach of -- embodied in the 2011 strategy. If you remember, a few weeks before this, I'd been calling for COBRs, trying to get action, been blocked by the Cabinet Secretary. They'd quite rude about me, and they continued to be rude about me.

Q. Well, let's not worry about that.
A. No, no, it's important because what I'm trying to get you to understand is that Exercise Nimbus was based on the wrong doctrine it was the moment for me that I thought, "We cannot let this happen", and then there was a whole load of action that went from it. So that's my explanation why certain things aren't in there that, really, in a future exercise absolutely should be.
Q. Okay. I'm not going to take Nimbus any further with you. The point I put to you is that the problem about the proposal that was being put to you, you're chairing it and --
A. Yes.
Q. -- these are the minutes, they're not the Cabinet Office briefing documents, these are the minutes of it.
A. Yes.
Q. There's nothing in there about all the measures that you say you agree should have been taken thereafter, and this is 12 February.
A. Yes, and my response to that is that all you're doing is reinforcing the point that I would make in response to Nimbus, which is the exercise highlighted the wholly inadequate attitude that was being taken by the Cabinet Office to how to respond to a pandemic.
LADY HALLETT: Mr Weatherby, it's not your fault, you are

over your allotted time, but we're going to take a break now. And don't worry, if you could try to work out during the break what you can do if I allow you another ten minutes.

MR WEATHERBY: That's very kind, thank you.

LADY HALLETT: I shall return at 3.50.

(3.37 pm)

(A short break)

(3.51 pm)

LADY HALLETT: Mr Hancock, before we start again, I appreciate how difficult it is for you and how you wish to make sure that any criticisms that aren't fair aren't made, but there's limited time left, the stenographer has had an extraordinarily long day, and we still have a number of other questions from other Core Participants, so, please, if you could focus on the questions and just answer the questions, I'd be really grateful.

THE WITNESS: Absolutely. Could I just very quickly put on the record a further -- a little addition to the previous answer, though, to exactly this point, because I was asked about this point about who took decisions over prioritisation of care, and we could have shortcutted that whole section, because in paragraph 35 of that same paper it says:

"The chair stated that clinicians, as part of NEPP [which is the national emergency planning procedure] should be empowered to make decisions."

So it's stated there in the minutes, thank you.

MR WEATHERBY: Yes, well, thank you for that clarification. That wasn't my point. My point was about the other issues that should have come as a result of you rejecting the proposal that was put.

Two topics to finish my questions and I'll deal with them as briefly as I can.

Asymptomatic transmission. On 14 March of 2020, your department and the Office of the Chief Medical Officer received data on the Diamond Princess cruise ship confirming that 696 people on board the Diamond Princess had tested positive, 328 of which were asymptomatic, and some of the cases appeared to be superspreaders.

Just for the record the reference is INQ000048086.

Can you help us, those who had been repatriated from cruise ships were required to self-isolate for 14 days and tested within 24 hours of arrival, and that had happened on the 10 March return of passengers on the Grand Princess cruise ship.

Why were care home residents discharged from hospital at around this time not treated similarly?

A. The problem here was that the PHE clinical advice said that asymptomatic testing was not appropriate, and of course there weren't enough tests. I had stated in January that the policy should take -- would be: proceed on a reasonable worst-based scenario. Noting that there was evidence, even then, of asymptomatic transmission. You'll have to ask PHE why it didn't update its advice until April.

Q. Right. In terms of the self-isolation point, though, the requirement for returning cruise ship passengers for self-isolation for 14 days, why wasn't that something that could be done with the discharges from care homes, for example, by things that you've already discussed, about holding accommodation or hotels --

A. Yes.

Q. -- where care homes didn't have the availability to do it themselves?

A. Yes.

Q. Why was that not done?

A. You'll know from the discussions that we've had that that is something that ministers were pushing for, and -- but we weren't able to put that in place until the middle of -- the middle of April. In fact, because of my concerns about asymptomatic spread, I'd insisted that people coming back from Wuhan were isolated, in

February, as early as that.

So this was something that the clinical advice was clear from PHE, Sharon Peacock led I think on that advice. It's something you'll have to ask PHE.

Q. I'll come on to that in just one second.

Just on this point of the apparently different treatment at returning cruise passengers and discharged patients, and this position of discharges in the middle of March, and then more testing becoming available with the action plan on 15 April, why did you not stop elective treatments, elective surgery, for example, at the same time or before the discharges from hospital to care homes?

A. The NHS were working on their policy of elective discharge -- pausing electives at that point. That was a decision for Simon Stevens, so you'll have to ask him about that.

Q. That would have meant that the discharges could have been delayed until you had proper testing and more data --

A. Well, not necessarily because it depended on the spread of the virus and how many people ended up in hospital, but I mean I essentially agree with the thrust of your point. People coming home from cruises, of course, could self-isolate at home. For somebody in a care

home, their home is the care home. So there is a -- it is more difficult --

Q. Yes --

A. -- because there isn't a place automatically to go.

Q. -- I understand it's more difficult, that's why I put the point about holding centres.

A. Yeah.

Q. Finally, onto asymptomatic transmission more generally. You've said today and in your statement that the initial consensus that the virus could transmit asymptomatically underpinned many decisions, including, for example, the Department's initial advice on the management of the virus in care homes and, to be fair to you, in your statement you set out your reservations about that.

