Thursday, 17 July 2025

(10.00 am)

MS CAREY: My Lady, good morning. Can you hear me?

LADY HALLETT: I can. Good morning, Ms Carey.

MS CAREY: Good morning.

Today's witness is Mrs Helen Whately and I'd like her to be sworn, please.

MS HELEN WHATELY (sworn)

LADY HALLETT: Mrs Whately, thank you so much for coming back to help us again. I'm sure you appreciate it's absolutely essential that we called you for this module.

THE WITNESS: No problem.

Questions from LEAD COUNSEL TO THE INQUIRY FOR MODULE 6

MS CAREY: Mrs Whately, your full name, please.

A. Helen Olivia Bicknell Whately.

Q. Ms Whately, there's no rush today. Take your time. Please try to speak slowly. I'll try to do the same.

A little bit by way of introduction for you, in your statement, which is INQ000587788, you set out that you've been an MP for Faversham and Mid Kent since 2015.

A. Mm-hm.

Q. Importantly, for this module, from 13 February to 16 September 2021, you served as Minister of State for Care?

A. Yes.

Q. Under both Mr Hancock and, indeed, Sir Sajid Javid as he became?

A. Yes.

Q. And before your time as a Member of Parliament you worked for eight years as a management consultant specialising in the healthcare consulting, and in that role worked with NHS hospitals, mental health, and community care providers. Can I ask you, in that role, did you gain any experience of the adult social care system as it was pre-2015?

A. In that role I was working in healthcare rather than social care.

Q. Thank you, right.

As I understand it, your role as minister is not solely focused on adult social care but social care more widely; is that correct?

A. No, my role was responsibility for adult social care --

Q. It is for adult social care.

A. -- and children's social care is focused on in a different department.

Q. Fine. Thank you very much for clarifying that.

A. So yes, adult social care and also then other areas including dementia, autism and also NHS workforce at the time.

Q. Thank you. It's probably my fault for badly phrasing

it.

Can I ask you at the outset for some observations, please. We heard from Dr Jane Townson last week that you had been on some visits with homecare workers, and can you help with when that was? I don't mean a precise date, but the rough period of time.

A. Yes, I mean, as a constituency MP you get involved in all manner of issues in your constituency and want to know as much as you can about what goes on in the area, so I spent time as a constituency MP visiting social care providers and as part of that, I went sort of on the rounds with a homecare worker because I was interested to see for myself, day-to-day, what that involved.

Q. Do you think that helped you, then, when you took up the post as minister?

A. Yes, as an MP you bring, and as a minister, you bring your experience to the job that you do. So having spent time -- I've clearly also done visits in care homes, whether that's as a Member of Parliament or also because you have family and friends who will be receiving social care. So yes, you bring that experience to have an awareness of the front line.

Q. Was there anything in particular that you observed during those visits, whether to care homes or to the

homecare sector, that really helped the way that you responded to the pandemic, come March 2020 and thereafter?

A. My most vivid recollection from the particular home visit -- series of home visits that I did pre-pandemic was particularly the rapport between the care worker that I was with, who was called Jackie, and the people that she looked after and how isolated many of the people that she looked after were.

Q. We'll come on to that, I suspect, maybe in relation to visiting policies and the like.

Can I start, though, before we descend to a number of topics, by asking for your, really, overall reflections on what you think went badly during your time as minister, but importantly, as well, what you think went well. And can you give us an overview of both of those, please.

A. Yes. I mean, I take it you want me to focus on the pandemic and the social care part of the pandemic, given the --

Q. Yes, please.

A. -- the module. I mean, my overarching reflection is that in a pandemic such as we experienced, things are going to be really bad, and as we saw, many people will die. So the overall context is going to be horrible.

And in some respects, it's like, certainly felt like sort of fighting a war but the enemy is invisible and you have no choice but to fight it. It's not that you chose to be part of that war.

So that is the context.

I mean, for me, as a minister, things that were particularly bad at the time was the struggle at the beginning to get PPE to social care providers, you know, in the context of overall, there was a shortage, we knew that NHS staff didn't have it and therefore I was hearing from the care sector that care workers were having to care for people without PPE.

Now, PPE is, we know in retrospect, isn't perfect, and doesn't always stop people catching Covid or giving Covid to anybody, but the fact that care workers were having to go to work and try and care for people without even the level of PPE that the public health team thought they should have, was clearly an incredibly bad situation to be in.

Another thing that I found incredibly hard was, I think, it was a bad thing that happened, was the experience of care homes receiving patients discharged from hospital either that were Covid-positive or that they didn't know their Covid status and turned out to be Covid-positive and how, you know, I heard at the time

from some of the communications I got directly from care homes that they felt they were just being forced to take people, and in some of the stories that the Inquiry has assembled in your pack of stories from the front line --

Q. Every Story Matters?

A. Yes, that's the one. You know, that describes care homes' feeling they're just -- somebody turning up in the middle of the night, just from a hospital, and being told "You're taking this person", which is clearly not what should have happened.

And so I think although -- and I'm sure we'll get into this more -- there's, you know, the evidence about a lot of the infections in care homes probably came from the -- you know, just from the community, as in staff bringing them in unwittingly, but, you know, that was a very bad period of the pandemic, clearly, at the beginning, when those discharges happen.

And I think the other thing, on reflection, that I find very hard to think about, and regret, is the impact of visiting restrictions, and how, for many, many months people were unable to see their loved ones and how incredibly hard it was, particularly for somebody who had dementia or a younger person who, for instance, had learning disabilities and obviously couldn't understand why they weren't having visits from loved

ones, and for whom the alternative methods, like window visits and things like that, just didn't work.

And also, when there weren't -- people weren't given the chance to be with somebody at end of life, and I think that was -- you know, that combination of visiting restrictions was incredibly hard for people and has, you know, long-term ramifications for people personally affected.

Q. What about something positive? What went well, Ms Whately?

A. It's interesting you ask that. I put a note to myself on the wall in my office at the beginning of the pandemic which was along the lines of, you know, sort of two objectives: try to save as many lives as we can and try to look for some silver linings out of what's going to be a really bad time.

I think, and from my experience, it was extraordinary how people pulled together. Whether that was people I work with in the Department of Health and Social Care, and most obviously with Ros Roughton at the beginning and then Michelle Dyson, who I know gave evidence yesterday, and they did an extraordinary amount of work, and all the other people around them, and my private office, actually, who were working all hours to support me.

And some of the care sector representatives who really pulled together, people like Vic Rayner and Jane Townson, who you mentioned a moment ago, and others from the sector who -- I mean, it definitely felt like, you know, people put their all in to try to get through the situation. And obviously the staff at the front line, who kept working. And that was, you know, the extraordinary thing, where -- it was a time when people in many jobs were furloughed and able to be at home and still receive most of their income, but if you were a health or social care worker you were having to go to work, and working in places where people had Covid, and you might have been somebody who was at risk of Covid yourself, and people still went to work.

I think another, you know, reflection on the experience was that was a working together -- people did things and I felt we in government did things at an extraordinary pace. The time it usually takes to legislate to set up a new service to do something is, you know, months and years, but within a matter of weeks we were distributing PPE to thousands and thousands of care providers. We distributed an extraordinary number of tests and those were processed. The vaccination programme was quite amazing.