A. Yeah.

Q. But does it follow that if you had worked on the precautionary assumption that the virus could transmit asymptomatically you would not have supported the decision to discharge patients untested in March 2020?

A. Oh, not necessarily. I think if we -- if there had been concrete evidence and clinical advice of asymptomatic transmission that would not necessarily have changed that policy because for instance, then we would have known that asymptomatic transfer in hospitals would have been more prevalent and therefore hospitals would have

been even -- would have thought to have been even more dangerous settings than they were thought to be at the time. So I don't think it follows that an -- a policy assumption of asymptomatic transmission at that stage would have changed that policy. It's a difficult counterfactual question, but there is a case that in fact it would have made the policy as enacted --

Q. Yes, I follow that. I follow that your case is that there weren't enough tests available, hospitals are dangerous places.

A. Yes.

Q. But the question is you would have stuck to the same policy decision --

A. As I said --

Q. -- (overspeaking) --

A. -- it's a difficult counterfactual question --

Q. Yes.

A. -- but there is an argument that in fact knowing about asymptomatic testing categorically at that point might have made the policy choice that was made, more, rather than less strong.

Q. Yes. Now, you say that -- finally this. You say that you'd received advice from PHE that tests didn't work reliably on asymptomatic individuals.

A. Yes, yeah.

Q. Were you made aware of any evidence that that was based on?

A. Oh, I was advised this repeatedly by my clinical advisers from early on. There was then a disagreement that we went through in a previous module between Chris Whitty and Patrick Vallance on this point. I asked for advice from the two of them, and a month later, Patrick Vallance finally came up with that advice. So we went through this in the previous module and --

Q. Yes, and did you suggest or consider ordering, as Secretary of State, a trial of whole care home testing, for example, in one of the locations with an outbreak to test for --

A. We did that when enough tests were available, when we'd expanded the testing capacity but, as you know from another module, that took longer than it should have done and I had to take personal responsibility for making that happen.

Q. Bearing in mind the answers you've given, even if it was necessary to go ahead with the discharges without testing being available, was it something that you considered to only require care homes to accept patients if they had facilities to isolate them? Is that something that you --

A. Yes, so we did consider that at the time, and the

problem was what you do with people who don't have that available. And the point about the danger of hospitals, you know, remains the same. So --

Q. But you would have had a position where maybe half of the care homes or three-quarters of the care homes in a particular area had isolation facilities, so you would have had that capacity, and then you'd have been able to consider what to do with the others?

A. Yes, but all of that presumes that people are safer in hospital than in a care home, and I don't think that was true at the time.

MR WEATHERBY: Nothing further. Thank you.

LADY HALLETT: Thank you very much, Mr Weatherby.

Next I think it is Ms Beattie.

Over that way, Mr Hancock.

Questions from MS BEATTIE

MS BEATTIE: Mr Hancock, I ask questions on behalf of Disabled People's Organisations. You gave evidence this morning that it was when you saw the two local authority plans that you realised that local plans were as good as useless, I think you said?

A. Yeah.

Q. Now in June 2018, which is just before you were appointed Secretary of State for Health and Social Care, a department briefing paper on pandemic influenza in

adult social care and community healthcare had highlighted that Exercise Cygnus in 2016 identified "a knowledge gap in community services preparedness"?
A. Right, I didn't -- I don't think I knew that.
Q. Including for adult social care.
A. Mm.
Q. So do you agree that the adult social care sector's lack of preparedness for a pandemic was well known prior to Covid-19, including to your department?
A. I can't testify that because I haven't seen the evidence you refer to. If that's what it says, I didn't know that until you just said it.
Q. So you didn't have to see those two local authority plans to know about the knowledge gap in community services preparedness; is that right?
A. I can only testify what happened to me and what I did, and it was when I saw those plans that I first realised that that was a major problem.
Q. Had you made any investigations between becoming Health Secretary and the outset of the pandemic into that level of preparedness?
A. Yes, I was briefed when I became Health Secretary on our pandemic preparedness plans, and I went back in some detail with Clara Swinson, who was the lead official, on this -- on this question.

Q. But you weren't told what was in that June 2018 paper?
A. No. Not that I can remember.
Q. Now, at the beginning of March 2020 -- Counsel to the Inquiry took you to the coronavirus and social care meeting of 6 March this morning; do you remember that?
A. I do. I remember it very clearly.
Q. And at that meeting you said the impact of Covid posed a complicated set of problems for the social care sector which needed to be gripped as soon as possible.
A. Yes.
Q. You recall that?
A. That's right.
Q. And I think at the same meeting, the Minister of Care, Helen Whately, said: We need to ramp up preparedness around social care. Is that right?
A. Yes. The essence of this meeting was it was when the department decided -- and it was my decision ultimately, but it was a strong consensus in the department -- that we needed to take responsibility for what was going on in care homes, irrespective of the fact that the -- some of the policy levers were not our formal responsibility. We just decided that nobody else was doing it so we'd better had.
Q. You say "care homes", I assume you mean social care generally -- (overspeaking) --