So I do actually think that government, the NHS,

local authorities, everything -- the care sector, demonstrated an extraordinary ability to do things at pace and scale in an emergency.

And I think, if you'll allow me a third thing, that, you know, social care is often seen as the underdog or Cinderella service, and for the very worst reasons that so many people died in social care. There was a period when people talked about social care. There was an extraordinary moment when Her Majesty the late Queen made -- talked about health and social care workers. Like, that was a real moment. Suddenly social care was in people's consciousness and that continued for some time after the pandemic and people realised and began to understand a bit, a bit, what it was, and how important it was.

And actually with unpaid carers, as well. And that recognition was significant, and it enabled us in government, me, to make progress on some reforms to, for instance, improve the careers of social care workers and try and increase their status and increase the accountability, which is one of the big problems with the social care sector and the launch of CQC assurance for local authorities, it's quite technical but it's about increasing accountability of social care, so people actually notice whether the social care in their

area is good or not good, which is a long-term problem.

I think -- I have some regret that I think the awareness of social care has probably regressed somewhat, and --

Q. I was going to say.

A. -- and there is more of a focus back on the NHS. I don't want to make this political but I see a government that's much more focused on the NHS than on social care, and I think, you know, one of the things this Inquiry can do is raise -- remind people about the importance of social care in our system. That would be a could outcome.

Q. Her Ladyship has heard lots of people speak about the need for recognition, and the ongoing need for recognition, so what you say will, no doubt, resonate with other evidence we have heard.

Can I go back then, please, to the start of the pandemic. And you were appointed on 13 February, so I'd like to ask you, please, about sort of what happened once you came into the department, and then we'll try go and through some of the chronological changes but also talk about some of the things that you've just spoken about that perhaps didn't go so well, or were more challenging.

Can I start with preparedness. And if it helps you,

Ms Whately, I'm starting at your paragraph 60. But you say there that there was obviously concerns about Covid-19 growing from February into late February, early March and you say, "I asked about responsibilities of the department in the event that the pandemic struck and about the department's preparedness."

And you say:

"I discovered ... for social care that [the department] and [indeed the Minister of Housing, Communities and Local Government] looked to local authorities to lead the response ..."

That's where I'd like to start, please. Why was it you wanted that assurance when you first joined the department?

A. So I joined the department, as you said, on 13 February at a point at which the pandemic was -- there was a thing happening in China, and, you know, discussions about what would happen if it came to the UK, but the feeling was it was quite unlikely that it would come. And I had, I guess, the normal set of briefings that a minister gets when they're new to a department, so they go through all your policy areas and you have, like, back-to-back meetings, meeting lots of people and I got going on the biggest objective which was to do with 50,000 more nurses for the NHS and social care

charging reforms.

But I also recall saying, well, kind of, what about the pandemic? What if it does come here? We clearly need to be prepared for that, and which is why I asked for and received some early briefings on the preparations being made. And I do know, even before I became a health minister, preparations were being made in the department clearly so it wasn't that it didn't start until I turned up. That was already going on.

Do you want me to talk particularly about the local authorities?

Q. I'm going to come on to that, exactly, because I think you asked to see the local authority pandemic response plans. You wanted assurance that they were going to do what they said on the tin, to put it colloquially, and I think you received two plans on or around 3 March which you say in your statement you did not consider them to be adequate. Can you help us with in what ways they weren't adequate?

A. Yes. Can I just get to why I was asking for local authority plans?

Q. Of course.

A. So I was there and one of the things I said was, well, I need to know who's responsible for what? To what extent is it my job as social care minister to make sure

we are ready and have a plan, can respond to the pandemic across social care, or to what extent is it somebody else's job? And my recollection is, you know, that Ros Roughton and others went away to, you know -- came back with the answer to the question, which was that the social care response to the pandemic is to be led by local authorities because that's where the responsibility lies, that the department sets policy, but, you know, oversight of delivery, operational stuff, is at local authorities. And that's where the pandemic plans should sit.

Therefore, my question was, okay, but I want assurance, I'm not just going to go "Okay, I'll take it as read, let the local authorities get on", I said I want to therefore see some of those pandemic plans.

And I remember that then being incredibly difficult, that there was some delay, and I also recall getting pretty frustrated and having a conversation with Robert Jenrick around this time, because he was the Secretary of State for MHCLG, and somehow managed, I said, "Just get me one plan, two plans", and I got -- was given two plans. And they were shocking. Because there was next to nothing in those plans. I mean, if I recall right one of them just said well, we expect care providers to have their own pandemic plans. That was the extent of

the plan.

And that was a point at which that I thought: well, okay, we need to really get motoring on the social care preparedness, clearly.

Q. I am going to ask about a little bit of that, please. We know -- can we have up on screen, please, INQ000327767.

I think you've been asked about this before in a different module, but clearly we've got different people following it so, Ms Whately, forgive me if there's occasionally some repetition with things you said in M5, but this is some WhatsApps between you and Mr Hancock on 3 March.

If we could, forgive me, just scroll down the page slightly. There you are.

At 6.29 in the evening you said:

"I am chasing it. Have got hold of what I'm told are two LA plans (Herts & Essex). My opinion is that they are inadequate. Have asked for someone to brief me tomorrow on a plan for getting these and other plans into shape."

And there are some meetings that I'll take you to which follow this.

"Was ... about to message you [about] my concern."

You said you bumped into Rob Jenrick, who I think

was leading at the time for MHCLG?

A. Yeah.

Q. "... he has similar concerns ... he's working on setting up an assurance process similar to one used for [local authority] Brexit no deal[s] ..."

And a little bit detail you gave there to Mr Hancock:

"The Essex doc says providers are required by CQC to have plans in place to provide safe care in the event of a pandemic. And, during ... flu ... [the] Directors of Adult Social Services need to know the effectiveness of providers plans, emerging risks and capacity to meet demand. That's basically it. Their plan."

A. Uh-huh.

Q. And Mr Hancock then asked you to put what he called "some serious drive into getting them to a credible position". And we'll look at what happened thereafter. He then basically said to you "it needs a rocket under it"?

A. Mm-hm.

Q. And I don't think you necessarily disagreed with that sentiment? I can see you nodding.

A. Yes.

Q. Now, can I just ask you, what role, if any, do you think the Minister for Social Care should have in making

themselves assured that local authority plans are up to scratch?

A. Looking into the future?

Q. Mm.

A. I mean, I think I'll take one step back from that, which is I think they're -- as part of our plans for future pandemics, we need companies to know, you know, whose job is it to have the plan at what level, and you probably need multiple plans. I mean, you need a plan within a care provider.

Q. Yeah.

A. You need a plan at a local authority level. You need a plan at the government level. And you probably need, like, a routine oversight of that process. I mean, to me, CQC is a natural organisation to, as -- given that it does lots of checking, that "Have you got all this set of documents?", CQC is an organisation that could effectively check whether providers have got plans. And now they do assurance of local authorities, they could also be checking the local authority social care pandemic plan.

At a government level, the minister ought to be looking at the pandemic plan at a government level and should have some oversight.