A. I do mean social care. Thank you for picking me up on that. You're quite right.
Q. So having decided that at the beginning of March 2020, why did it take until mid-June 2020, almost three and a half months after you thought that there was a complicated set of problems which needed to be gripped as soon as possible, and what you've just told us, to set up the social care sector support taskforce?
A. That's a misrepresentation of what happened. What happened after the 6 March meeting was immediate action on a whole series of fronts. We saw earlier the minutes from that meeting saying that I'd set out ten different areas in which we needed to take immediate action, and a huge amount happened from that moment onwards. The Social Care Taskforce was a way of bringing together a disparate sector to -- and a way to have a formalised engagement with the sector that, I, on recollection, was led by the minister rather than me, largely, but that was a -- you know, it comes back to the problem that we were discussing with the -- with the Bereaved Families Group, that there is no single leader of social care, you know, at that -- I've looked at the minutes of the exercise that we just talked about, Clara Swinson was there as a departmental official leading on social care, and as part of the -- was part of the discussion. So

she was doing that job, so it was done, but there wasn't a sector-wide formal grouping, in that sense, and so I understand that's -- that's my recollection of why the taskforce was set up.
It absolutely does not imply a lack of action.
Q. But are you telling us that it wasn't until mid-June 2020 that it occurred to anyone that that formalised engagement structure needed to be put in place?
A. No, I'm not saying that. There was a huge amount of engagement, largely led by Helen Whately and the Civil Service team, Ros and the rest of the team. The -- it was put into a taskforce form, so a reasonable thing to do.
Q. One of the things that taskforce was set up to do was to oversee the Social Care Action Plan; is that right?
A. I don't recall.
Q. Right. I think that's stated in the letter that you sent to David Pearson in -- (overspeaking) --
A. At the time, right.
Q. -- (overspeaking) -- June setting up the taskforce.
A. Right, okay.
Q. And that Social Care Action Plan had been published in mid-April 2020; is that correct?
A. Okay.

Q. Sorry, you understand the action plan was published in mid-April --
A. If that's what you're telling me. You mean the 15 April document?
Q. Yes.
A. Yes.
Q. And would you agree that it's not very useful to set up a taskforce to oversee delivery of an action plan that had been published two months earlier?
A. No, I don't think that's true at all. I think we published the plan, and we got on with delivering the plan. The plan itself changed the advice in a way that reflected the now agreed clinical recommendation of assuming asymptomatic transmission, for instance, and many, many other things. A huge amount of further work was done, including the changes announced and the extra money announced, for instance, on 15 May and many other times.

Formalising that after this period of intense activity into a group that could take it forward, led by somebody from the sector, in David Pearson, was a good next step. It was entirely reasonable to do it in that timeframe.

Q. And you've given evidence already that it was -- your department was overstretched and had no levers. So was

it an overstretched department with no levers that had been overseeing that action plan?
A. Of course we were all unbelievably busy responding to the greatest civil emergency in 100 years. So yes, we were busy, yes.
Q. The next March meeting which Counsel to the Inquiry took you to was 11 March. Do you remember that? It's the social care coronavirus meeting --
A. I don't remember that specifically. It wasn't as momentous as the previous one.
Q. Right. Well, I'll ask the questions and you can tell me if I need to been up the note of the meeting, but it is a social care coronavirus meeting of 11 March at which there was discussion of speeding up hospital discharge.
A. Right.
Q. Do you accept that?
A. I don't know. It was five and a bit years ago, so --
Q. Right, well, if it assists the witness, it is INQ000328131.
LADY HALLETT: Can you get on and ask the question while it comes up, Ms Beattie, please. You're running short of time.
MS BEATTIE: Yes.

At the meeting there was discussion of whether everything was being done to speed up hospital

discharge. A discharge to assess option was proposed, which you agreed with?
A. Right.
Q. And just to put that in context, is it right that discharge to assess essentially aims to discharge patients from hospital as soon as possible, as soon as they no longer need acute care, but they might still need care services, and that would be assessed once they're out of hospital? Is that right?
A. That is -- that's the definition of it more or less, yes.
Q. And you were at that time trying to free up tens of thousands of beds, and so discharge to assess was accelerated; is that right?
A. Yes, and it's entirely reasonable if you don't clinically need to be in hospital but do need continued help, making sure that people -- that the assessment of what continued help is needed is done after discharge is an entirely reasonable way of going about things.
Q. So what safeguards did you understand existed, then, to ensure that patients who were discharged to be assessed did in fact receive full assessment of their support needs once they were out of hospital?
A. Yes, it's incredibly important that they do. For instance, we were putting in place at the same time the

financial arrangements to make sure that the initial period of care -- an initial period of care was paid for in all instances, rather than having to be assessed for payment. So removing the financial barrier to getting that care was one of the steps that we took. It's -- because what you wouldn't want to do is to undertake a discharge to assess without a care package in place. And normally the care package is agreed in negotiation, and it's based on the assessed care needs, but instead, we simply put the care packages in place.
Q. Now you're aware, I presume, of Healthwatch England survey material which showed that in fact in the first six months of the pandemic, 82% of respondents did not have their recovery and longer term support needs assessed. Nearly one in five of these was reported as having unmet needs. 45% of people with a disability, and 20% of people with a long-term condition said they had support needs that were not being met following their discharge?
A. Yes, well, the -- you'd need to consider that evidence alongside what is the normal reported level of unmet need in that group, because some of those needs will be significant in normal times as well. Because we're generally talking about non-Covid needs, those who were in hospital for non-Covid reasons.

The one possible explanation for why the proportion of those who didn't have assessments is so high is because we were paying for the care irrespective of a needs assessment, whereas normally the payment only comes following a needs assessment, and therefore, the needs assessment is critical to unlock the payment.

So ironically the generosity of the support for the care sector, and the £5.1 billion that I outlined, may have led to fewer assessments being done, along with the fact that this was in the middle of a pandemic, so there would have been -- people would have had other priorities as well.

Q. Right. So that's the formal aspect of -- you're talking about the procedural aspect of the assessment, but are you aware of any auditing of discharge to assess cases to ensure that patients have not remained, post-discharge, in unsuitable placements and without adequate support and needs being met?

A. I'm not aware of whether there was or there wasn't. It's a level of detail that you'll have to ask Helen Whately or maybe even -- or maybe one of the officials. It wouldn't have come to my desk.

LADY HALLETT: I'm afraid you're going to have to wrap it up, thank you, Ms Beattie. I'm sorry we're in such a rush this afternoon. Thank you.

Ms Weston.

Questions from MS WESTON KC

MS WESTON: Good afternoon, Mr Hancock. I am asking questions on behalf of the Frontline Migrant Healthcare Workers Group. We represent care workers who were at the sharp edge of the pandemic.

A. Yeah.

Q. Our questions concern how the employment conditions for workers in the adult social care sector, impacted on the spread of the virus.

A. Yes.

Q. Can I ask that we turn up INQ000088388, which is the early draft of the Adult Social Care Strategy Document, if I can ask you to look at 0020, which is paragraph 2.27.

So in that paragraph, we can see that the proposal was for paying workers their full wages for up to so many weeks of sickness or isolation during the pandemic.

A. Yeah.

Q. And that:

"Where local authorities face particularly disproportionate costs ... Government [to] meet the costs, (policy not agreed with ministers)."

A. Yes.

Q. Then, if it wasn't happening, you'd want to know, and

you would work with those representing care workers to ensure there's a way that staff can flag if they're not getting that support through.

A. Yes.

Q. Then if we cross-reference that with INQ00088629, which is the minutes of the Covid-O meeting at which that draft strategy was discussed --

A. Right.

Q. -- page 4, it explains the reasoning for rejecting that Statutory Sick Pay proposal as follows:

[As read] "The commitment in paragraph 2.27 [which is the one I've just taken you to] might cause difficulty for the government as it would be the first time that the government acknowledged that Statutory Sick Pay was not appropriate ..."

A. Yeah.

Q. "... and clarification would be needed ..."

A. Yes.

Q. "... about why the policy wouldn't apply to all key workers who had been declared as essential."

A. Absolutely.

Q. So my question is this: do you accept that it was well understood at an early stage that an increase in Statutory Sick Pay was needed to protect care workers and service users alike, but that it wasn't immediately

adopted for ring-fenced?

A. Yes, it's safe to say that I campaigned in favour of that. I was strongly in favour of the language that you highlighted in yellow in 2.27 of the previous document and I would have made the case for that in this meeting but clearly didn't get my way.

Q. Well, wasn't the reason to save the government the embarrassment of admitting that Statutory Sick Pay was inadequate across the board?

A. No, I thought that Statutory Sick Pay was inadequate and I still think it's inadequate and I made that case firmly.

Q. So how would you describe, then, could you explain what was the nature of the difficulty that such a policy would present for the government that's referred to --

LADY HALLETT: Ms Weston wasn't suggesting that was your attitude.

A. No, no, I know, but all I can do is tell you what I think. I think Statutory Sick Pay should be higher, I don't think there's a difficulty, that point would have been made by somebody else. I lost the argument.

MS WESTON: Yes, but presumably you were at meetings where that was discussed --

A. Yes.

Q. -- and what the objections were were discussed. Can you

help us with that?
A. No, because I don't recognise them. I don't think there are any.
Q. So you didn't hear anybody talk about any objections?
A. Well, I can't remember but lots of people make rubbish points that you forget, don't they?
I mean, I can't -- the implication of the question is that there should be better Statutory Sick Pay. I strongly agree. I can't think of reasons not to, other than the direct cost of it. The direct cost, in my mind, is massively outweighed, in normal times, let alone in a pandemic, by the benefits of such a policy. I apologise that I can't remember what the people who, unfortunately, won the argument at that time said in doing so.
I regret that they won the argument and I think that the government should sort out Statutory Sick Pay now, and I would recommend that to the Inquiry.
Q. Just moving on --
A. Yes, sorry.
Q. Dame Jenny Harries has noted in her witness statement -- for my Lady's note it is paragraph 9.13:
[As read] "The financial position of the carer also served to encourage them to return prematurely to work when staff in other sectors would have isolated,

supported by adequate sick pay."
A. Yes.
Q. And that's because of the nature of the peripatetic workforce?
A. Absolutely. Yes.
Q. So given that subsequent scientific evidence -- I'm thinking particularly of the Vivaldi Study -- did confirm the link between inadequate sick pay and the spread of the virus --
A. Yes.
Q. -- firstly, understanding that it wasn't your decision to take, but do you regret the decision?
A. Of course. I disagreed with it at the time. I'm sorry I can't be more use to you other than to say that you're completely right.
Q. Mr Hancock, I'm going to move on to the position of domiciliary care workers.
A. Right, yes.
Q. So you accept, I think, and you've already recognised today, that workers in domiciliary care are frequently on zero-hours contracts working multiple jobs?
A. Yes.
Q. Do you accept that they're also frequently migrant workers on tied visas?
A. Yes, frequently and disproportionately, yes.