I think there is a --

Q. Can I just pause you there. Do you mean of a departmental plan and/or do you mean also of some of the local authority plans?

A. I would expect a minister to look to CQC to give them the: you know, this is the state of the pandemic plans at local authorities, and, you know, we think that local authority X needs -- and Y, Z needs to do something about theirs.

And so that would be the way I think you work with CQC.

I do think there's a challenge, though, that's -- it's easy to say with hindsight: oh, well, ministers should be keeping an eye on this. The reality of our system as a minister is you -- your job is, you know, to try to, you know, solve the biggest problems that the country most cares about in the area that is your brief, and to deliver your party's manifesto commitments and to try to avoid crises which are very foreseeable or handle them when they're happening.

And I can see that there is a risk that the -- something like a pandemic, something that is a very bad event as it happens but may feel at any point in time like it's probably not going to happen tomorrow, how do you stop that slipping down the to-do list of every minister of every secretary of state?

You know, we do have a whole department that prepares for in case we have a war in the sense of a Ministry of Defence, but other departments are all dealing with much more the day-to-day of what's going on.

And I think there is a question, how could you make it that somebody felt that it was their job in government, and it would be worthwhile really making sure that proper consideration had been given to things which were, you know, less -- not day-to-day likely to happen, though possible, and if they happened, very bad, like pandemics.

Q. Can I just move on a couple of days, because shortly after that WhatsApp exchange, you were in a coronavirus -- social care coronavirus meeting on 5 March.

And to help you, Ms Whately, could I have up on screen effectively the readout of that -- it's INQ000609933_4.

5 March, we can see the participants. And there's reference there, as we've just looked at, to the two plans for Essex and Hertfordshire that you were concerned about.

And if we can just scroll down for a moment, "JH" is Jenny Harries:

"... the assurance you need [as in you the minister needed] is several layers below the plan."

She told you:

"There are hugely detailed plans sitting at local levels that may not surface."

You flagged that you "were concerned that perhaps these plans don't exist" but were "reassured that there are plans that sit below this plan that include how do you prioritise plans" -- lots of "plans" in there.

A. Yes.

Q. But just to strip it back. Obviously, you wanted to look at what was under the local authority plans.

Why did you get the sense that those plans might not have existed?

A. I don't know, I mean, I've read this in some of the preparation. I'm intrigued Jenny Harries is saying there were hugely detailed plans because I never saw them. And I guess, you know, why did I get the sense? Well, because if you ask for something and nobody will give it to you, the most obvious conclusion to reach is that it doesn't exist.

Q. You can see Ros Roughton flagged, as we go on to page 5, that:

"... she is not sure that the current process will get to the level of detail that [you] necessarily

wants."

She thought that it was more important that we start articulating what the sector needed to actually do, and she flagged that "we may need local authorities to move away from containment [to start on mitigating]."

I won't go through all of the bullets there, Ms Whately, but there was an idea, certainly in the middle of the page, that we will try to find a good plan and for it to be replicated and rolled out.

Now, that didn't happen, did it?

A. Correct. So, it was around this time -- I don't think I was asking for a lot of detail, just some sort of plan -- anyway -- there was a discussion at which, well, if local authorities haven't got plans, or many of them don't, let's find one that's got a decent plan. Surely somebody has, we've been told that they exist. And then others could work up their plan based on that as a template. That would surely save time and effort. However, no such good plan was found. And then yes, there was a process that was intended to happen to do with reviewing plans and assurance but, actually, in practice, then, things started moving very fast, the sector was, you know, desperately asking for guidance, asking for support, felt that they weren't being supported or told what to do, and there was a point,

sort of, you know, sometime around this time, that I had a conversation with Matt Hancock about the situation and we basically said, "We are going to have to grip it from the centre."

Q. Yeah.

A. We're just going to have to do this. And it was quite a, almost a sliding doors moment, because I think there was a situation in which perhaps, in government, we could have said, no, it's local authorities' responsibility to do the pandemic response, but that was neither Matt Hancock's mindset nor my mindset, it was, well, we are here and we should step up and do this job.

I would say this, because this is quite negative about local authorities, actually local authorities did a huge amount during the pandemic to support care providers and some of them were really, really good and really helped with PPE and were doing daily calls to their providers and supporting them when they had staff problems and all sorts of things. But I think it is clear from this that in general they weren't ready at the beginning, and that's why we stepped up to do stuff on that -- (overspeaking) --

Q. Just a couple more points on this readout. On the fourth bullet point there was reference there to help getting ADASS to help agree with communications, which

products are needed and a direct route of concerns from the sector through ADASS, and Ros Roughton flagged that a third of people receiving care are not known to the local authorities, this is a major risk.

Do you know what the third was referring to, was it the unregulated sector or unpaid carers or both?

A. I don't know what exactly she was referring to but it was true that she knew and I knew that in our landscape of social care we clearly had, you know, residential homes, nursing homes, domiciliary care, but also unregistered providers who would not be providing personal care because if they were they would have to be registered, and obviously unpaid carers supporting vulnerable people often in their households.

Q. Right. And then just finally on the bottom, at the bottom of the page there, you asked:

"Are we thinking about the comms aspect? No one is thinking about social care preparedness or talking about it at least."

And Jonathan Marron from the department said he agreed, "We're not saying the right thing, we're not talking enough -- about social care enough." [As read]

When you say, "by no one", did you mean in government, the department? What did you mean there, Ms Whately?

A. I think I -- I'm talking about the communications there. I mean, clearly in government, as you can see from this conversation, and other things on the record, we were thinking and working on social care preparedness and, as I said, it started before I even became a minister. I think it was more in the comms team that the comms were much more focused, whether it was on the NHS or on, sort of, public concerns about the pandemic, rather than communicating about social care.

Q. Right. Now, we know that there was in fact no review of local authority plans; events, as Ms Dyson told us yesterday, overtook us. Following that meeting, so here we are now on 5 March, there had been some guidance put out to the sector on 25 February and then some further guidance that came out on 13 March. And I think in an email certainly that your office had forwarded, an email from Mr Hancock, where someone had commented that, "One of the largest social care charities in the UK was very concerned about the lack of preparedness."

And you were worried that the 25 February guidance was insufficiently detailed, for example it still said that Covid-19 was not being transmitted within the UK and we know by the beginning of March certainly there was evidence to suggest it was. You asked, "What are the plans for this to be updated?"

A. Mm-hm.

Q. I think really the question I'm asked to ask you is, given we knew by the beginning of March there was community transmission, do you think that the 13 March guidance should have actually been published sooner? As soon as we knew there was community transmission, we should have tried to get guidance out sooner?

A. I mean, I always wanted guidance to be out sooner, everybody would want guidance to be out sooner. The fact was that it took time to produce; the knowledge of Covid and how it was transmitted and what we should do about it, was changing-on a daily basis. And there were only so many people in the Department of Health to produce guidance.

I mean, there's also criticisms that guidance was updated too often and why did we have so many iterations? And I know the department tried to strike a balance between getting guidance out promptly but doing enough work that the guidance was worth the paper it was written on, and there had been some consultation, for instance with the sector about whether it worked for them.