Q. And they are also undocumented workers who have come to the UK legally but whose visas have expired?
A. I haven't seen evidence of that myself.
Q. These were important aspects of the sector, the significance of which I suggest was overlooked by government when looking at the impact of working conditions on the spread of the virus; do you agree?
A. I agree that the decision by the government that I had argued against by its nature, therefore, didn't take into account this important factor.
Q. For example, whistleblowing for a care sector in such a precarious position would be impossible, even in, to use your language of a short while ago, the worst extremes, wouldn't it?
A. Yes, it would. Well, it depends on the exact circumstances of the worker.
I mean, I strongly support those who are in the sector and I absolutely recognise, and we all should, the huge contribution of migrant workers in this sector.
I do not endorse the continued employment beyond the period of their visa of workers in that situation, and I think that the policy that I proposed, some of which became policy and some of which didn't, reflects that balance, and I think it's a reasonable position to take.
Q. Mr Hancock, do you accept that the government's pandemic

strategy suffered from a lack of understanding of the realities for this cohort of workers who were already at the bottom of the hierarchy?
A. No, I don't think that we in the department failed to understand the situation; I think that the situation was exceptionally different because of the nature of the virus.
You know, the question is a very reasonable one. You're saying, was there a lack of understanding? There wasn't a lack of understanding, it was just really hard.
LADY HALLETT: Thank you, Ms Weston.
MS WESTON: Those are my questions, my Lady.
LADY HALLETT: Mr Straw.
Mr Straw is over there.

Questions from MR STRAW KC

MR STRAW: Thank you.
Mr Hancock, I represent John's Campaign, The Patients Association and Care Rights UK.
In January 2021, Helen Whately pushed to have visitor restrictions relaxed.
A. Yes.
Q. You refused and you said that this was because we needed to save lives.
A. Yes.
Q. Could we have on screen, please, a document

INQ000492343. Thank you.

You can see, this is a letter here from -- we can see from the bottom of the page -- John's Campaign, Dementia UK and others --

A. Yes.

Q. -- addressed to you, dated 2 July 2020.

A. Right.

Q. I'm just going to refer to a couple of aspects of it and then ask you the question, please.

So it refers there to the "hidden catastrophe ... taking place in care homes". A little further down:

"... much suffering and a deterioration in mental and physical health among many of the residents because of the ban on all visitors.

"This enforced separation has had particularly damaging consequences for those living with dementia (who make up over seventy per cent of the population in care homes) ..."

And then a couple of paragraphs down:

"What's more, without these essential family carers, the cognitive abilities of a person with dementia can deteriorate rapidly ... this enforced isolation from family and friends can be fatal."

There's been:

"... a significant rise, 52%, in

non-coronavirus-related deaths for people with dementia."

At that time, were you aware of this type of evidence that restrictions on visitors themselves caused many deaths as well as other widespread harm?

A. I was aware of the difficulties caused by the restriction on visits, yes.

Q. Was this is an area of data lack, where you didn't have enough information as to the seriousness of the harms including deaths and other illnesses caused by visitor restrictions?

A. It's true that the data on this improved over time and was weak at first. It is something that we considered in making the difficult balanced decision about visiting.

Q. In terms of recommendations for a future pandemic, in order to ensure that the data on this very important area is better, can you recommend any changes? For example, the better involvement of stakeholders representing those with lived experience in information coming to government?

A. Well, the -- I largely left it to -- delegated to Helen Whately the discussions with stakeholders in this space. I, as you've seen from the earlier discussions, I essentially took her advice in this -- at this time.

I understood these considerations. I also had a duty to ensure that as few people died as possible overall, and this was, as I said, a difficult balance to strike.

I'm sure that the policy, over time, can be improved by consideration now about how you can better -- have better options, essentially, but ultimately, visitors were one source of bringing the disease into care homes, which we had to take seriously.

Q. Well, looking at that side of the picture, were you aware of evidence that permitting visitors by an essential care supporter with appropriate safeguards, and so for example, a negative test, PPE, limited contact with others, didn't greatly raise the risk of harm from Covid? And to give you one example of that evidence, the Department of Health and Social Care's paper on the winter plan, dated 15 September 2020, said: There is currently little evidence that visits are a source of outbreaks.

A. Yes. So, firstly, I was absolutely aware of that sort of evidence, and it was duly considered, as your question implies. The second thing is that the case rate in September 2020, whilst rising, was still relatively low. So that might explain that statement.

Q. Looking --

A. Whereas by January, the case rate was absolutely off the

charts and extremely high. So the level of background prevalence of the disease is a very important consideration, which is why the rules around visiting changed over time.

Q. But even in January 2021, in terms of an essential care supporter, would you accept that the balance of harm, so the harms that would be caused by refusing access to essential care supporter, clearly outweighed the risks of harm through Covid of allowing them in?

A. No, that wasn't my judgement. On the contrary, by -- in January 2020, the disease -- sorry, January 2021, the prevalence of the disease was at the highest point that it had been throughout the entirety of the pandemic, higher than in the first wave, and it was when the vaccine programme was only just getting going. If you recall, the rates shot up over that Christmas period, and it was extremely serious, and so my guiding principle, then, as throughout, was to save lives, and that's why I took the decision that I did. I think the balance actually was pretty clear.

Q. Would you accept that in decisions like this, the harms due to Covid were prioritised over the harms from other causes?

A. No. That isn't how we operated. Right from early on, Chris Whitty set out the direct Covid harms, the

indirect harms due to Covid, the non-Covid harms, and we took all of these into account. That was a really important principle of how we did things.

Q. A linked but slightly different question. So going back to CQC suspending its routine inspection and a question linked to that. Do you accept that the vacuum of oversight that was caused by that could and should have been mitigated by giving a right to visit from an essential care supporter to each person who was living a care home?

A. I think that is -- when prevalence of the disease was low, that would be a reasonable option to consider. But I think the challenge with all of these policy proposals is you have to set them against the cost of increasing the likelihood of people dying, and that's what we did.

Q. A different issue now about PPE. You covered this earlier but there's a slightly different question you haven't been asked. So guidance dated 16 March 2020 advised that the provision of care within the home should continue as normal essential care. However, you didn't decide to provide free PPE for extra resident unpaid carers nationally until 20 January 2021.

A. Yeah.

Q. Would you accept that the needs of unpaid carers for PPE should have been met well before this, particularly when

their essential role in the home was noted as early as March 2020?

A. Well, that is a very, very good question. There were a number of challenges there. The first is that we didn't have enough PPE, and you'll know from the whole PPE module, the extraordinary lengths that we went to to buy more PPE, and the challenges that that in turn threw up. So that's the first thing to say.

The second thing is, as per the previous discussion, defining who is an unpaid carer is hard. I think this is an area where we could seek recommendations from the Inquiry for the future because there should be more PPE more widely available in a future pandemic, and the concept of a definition of an unpaid carer has been -- is improved. There's been a lot of work done on that including during the pandemic.

So I think it was a reasonable judgement at the time but it is an area where we should be better prepared in future.

MR STRAW: And so, if I -- may I do one final question, my Lady, or is that my time?

LADY HALLETT: I think you have had your time, I am sorry, Mr Straw.

MR STRAW: No problem at all.

LADY HALLETT: I'm really sorry. Thank you.

Right. Mr Payter.

Questions from MR PAYTER

MR PAYTER: Mr Hancock, I represent the National Association of Care and Support Workers, and the topic for you is the vaccination as a condition of deployment --

A. Yes.

Q. -- in CQC-registered care homes.

And at paragraph 247 of your Module 6 witness statement you said that the concerns about the mandatory vaccination policy raised during the consultation period "especially about staff leaving these caring professions did not materialise"?

A. Yes.

Q. And, indeed, you repeated that evidence in response to a question from Ms Carey this afternoon.

A. Yes.

Q. Item 56 on your evidence proposal is a record of a meeting of the Covid-19 Operations Committee on 31 January 2022.

Could we have INQ000091577, page 6, on the screen please.

Just while that's being brought up, Mr Hancock, at that time the government was considering revoking the policy and associated legislation, which had been in effect for about two and a half months. And as we'll

see on page 6, your successor as Secretary of State, the Right Honourable Sajid Javid, was recorded as having said that there was "an estimated 19,000 people who had lost their jobs as a result of the policy."

And you will know from your own time as Secretary of State that 19,000 job losses was well within the predicted estimated range as set out in the legislative impact assessment. So Mr Hancock, in view of all of that, do you accept that the concern about the reduction in workforce capacity as a result of the policy did in fact materialise as predicted?

A. No. This was at the lower end of estimates, and you've got to put this in the context of around 2.5 million people who work in the sector. The turnover in the sector is significantly higher than 19,000. It didn't have a material impact no.

Q. Well, Mr Hancock, the 19,300 figure was the net reduction in the size of the workforce in the relevant period and takes into account both normal turnover and new staff joining and staff leaving. And in December '21, a survey, undertaken by your former department, of workers gave the second most likely reason to leave as the policy. So again, in view of that evidence, do you accept that it did in fact lead to a reduction in workforce capacity?

A. No. The number isn't material in the context of the normal turnover of a workforce of 2.5 million people, and you're modelling up gross and net numbers to say that people left because they chose not to be protected against harming people in their care, is -- they will have been -- they will have been hiring to replace them. So no, it didn't reduce capacity, and the actual number of people who chose to go down that route was lower than the central estimate in the impact assessment.

So I absolutely stand by the position. In fact, my -- the lesson from this is that vaccination of a condition of deployment has a lower impact than we had feared before bringing it in, and therefore, the balancing item, the only argument you can make against it -- the only moral argument, in my view -- is weaker than we thought at the time.

The logical case in favour of vaccination of a condition of deployment for people in caring professions is absolutely categorical, stronger than when I brought that policy in, and is a deeply ethical and moral policy.

LADY HALLETT: Thank you, Mr Payter.

Mr Burton.

Mr Burton is over there.

Questions from MR BURTON KC

MR BURTON: Thank you, my Lady.

Good afternoon, Mr Hancock. I ask questions on behalf of the TUC.

A. Yes.

Q. The first topic I want to ask you about is financial support --

A. Yes.

Q. -- for people working in the care sector, and in particular the Adult Social Care Infection Support Fund.

A. Yes.

Q. Now I'm going to refer to that as "the fund" if you --

A. Okay.

Q. It's true, isn't it, that as a consequence of the paucity of Statutory Sick Pay and the general insecurity in low wages in the sector, that a particular problem was that employees in the care sector stood to lose out very significantly if they were required to self-isolate?

A. Yes.

Q. And as a consequence, that posed a risk for care workers properly being tested because of fear they would have to self-isolate?