So I think this is, you know, the frustration reflects the challenge at the pace at which things were moving and you only had so many people, even in an

expanding department, as it did, to do the work.

Q. Can I come on then to the hospital discharge policy in and around 17, 19 March and that period of time.

Now, I think you say in your statement that you were not involved in the 19 March discharge guidance or indeed the NHSE letter that went to the trusts asking the trusts to expedite discharges, but did you agree with the decision to expedite hospital discharges, and if so, why?

A. So I understood the reasons for the NHS wanting to empty out space in hospitals. They were expecting an influx of very sick people who they wanted to be able to treat.

We, I think, at the time, were seeing hospitals in places like Italy having to turn away people over a certain age because they did not have beds. I could understand the NHS not wanting to do that. I also understand the clinical perspective -- I think the Chief Medical Officer has been -- is very articulate on this -- that if you think the hospital is going to become, you know, an environment with Covid in it, that's also not a good place for an elderly, vulnerable person to be there, at risk of catching Covid. Though, I think, you know, the NHS is particularly driven by an NHS effort to free up beds ready in participation of arrival of a large number of patients with Covid. Which

I can understand.

And as you said, it was clearly put out in the discharge guidance that they published on 19 March, that NHS England published -- and it would be interesting to know whether actually those discharges increased, started happening before that date. They may have done. But it's been very hard to find data for what actually happened with discharges during that period.

Q. Can I pause you there --

A. Yes.

Q. -- because whilst you've said that you understand the reason, I actually asked did you agree with the policy.

A. Um ... so clearly I've looked at -- I want to give you a straight answer.

So what would have been the alternative? And I was -- I mean, the record will show that I -- when I -- when I received in late -- later in March, concerns from care homes that they were having people with Covid discharged into their care homes, and sort of forced on them, and I clearly get involved, therefore, in the conversation about discharge, and the next iteration of discharge guidance, which was then published on 2 April, comes past me for sign-off, and I am asking many questions, as the record shows, about whether care homes really can cope with having people discharged who have

Covid into them and what about testing and can they isolate.

And ultimately I'm given assurance that care homes will be able to isolate safely. That is the clinical guidance that I am given. And on that basis, I kind of accept -- accept that, because I'm -- basically I'm told: yes, care homes will be okay, it will be safe, they will be able to manage this. And also, that they will be able to choose whether someone -- whether to accept a discharge or not.

So I am told as -- part of the guidance says that care homes can risk assess will they be able to manage, will they be able to cope with somebody Covid-positive. Now, the problem is that many stories out there indicate that care homes weren't given the opportunity to always do a risk assessment and check that they could isolate. They didn't always have the PPE to care for somebody safely. So -- and it appears, in fact that it was incredibly hard to isolate somebody effectively and stop Covid spreading in a care home once it was -- it was in there.

And in fact, at the time, she -- there was a view from a -- public health teams that there was no such thing as asymptomatic transmission, you were only infectious if you had symptoms. Actually we know that

not to be the case. So, actually, it turned out that care homes -- you know, that they weren't safe when somebody was discharged with Covid to them. And I think if we had known those things, if that had been in the advice that I was given, I would have said: try -- like, look again for some alternative to this.

Now, we may or may not have been able to find any alternative, because as we know, in fact, as it happened, hospitals did end up being full and people being transferred to hospitals far, far away because there were essentially no beds nearby. So there was a huge pressure on NHS beds. But still the fact that this happened and that people were discharged to care homes and care homes being assured that it would be fine, or having no choice in the matter, that should not have happened.

And I think the record shows that -- and this I have a frustration with the NHS in, is that they appearing to take a view that care homes should serve the NHS in this. And you'll see, you know, they say, sort of, care homes are required to do this. And my back and forth saying: no, you shouldn't require them, care homes should be able to choose.

And I think there was an attitude in the NHS at the time -- and I do think this was driven from the top of

the NHS, and I have read Simon Stevens' submission to this Inquiry, and I'm surprised he doesn't reflect on his role in this policy, because people who worked for him were pushing very hard for the NHS to discharge into social care.

Q. Can I pause you there, because I do want to look at some of the efforts you made, particularly in the run-up to the 2 April guidance, voicing perhaps some of the concerns you've just outlined.

I don't want to be unfair to you, then, Ms Whately, I am trying to work out whether it's -- that you did agree with it at the time and that you regret it or have concerns about it now, given what we know, or whether you didn't agree with it as at 19 March. And are you able to answer that?

A. Well, at 19 March, should the NHS have discharged people into care homes? Not without identifying that care homes were able to effectively isolate people. Otherwise they were discharging somebody potentially with Covid from a hospital into, you know -- and to an environment in which we know people were going to be very vulnerable. An alternative, I think with hindsight, should have been found.

And for a future pandemic, this is exactly the sort of thing that should be looked at, is: what is an

alternative? When recognising the hospitals will (a) want to free up beds and (b) are not safe places for somebody who is frail and vulnerable, what would be an alternative?

Q. Can I just take a step back from that, given that obviously there are these concerns. Do you think you perhaps should have been involved more in either the decision or the actual guidance of 19 March?

A. Yes.

Q. Or do you -- the office of the Minister of State?

A. I mean -- I mean -- I mean, yes. As I was -- I was involved in subsequent discharge guidance, because I'd started, you know, asking what was going on. But given that that NHS discharge guidance specifically referred to social care, surely they should have run it past the minister with responsibility.

I think there was consultation with other people in the Social Care Department potential -- that is indicated, I think, somewhere, but in practice, clearly -- clearly I wasn't. And I don't know whether, actually -- I mean, I don't know whether that had any ministerial sign-off, that particular guidance, or whether it was an entirely NHS England document.

Q. Can I look at what happened then in the run-up to the 2 April guidance, and I'm at your paragraph 95 if it

helps you, Ms Whately.

We know that, in due course, the 2 April guidance did not advise discharge patients to be isolated but did advise symptomatic residents to be isolated, and it included the words "all of these patients can be safely cared for in a care home if this guidance is followed", and negative tests at that time were not required before a patient was discharged from the hospital, just to try to wrap it together.

A. Mm-hm.

Q. You received a submission on 25 March highlighting how many social care providers were concerned about how the policies on discharging patients into care settings would affect their indemnity arrangements.

Can you help us with what concerns had been brought to your attention, please? It's your paragraph 96, if it helps.

A. Yes, I mean, I think there was a submission that was brought to my attention about this indemnity point. So I hadn't been hearing about it through other channels; there was a specific submission reflecting care providers' concerns about whether their indemnities would be valid in the event that they admitted Covid patients.

Q. You did say in your statement that you noted that the

submission focused on care homes and did not include domiciliary care providers.

Can I ask you, was there a perception that the focus was very much on care homes at this stage, to the detriment of both domiciliary carers and indeed unpaid carers? Did you get a sense that the priorities were all about care homes?

A. I think the -- so, I think the -- we were hearing from care homes at the time who were very concerned about, for instance -- you know, in that late part of March, care homes were very concerned about receiving discharges. That is not to say, however, that other parts of social care weren't considered. In fact they very much were, and you -- I think you can see in plenty of points in the record where we're talking about care homes, the residential nursing and domiciliary care.