A. A risk. That's a reasonable way of putting it, yes.

Q. And that was one of reasons the fund was set up, wasn't it, to address that risk?

A. Yes.

Q. And the way the fund worked is that 75% of the grant that would go to care providers had to be allocated to specific measures, including paying staff full wages if they were off work because of self-isolation?

A. Yes.

Q. But also to ensure that they could employ more staff if necessary, and indeed limit the use of public transport by staff, and indeed, if necessary, provide them with accommodation. That's right, isn't it?

A. I will take as read the points of detail, but broadly, yes.

Q. Now, those objectives were discretionary on the part of the providers, and as early as June 2020, a month after the fund was set up, UNISON warned the department that they were worried that providers wouldn't actually use the fund to pay staff who were self-isolating.

A. Yes.

Q. Were you aware of that warning?

A. Yes, I was aware of both that concern and the concern that some of the fund hadn't yet reached the providers from the councils. So the flow-through of the fund from Treasury to MHCLG, to the councils, then to the providers, and then to staff, had, frankly, drop-off at every point.

Q. So there were problems with the flow, but the specific problem of reluctance on the part of care providers to use this money to pay individual care workers who couldn't work because they were self-isolating, were you aware of that discrete problem?

A. Well, I didn't personally see evidence that I can recall now, but I wouldn't be surprised at all.

Certainly, you know, in a sector of 2.5 million people, with tens of thousands of providers, I wouldn't be surprised at all if some of that flow-through didn't happen.

Q. Well, Mr Hancock, the evidence is that by October, six months -- sorry, four months after that warning, only 25% of employers were using that money in that specific way, ie to compensate workers who were self-isolating. Were you aware of that problem?

A. I am surprised that the figure was that low.

Q. You were surprised it was that low?

A. Yes.

Q. As in you would have imagined a higher number of employers to have been doing what they were asked to do in accordance with the fund?

A. Yes. Are you saying that only 25% were doing what they were asked to do -- (overspeaking) --

Q. Yes, only one in four were using the fund for that

purpose.
A. Yeah, not good enough --
Q. Were you ever made aware of that?
A. Hmm?
Q. Were you aware made aware of that?
A. I may well have been but I don't specifically recall --
Q. Do you ever remember taking any specific steps to address that?
A. Well, this comes to the point of levers that we have been talking about all the time. It was not within my direct bailiwick to be able to put those -- put requirements on these funds, because that was a matter for MHCLG in agreement with Treasury. So it all comes back to this problem of -- this problem of governance again.
Q. Can I just ask you one further question on that, then?
Did you ever invite either of those two other departments to stipulate that that money should only ever be made available to a care provider if they did indeed use it to mitigate infection control by ensuring they paid employees their full wages if they had to self-isolate?
A. I can see where you're going with this. I essentially agree with the thrust of the question. I wouldn't be surprised if I had asked for that to happen. The

decision would have been outside my departmental purview. It would be a more -- if we had paperwork, I would be happy to go through it, but I -- it was a long time ago now.
Q. Can I just ask you one final question on a different topic then, which is just about the suspension of routine inspections by the CQC?
A. Mm-hm.
Q. You gave effectively, I think, two reasons, in broad terms, for your agreement that those inspections should be suspended.
A. Yeah.
Q. One was that there was a risk of tick-box exercises getting in the way of fighting the pandemic, if I can put it that way.
A. Yeah.
Q. But the second one was perhaps more important, which was that you wanted to ensure that any medically qualified inspectors were available to be redirected towards, as it were --
A. The front line.
Q. -- the front line?
A. Yes.
Q. Now if that second reason wasn't necessary, let's imagine a future pandemic where we were prepared

properly, we didn't have to rely on dragging in employees from other departments or other agencies like the CQC, in those circumstances, would you have taken a different view? Would you have recommended that inspections carried on if at all possible?
A. Well, we still may have needed an adjustment to inspections, because of the fact that the frontline workforce would have been doing unusual -- an unusual array of things. So I'm not categoric about it. But your broader point I agree with, which is that if we hadn't been at fear -- had a fear of the NHS being overwhelmed, then we wouldn't have had to take such drastic decisions.
But that of course applies to a number of areas, and it comes the back to the doctrine point at the start, which I've agreed with the TUC representative on before, which is: when a pandemic strikes, you don't have a choice about whether to lock down or not. You have a choice about whether to lock down at a low prevalence, where some of these negative consequences could be mitigated, or at a high prevalence, when you have to act in a way that we had to in this instance. You don't have a choice of not locking down, so you should get on and lock down early.
That is the single-most important thing that the

Inquiry and the nation can learn.
I fear currently the nation's learning on that is gong backwards, and -- but I'm in total agreement with you that the -- the impact on things like CQC inspections, which overall are a good thing, would be lesser if the response was early and robust.
Q. So in other words, the inspections could have still happened with some modifications if it wasn't necessary to redeploy the staff who would otherwise be carrying them out?
A. I think it's better to answer that question in the future. In the future I would wish the action at the macro level to happen sooner, and therefore fewer mitigations like pulling staff from CQC to put them into frontline situations would be more avoidable.
LADY HALLETT: Thank you, Mr Burton.
MR BURTON: Thank you very much.
LADY HALLETT: And lastly we have Ms Wilkinson.
I appreciate there are a number of matters that the CQC wanted to correct, but don't worry, we don't have to have oral evidence, we can do that another time. So we just have the one last question.
Thank you, Ms Wilkinson.
Questions from MS WILKINSON KC
MS WILKINSON: Mr Hancock, I ask questions on behalf of the

Care Quality Commission, the independent regulator of health and social care in England, and I'd just like to clarify the one matter in relation to a number of -- something you have said on a number of occasions, and most recently at paragraph 39 of your statement for this module, regarding the absence of a list of care home providers.