And in fact around the discharge, I remember one of the conversations, when I was expressing concerns about the discharge, was: well, of course, the numbers going into care homes will be quite small, most people would be discharged to home care.

So home care was very much part of the early conversation.

Q. Can we have a look at, perhaps, an email chain that sets out both your concerns about drafts of the 2 April

guidance and, indeed, then the response.

Could we have up on screen, please, INQ000575576, starting at page 6. Thank you very much.

You'd obviously seen a draft -- this is 31 March 2020, Ms Whately.

A. Yeah.

Q. You say:

"[The minister] is concerned this is written as if the NHS is going to direct care homes to take patients while in practice it is at the care homes' discretion."

And the response to you was:

"The text ... has been amended to show that accepting discharges will be an ask from [NHS England], not a mandated requirement."

And they give you an example that on page 4, it says:

"... Hospitals around the countries need as many beds as possible to support and treat an increasing number of COVID-19 cases. This means the NHS will seek to discharge more patients in a care homes for their recovery period."

Did you think that amendment, such as it was on our page 6, was clear and didn't make it clear that this was a discretion rather than a mandation?

A. I mean, there was a lot of back and forth about the

wording and, I think as the record shows, there was quite a level of impatience with me that I was kind of putting a spanner in the works and delaying things by pushing back on the wording. And as I said a moment ago, there was this very strong mindset that was coming through from the NHS that care homes needed to do what the NHS needed them to do, and I was arguing that that is now how this should work.

I know that ultimately I did accept the guidance, and my biggest concern, and that's in bold in front of me, is about patients being discharged from hospital taking Covid into the care home and whether they can be effectively quarantined.

Q. Yes.

A. And that, to me, was the thing I was particularly pushing the Deputy Chief Medical Officer to advise me on, whether that was really something I could be confident in. And I remember a call and, unfortunately, and I have tried really hard in all my submissions to base it on the written record because clearly it's some time ago. Unfortunately, there appears to be no minute of the conversation that I know very much took place in which I was saying, "Hold on, every winter flu goes through care homes, norovirus goes through care homes, how can we be sure that they will be able to stop Covid

going through the care homes?" and being told, "No, care homes can do this, they are used to doing it this", and in effect, therefore accepting the guidance that was then published on 2 April.

Q. You clearly, if we look at page 4 on the screen there, you've got the concerns about discharging patients into a care home, "unless it already has Covid cases", you're really concerned about this, and even with PPE, that surely materially increases the risk to others.

And the response from the department was:

"Due to capacity ... care homes may need to accept patients in these circumstances. We would expect care homes would do a risk assessment to ensure that appropriate isolation facilities are available. [The] DCMO [was] content with that advice."

Then you pick up, again, the use of the word "need". Does that really feed into your sense that there was a degree of pressure being brought to bear by the NHS to make sure that there wasn't blocks to the system and that people were discharged as quickly as possible when they were clinically able to do so?

A. Correct. I think there was pressure coming from the NHS. As I say, I can understand why, and the, you know, various anecdotal stories from care homes support that, that patient -- ambulances just turned up dropping

people off. So the assurance from the DCMO that they would be able to risk assess and make sure they had appropriate isolation facilities didn't appear to happen, in practice.

Q. Just in relation to that, obviously you are expressing your concerns here and you're receiving the advice back from the department, but do you know who was pushing back on the NHS's pressure, aside from you? Was there anyone else saying, "Hold on a minute, there's these implications and these ramifications"?

A. I don't think so, in the sense of -- so I was receiving the guidance, I was clearly working closely with Ros Roughton and expressing, I think, my concerns to her. I had, as I say, conversations and advice from the Deputy Chief Medical Officer who was, in general, providing reassurance about the safety for people being discharged. And there was the pressure from the NHS that this was needed and the right thing to do.

Q. I think in your addendum, your lessons learned part of your statement, you make the observation that sometimes you and maybe Mr Hancock, as well, were the only voices in the room speaking up for social care trying to have to both speak to the policy but also explain the expert or the scientific advice. Do you think, whereas, I suppose, NHS would have scientific or medical advisers

plus the chief executive plus the COO and the like, do you think of any way there is of addressing that potential imbalance, and if so, what is the potential solution?

A. So yes, there was a significant imbalance and as you saw, or you'll see in the record, and it's particularly in the next iteration of the discharge advice which I then escalate to Matt Hancock as Secretary of State because, by then, we start having stories that people are actually dying and clearly it's not working. And he in general was very supportive of me, and, you know, did, you know, back me to speak up for social care, or in circumstances when I wasn't in the room, you know, I believe spoke up for social care himself.

But definitely there is an imbalance. I mean, I guess it's not that surprising there's an imbalance in the sense of if you look at the amount of taxpayers' money that goes on the NHS, and, social care is a much -- less of -- a smaller part of the government's budget, though material, lots of people pay for their own social care themselves, so that's not so much an area of, you know, there is some government oversight but it's not the same thing as, you know, the NHS, which is delivered directly within ministerial accountability, and the public sympathy for the NHS is -- people, the

first thing that -- it's the number one thing that loads and loads of people care about.

So that is reflected in many, you know, situations, and at the beginning of the pandemic, not surprisingly, you know, everyone was like, "How is the NHS going to cope?" That's -- because the NHS is where we go where we're sick and we all worry about it.

So I think it's not surprising, but yes, I mean, I certainly found, and it was quite extraordinary moments when it would be situations, for instance, in 10 Downing Street when there would be like, you know, five people from the NHS and the DHSC perm secretary and then me from -- representing social care and I might be able to get one additional person in the room but at one time I was told no, we can't have so many people in the room. So you -- so I had to be the only person from social care speaking.

So there is that serious imbalance. I mean, I took action, that was one reason I said quite early on in the pandemic, well, at the time I had Ros Roughton who was a director-level person for social care and then Jonathan Marron was the Director General, and social care was part of his responsibilities, and there are meetings in which you only have Director Generals in the room. So I said, well, I think we need a Director

General for social care so that somebody is there, and their number one thing and the reason why they're there in that room is because of social care. And I think Matt and the perm secretary very quickly, you know, that was agreed, and actually, I mean, Ros Roughton was extremely experienced in any event, and she became the Director General for social care and then that has continued as a Director General role.

I also created the role of a Chief Nurse for social care, again to give another voice to social care, but I think there's more to do to give social care greater, you know, some level towards parity of consideration in our system.

Q. Can we move on to the action plan, which was published on 15 April. And in between time, we know that there was some death data, which I'm going to deal with as a separate topic, but certainly by 9 April the CQC were reporting on Covid-19 related deaths in care homes. That's just to provide some context.

Can I have up on screen, please, INQ000274068.

It's some more WhatsApps starting -- forgive me, let me just turn up my page -- and page -- bottom of page 8. Thank you very much.

Can we see there, helpfully highlighted, this is 13 April so just couple of days before the action plan

is published, and you say to Mr Hancock:

"The discharge policy is my biggest concern. That's an argument with Simon ..."

A reference to Simon Stevens, I believe.

A. Mm.

Q. "... clearly.

"Dom, [possibly Dominic Raab] asks for more detail on testing and PPE are the same as mine have been for the last few days.

"No one seems able to give it."