A. Yes.

Q. You understand now, and understood at the time in 2020, that what underpinned CQC's ability to regulate care home providers in England or, to use your phrase earlier this afternoon, what gives it its teeth, is that it is a criminal offence to provide care home services without being registered with CQC, isn't it?

A. I have looked into this, because the CQC wrote to me, made the letter public, and said that I'd got this wrong. In the letter, they say that there are care settings that aren't regulated by the CQC. That proves my point. I think we're dancing on the head of a pin. There are care settings not regulated by the CQC. Our problem, which I was being -- which I was making clear, and I stand by, is that there was not a list of all these settings. It isn't a criticism of the CQC, but it is a matter of fact.

Q. I'm going to be precise about the language you used,

actually, Mr Hancock, because the language you used was "care homes", care home providers and care homes. Not care settings, not unpaid carers, not domiciliary care settings, but care homes and you used that language a number of times, including most recently in your statement for this module, and it's in relation to care home providers that I draw your attention.

A. Thank you.

Q. Because it is a criminal offence to provide care home services without being registered with CQC. That is a criminal offence contrary to section 10 of the Health and Social Care Act, and it's in that context in which I point out to you that that must obviously mean that the CQC holds a complete list of all those registered to provide care home services in England.

A. You see, the challenge I've got is that I have sworn an oath, and I take my oath extremely seriously. And I only will say things that I believe to be true. And this has been true in all the modules --

LADY HALLETT: I think the fact that Ms Wilkinson is putting to you, if you just forgive me, could you just repeat the question -- (overspeaking) --

MS WILKINSON: Yes.

A. No, no, I'm answering the question, my Lady, because --

LADY HALLETT: Please don't interrupt me, Mr Hancock.

Right, one more time, Ms Wilkinson.

Please listen to the question.

MS WILKINSON: Can you now acknowledge that whatever you were told, by whomever in your department -- and I'm referring to your paragraph 39 -- that it is not correct to say that nobody knew how many care homes were in operation across England, because CQC did know that? It has been publicly available on their website to download since 2012. And indeed CQC took steps to check that your department knew fully of that list as early as 25 March 2020. Can you now acknowledge that?

A. I can tell the Inquiry what I was told. I put it in my statement. I stand by that that is what I was told.

There are other points where I've been challenged in terms of the veracity of my evidence and I take it exceptionally seriously, and I take quite a lot of offence at being -- the implication that I haven't stated the facts as I was told them. And that is all I can say.

And the CQC have acknowledged, in their letter, the complication around language, and it may be that that's what we're getting caught up on. But all I can do is faithfully and honestly tell you what I was told.

LADY HALLETT: That was your understanding. Thank you.

Thank you, Ms Wilkinson.

That completes the questions we have for you, Mr Hancock, except one more from me, I'm sorry.

Questions from THE CHAIR

LADY HALLETT: It's just going back to one of the first questions Ms Carey asked you and it was -- I was thinking back to the decision to discharge patients from hospital to care homes. You mentioned that there was pressure from NHS England, I think you said, that it was a joint decision, members of the cabinet, Prime Minister, everyone involved. That I totally understand. But I was looking earlier at the decision of the divisional court in Gardner & Harris against you and others -- and that was you as Secretary of State for --

A. Yes, it wasn't me personally, it was my office, if you like.

LADY HALLETT: Yes, but it was taken against you as to one of the decisions, which was the discharge decision.

Were you involved in that litigation at all?

A. No.

LADY HALLETT: It took place after you'd left --

A. So it was very frustrating, because --

LADY HALLETT: Just please answer the question. Were you involved in it?

A. No.

LADY HALLETT: You weren't? So you didn't provide instructions or anything -- (overspeaking) --
A. I didn't provide instructions --
LADY HALLETT: I don't want to know what they were.
A. No, no, but I wasn't given the opportunity to state what I easily could have stated and I think would have changed the outcome of that case which is of course I considered asymptomatic transmission, I was worried about it from January and if I -- I could have sworn an affidavit or appeared in court and said that. Nobody asked me. The finding was that I didn't consider it. I couldn't believe it when the finding came out, I was like, "Well, hold on, I was worried about that from a long time before."
LADY HALLETT: I just wanted to give you a chance to answer it, because obviously it's a decision of the High Court and I just wanted you to say. So now at least I know.
THE WITNESS: Thank you very much for that opportunity.
LADY HALLETT: Thank you very much indeed, Mr Hancock.
I expect that is the last time which we'll call you to give oral evidence. Apparently I'm not allowed to say it is the last time but I --
THE WITNESS: Thank you.
LADY HALLETT: -- am feeling pretty confident that it is.
So thank you very much for your help to the Inquiry.

I appreciate it's been a long session today and indeed long sessions on other occasions, so thank you.
I shall now retire and I shall be back at 10.00 tomorrow morning.
(4.47 pm)
(The hearing adjourned until 10.00 am the following day)

I N D E X