Can you help us now with what was your concern, and what was the argument with NHS England and Simon Stevens?

A. Well, I mean, and just taking us back a minute, so on 17 March there was a letter that was sent by Sir Simon Stevens out to the NHS really pushing the enforcement of discharge. So that was being driven very strongly from the top of the NHS. As I say, I can understand why, if you're running the NHS, you want your beds to be freed up. But I am saying by this point -- so this point okay, we don't have, if I recall right, sort of robust official death data but I am hearing stories --

Q. Yes.

A. -- that people are dying in care homes and care homes were very unhappy about it, and therefore I'm trying to

get the discharge policy that was published on 2 April updated to stop what's happening -- (overspeaking) -- so this is where have a different objective from the NHS.

Q. Sorry to interrupt you.

Can I ask you just to slow down a tiny fraction for the stenographer, please.

A. Yes.

Q. It's my fault, I might have sped up as well, so forgive me if I did.

So I interrupted you, though, you said obviously you were hearing accounts of people dying in care homes, the unhappiness that that caused to the care homes themselves and then I sort of -- I'm afraid I overspoke.

A. So in this there is, and again it's in the record, I'm sure, the back and forth of the text of trying to revise that discharge policy, and that was one reason why I escalated it to Matt Hancock was that I'm trying to say, no, it can't still be written the way it was, and I keep getting these drafts coming back from the NHS where my comments have been ignored.

Q. Right. Let's scroll down a little bit to around 9.45 that evening and there is an entry from Mr Hancock where he says:

"Have you agreed a discharge policy with NHSE?"

Thank you very much.

And you say:

"The 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', for example a local authority-commissioned isolation facility."

Mr Hancock thought that sounded messy, asked:

"Why won't the NHS keep them if the alternative to having a system in place is them staying in hospital?"

And he told us that in what was being talked of here was potentially a proposal for not necessarily keeping the patient in hospital but them to go into an NHS facility before moving on to the care homes as a sort of middle ground, if I might call it that --

A. Yes.

Q. -- inelegantly. Is that your recollection of what this exchange was about?

A. Yes, so I was saying let's have an alternative, if they -- I understand that it's not a good idea for somebody to be in an acute hospital for longer than they need to, either for the sake of the individual and we know what happens to, you know, particularly frail, elderly people with long stays in hospital, and we know

that the hospitals were desperate for space. So I understand that they needed to, kind of, leave acute hospitals, but I was pushing for well, the NHS therefore should stand up some step-down facilities as an organisation with the sort of capacity/capability to do that. But as I said, the NHS were clearly that they could not, would not do that, that was a hard "no". And therefore, the proposal that was put to me was instead local authorities, who, and it is true to say that, you know, when somebody is fit to discharge, they should be then the responsibility of the local authority to solve that problem.

So the proposition was put to me that local authorities would be able to provide alternative, organise alternative accommodation. And in fact, there were some examples of that already happening, for instance local authorities kind of taking over hotels and staffing them as a step-down facility if somebody couldn't go directly to the care home where they were resident at the time.

So that is the alternative that was proposed, and that I ultimately accepted --

Q. Yes, because --

A. -- although I think I was intrigued to hear, I think it was in Matt Hancock's evidence a little while ago that

there was a conversation in which Simon Stevens and Ros Roughton were going to "handle" me, which led to that decision, but there we go.

Q. Right, we'll leave, if we may, the internal politics to one side, although clearly not unimportant to you, I appreciate that.

And by half past 11 that evening, you were asked by Mr Hancock to write your preferred language into the doc, taking account of the NHS concerns.

You say:

"[You've] been working on the text...and I can see the NHS point -- at last they have managed to win the battle of getting patients who are fit for discharge actually out of their hospitals. I'm asking them to go backwards on that. I think -- so long as it IS feasible for [local authorities] to source provision for small numbers of covid patients being discharged, which it seems to be for some at least -- I can live with that. The important thing is that we don't force care homes to take them."

Now, you've made the point about care homes feeling that they had to do it, and indeed you heard evidence of it. Do you think perhaps now, upon the reflection, the guidance should have said "You do not have to do this, but if you have the facilities, please do it"?

It's never expressed that clearly in the guidance, is it, Ms Whately?

A. Yes, I think you're right. So there was back and forth and back and forth and back and forth between me and the NHS on the wording, and I would make changes and they would just disappear.

I mean, it was quite extraordinary that I was kind of -- actually trying to write in wording, but, you know, there's -- and so you were asking me earlier about shouldn't guidance go out sooner. There was, you know, constant pressure to try to get guidance. At some point you say, okay, you accept the wording, this was -- we'd agreed an approach.

However, what I think I did is -- is I also wrote out to local authorities and others emphasising that they weren't -- they didn't have to take discharge -- I recall doing parallel communications about the guidance and how it should work at the time, to try to stop the social care sector feeling that they had to take discharges, to make sure that this was understood at the front line that it was their choice.

Q. All right. I just want to be -- to clarify one of the things you just said about some of your potential wording being overwritten.

A. Mm-hm.

Q. At your paragraph 110 you say:

"... somewhere the scenes edits were being made that ignored my steer and on at least one occasion my amendments were deleted and overwritten. Whether this was intentional or simply a consequence of a lapse in version control and multiple contributors to the document, was unclear. However, I was frustrated with the process."

Were you able to try to ascertain why it was that you, as the Minister of Care, were having her comments overwritten?

A. No, it was not possible to ascertain, as I said in my evidence. I couldn't tell whether it was accidental because of all the versions or whether it was somebody writing and hoping that I wouldn't read every word to notice that what I'd put in had gone.

Q. Do you think now that the department did enough to ensure that care homes did not feel pressured to admit patients from hospital?

A. As I said, I know that we did communications out to -- you know, via local authorities, and I think to hospitals as well, directly to -- about the process, and that it shouldn't be forced on them.

I mean, I think, you know, with hindsight you could always say: oh, we could have -- could we have done

more? But people were absolutely, you know, working all hours, and I think it was around this is time that there was -- there's a message that says somewhere that I am asked to stop asking for changes in guidance because it's all too much for the -- the staff were under too much pressure.

So --

Q. Yes, we have seen --

A. -- that's the reality of the --

Q. We have seen an email to that effect.

A. -- situation.

Q. Do you think, maybe, that this is an example of protecting the NHS at the expense of adult social care?

A. So I think the NHS leadership were focused on what they needed to do for the NHS at this time. And I don't see them being concerned about what that would mean for social care.

Q. One other topic I'd like to ask you about and that is of the ability to isolate people once there came the guidance out saying that there should be isolation for 14 days, whether symptomatic or asymptomatic.

And I think certainly in an email you had concerns not only about forcing discharged patients on care homes, but there were care homes who said they didn't have the facilities, which anecdotally the minister has

been told has happened.

Are you able to give us any more detail about what you were hearing about care homes that didn't have isolation facilities?

A. Not necessarily. I mean, so -- so, I had all sorts of informal and formal communication channels, and clearly some of the -- those channels are telling me that they can't isolate people and are worried about receiving discharges, but I don't think I have extra specifics on that.

Q. Did you ever ask at all for any work to be done to ascertain how many care homes that certainly, as I say the registered ones, had the ability to isolate? I'm not talking about those that ended up in the designated setting policy later in 2020.

A. No, I didn't. I think -- so we had established as a policy, which was that if they didn't have facility to isolate, local authorities were going to provide alternative accommodation. I was receiving advice that local authorities were happy with that, that that was a workable solution, that that was sensible. And, you know, that was therefore -- the discharge plan at that time, that's how it should work.

So, in a world where I'm also trying to get PPE and testing and, you know, thinking about other bits of the

sector as well, I think that was the point at which I, you know, accepted that that was the system we had set in place.

Q. That brings me on to PPE, Ms Whately, and it starts at your paragraph 213 in your statement. You say there that:

"During March 2020 [you] heard many concerns about the supply of PPE to social care. These included ... PPE shortages ... local authorities not being able to get hold of PPE, concerns ... the NHS was being given priority over social care ... and that the [National Supply Disruption Response] line [was] overwhelmed with calls."

And indeed we know that that became a 24/7 service by 21 March.

But it's the concerns that the NHS was being prioritised, please, I'd like to ask you about, firstly.

And I think you asked for an update on the supply of PPE in response to your concerns. It confirmed there were the PPE shortages. The department was working with wholesalers to ensure a longer-term supply of PPE. And indeed, the update confirmed that from 18 March, each CQC-registered care provider would be provided with the 300 face masks from the stocks available.

Put the 300 masks to one side for a minute, but

certainly in the run-up -- sorry, on 12 March, you wrote in a Covid-19 senior group WhatsApp thread there was a specific ask from social care to be given parity of access to PPE with the NHS.

[As read] "Recognising the response to Covid needs to be coordinated across NHS and social care system, treating it as one system. At the moment they are worried they are an afterthought."

What, if anything, prompted you? Was there a specific complaint being made here? But what prompted you to write that the social care sector thought they were, in terms of PPE, an afterthought?

A. I had multiple channels through which I was receiving information from the sort of front line of social care, whether it was through my constituency office, from colleagues, or representatives of the care sector and others. And so, through those channels, I was hearing that they felt that the NHS was getting PPE and they were really struggling.

Q. Can I ask you, you have made the observation that clearly those treating Covid-19 patients needed PPE, but we've also got the discharge policy now, discharging patients, certainly before testing was up and running, by mid-April, being discharged without knowing their Covid status and, seemingly, without PPE which might

provide a layer of protection; was there anyone who was making that observation: but you're discharging them to a place where there isn't the PPE, the balance should perhaps shift to more PPE going to the adult social care sector?

A. I recall the battle I was fighting was for PPE, just, sort of, in its own -- in its own right. And so in my -- my focus was to try to get to the bottom of the question of: was social care somehow losing out and the NHS getting priority on -- you know, is that what was going on? Or was it actually just because there was such a shortage everywhere across the country that it was -- what was happening was a consequence of that?

Q. Right. To give some colour to that rather bleak picture, can I ask on screen, please, INQ000327799.

This is a table that was attached to an email sent to you by Lisa Lenton of the Association for Real Change on 31 March 2020, Ms Whately, and it sets out the concerns of the social care providers.

I'm not going to read through all of them, but one can see there the dates and companies involved and then the comments on PPE. And even just a quick scan of this page shows repeated reference to stock being requisitioned for the NHS.

If we look down at 5 March, which is perhaps the

earliest one there, from Deliver Net:

"The manufacturer re sanitisers ... used the words NHS have 'Commandeered the stock' so it could not be supplied."

And if I could just go over the page, on to page 2, by way of example, below the table, 30 March, Careshop say:

"None of them would take us on as a supplier as had concerns about not being able to fulfill current orders and that NHS was the priority."

Just the final box, please, on page 3, again at the end of March, one of the members had contacted the NHS Supply Chain to ask if they could access supplies for his home care agency. Told no. Referred --

"When our members phoned the National Supply Disruption Service, they are referred back to their original suppliers.

"Original suppliers have had stock requisitioned by the NHS Supply Chains.

"So they are stuck in a hopeless circular loop."

Does that really mirror and sum up some of the difficulties you were hearing about for the adult social care sector to enable them to get hands their hands on supplies of PPE?

A. Yes, the social care sector was struggling to get PPE

and obviously, and as you can see here, their normal suppliers who they would normally go to found themselves unable to supply them, often with PPE. I put this, asked about this, put this to colleagues in the Department of Health, I think at the time it was Jonathan Marron who was the Director General leading on PPE, and at some point Emily Lawson, and I was told categorically no, that there was no national instruction -- I think that's in the written record -- there was no national instruction that the NHS should be prioritised over social care.

I think there were two things going on here. I think potentially there may have been some local arrangements where maybe hospitals, as quite large organisations in any area, were able to get PPE directly from a supplier, and the bulk -- and sort of the scale of the hospital would make it hard, then, for social care by comparison.

I think the other thing, and this is what I was told was going on here, was that the national stockpile of PPE which served both the NHS and social care was indeed taking up stock or, you know, (unclear) getting supplies for the national stockpile, but that that was -- a shorthand for that was the NHS. So I was told that they think it's going to the NHS but, actually, it's

going to the national stockpile which is serving health and social care.

Q. I think you have seen results from a Local Government Association survey which suggested that 44% of councils or care providers experienced PPE being diverted to the NHS in the first six months either very often or fairly often. And I just wanted to ask you about one rather severe problem that was brought to your attention.

Can I have up on screen, please, INQ000327793. Here we are, again, at the end of March. On the 27th you've attended a call on PPE distribution.

I won't go through all the bullet points but Robert Jenrick or certainly his office are making you aware:

"... I ... wanted to make you aware that we have heard that there is a serious issue regarding lack of PPE across Cheshire, the situation is most critical in the Warrington area. Tomorrow there will be an emergency meeting where the council will be asked to consider shutting all council services (including 18 care homes) which require council staff to use PPE as supply levels are critically low. Across the 18 care homes, there are approximately 1400 elderly residents."

Can you help me, Ms Whately, was that an isolated example of acute pressures or did you hear of other

stories where there was potentially going to be care homes shut and many hundreds, if not into the thousands, residents needed to be re-homed?

A. I don't recall hearing many examples like that of services going to be shut, but I did know that many places didn't -- had minimal PPE, were having to re-use PPE, were using, you know, homemade PPE or however they were sourcing it. I also knew, and I was minister with responsibility for the NHS workforce, that NHS hospitals were also struggling with PPE. So I did have that context, although in general, my arguments that were made were particularly on the social care side because of me being the person who was speaking up for social care in the system.

MS CAREY: My Lady, would that be a convenient moment for the mid-morning break?

LADY HALLETT: Certainly. I shall return at 11.30.

MS CAREY: Thank you.

(11.12 am)

(A short break)

(11.31 am)

MS CAREY: My Lady, can you hear us all right?

LADY HALLETT: Thank you.

MS CAREY: Thank you.

Ms Whately, can we stick with PPE, please, and

clearly we were looking at some difficulties there at the end of March 2020, and I think you say in your statement that on 5 April, at paragraph 231, you message Mr Hancock highlighting your concerns about PPE supply to care homes. You were finding it very difficult to get any accurate information about what supplies were available.

And can we just have a look at a little bit of that exchange, at INQ000274068_7. I'll just try and pick out for you the PPE thread, as it were, because often the WhatsApps cover a multitude of topics. We can see there at 15.56, you say:

"FYI, [the] care sector is up in arms about lack of PPE. I'm struggling to get clear answers, especially for provision within the next week. The National Supply Centre is just sending them back to their suppliers who have no supplies, I'm told. I ... have a call with Jonathan Marron to update me tomorrow. Ros knows the [situation] but want you to be aware."

He says:

"Thanks -- join [the] PPE meeting at [4.15]".

You said you'd be delighted to.

Who were you trying to get clear answers about the provision of PPE from?

A. Probably from Jonathan Marron as the point of contact

for that. And I was trying to get information, I think around this time, certainly at various points of, like, well, how many shipments have been sent out from the National Distribution Centre to social care? Because they're telling me, oh, we've got -- you know, we're doing this, but, well, give me the data. How many, you know, what have you done in response to the calls you're receiving? Have you delivered to them or not? And that data was not forthcoming.

Q. Can I ask you, do you know it's because the data didn't exist or it wasn't in the right format or there was a reluctance to give it to you? Do you know which it was other than the fact that you just didn't get it?

A. I don't know which it was, I just didn't get it.

Q. All right, okay.

If we look down the screen a little bit later on, at 5 o'clock in the afternoon, you asked Mr Hancock:

"... can I have someone in the supplies team dedicated to overseeing PPE to social care? It is still all over the place, they have sent me contradictory info in recent days and cannot answer [questions] about flow. I'm ... told [the] Clipper system looks NHS focused (and again, no one can tell me whether it will cope with 20,000 social care providers ordering stock day 1). There's only so long I can keep saying to the social

care sector we're working on it, without losing all credibility."

Mr Hancock said he thought that Jonathan Marron was fixing it:

"If not then ... let's do that -- can you talk to him?"

And a little bit down the screen on the next day you say:

"Thank you for pushing Emily ..."

Is that Emily Lawson?

A. Yes.

Q. "... to identify an individual to oversee Social Care PPE. She was clearly reluctant & wants to keep the operation across [health and social care] -- will see where we get to in next few days."

Do you know what the reluctance was to have a particular -- a specific person dealing with PPE supplies to the social care sector?

A. I don't know the reason. I know Emily Lawson is an extremely competent person, and dealing with, you know, a very difficult situation and a huge amount of pressure from many people and places to get PPE out, but I don't know why. What we ended up doing is -- was involving David Pearson who was sort of partly working with the NHS at the time but has a social care perspective and he

subsequently chaired our Adult Social Care Taskforce.

He did some work behind the scenes to make sure there was more of a voice of social care in the PPE discussion as the work around, given that I was unable to get someone specific to social care as part of the team there.

Q. I mean, one can understand that clearly there was a need to supply the healthcare system and, indeed, the social care sector, but it might be thought that there was someone wanting to keep their hands on it to ensure that the healthcare system was prioritised over the social care system, or is that, perhaps, reading too much into this?

A. I couldn't tell you if that was the reason or if there was another reason.

Q. All right. And indeed, was then a team set up to specifically oversee social care PPE or was it just David Pearson?

A. So David Pearson was, as I said, the person behind the scenes who was there as a go-to, to explain how social care worked better, for instance, to people who were overseeing the PPE distribution. And then I refer to clearly in that the Clipper system which was emerging, and at the beginning, I felt, as I indicate there, that the people who were setting that up didn't really

understand how social care worked, and the complexity. I did think that by the time that was probably up and running it did, actually, do an extraordinary job of distributing a huge amount of PPE to a very large number of care providers. So once it was properly established, it was successful but it took a while to get there.

Q. All right. You mentioned the Clipper system and I'd like to ask you about that, and it's at your paragraph 235 in your statement, Ms Whately, because there was certainly in the early stages of the Clipper system, reference to the fact that the Clipper system would not be available to social care in the week of 10 April 2020, and there was going to be a plan to continue with drops of PPE to the local resilience fora to keep things going?

Do you know why there was issues with the Clipper system?

A. I don't know what the delay was, no.

Q. All right. Okay. Clearly the drops to the LRFs were still happening, they had started in March and were ongoing.

Can I ask you, please, to look at INQ000327836, this was a submission that went to you on 13 April 2020, and there'd been some LRF drops and at the top it says:

"Subsequent drops are expected to be needed over the

next 4 weeks, whilst the new online portal is tested and developed, and we will come back to you ..."

And it goes through the history of the drops that have been made, and the proposal, if we can see there, is that there will be another drop to ten local resilience fora, they'd been identified based on local intelligence. And it sets out the -- what's going to be in that drop.

"This volume will need to be agreed with the NHS on 14 April but looks possible at present, and is much smaller volume than had been sent [out the preceding week]."

Why was there need for NHS England to agree a drop if it's essential and the LRF is -- really needs it?

A. I do not know, and whether that "NHSE" is a shorthand for, actually, the, sort of, oversight because NHSE was essentially running the whole distribution across health and social care. So whether it's, actually, a shorthand for that, or whether it's a separate conversation with NHS England, I couldn't tell you from just looking at that.

Q. We shouldn't necessarily read into this as an example potentially of the NHS being prioritised or safeguarding their stock of PPE?

A. Yeah, unfortunately it may or may not be. I can't

confirm.

Q. All right. Now, the concerns about the supplies to the adult social care sector, they persisted throughout April into May 2020. And I think certainly you, then, on 4 May had messaged Mr Hancock noting that you were scheduling a conference with Lord Deighton, who was involved in PPE, and PPE wholesalers.

Can we have up on screen, please, INQ000327869.

This is messages between you and Mr Hancock on 4 May. You said you were scheduling the call with Lord Deighton, as you suggested, and with wholesalers.

"However, I never get helpful answers from Jonathan and Emily in those supplies meetings -- they are far too vague -- do you mind if next time I push harder? Could we have social care supplies as a focus for one of them? Mindful I don't want to take up too much of your time and it's your meeting."

And he says:

"... we should do it properly as it's really a question about distribution not supply so let's do it in a meeting ..."

And you say:

"Thx ... my understanding on [Type 2R] masks is that we do have a serious supply problem -- so we hardly have any to distribute. Unless there's a supply solution

I don't know about."

It's another reference, some weeks on, for you not getting necessarily the answers you wanted in relation to PPE, and can you help with why you weren't getting the answers and what you'd done to try and get the answers to the questions you were posing?

A. I'm still wanting specific figures and data. I think one of the things I was wanting to know is further into the future, what -- to get more line of sight of future, sort of, arrivals of stock and therefore to know what was coming down the track for social care, and evidently from this, I'm not getting answers. We know, in fact, things that were happening were things like, you know, a plane landing or you thought it had stock in it and it didn't or it wasn't fit for purpose, or there were all sorts of problems, in fact, with the supply, which may explain why it didn't, but I was wanting specific answers that I wasn't getting them, clearly.

Q. Again, do you know if it was because they didn't have the data -- because you had some data there on the supply problem potentially with the masks?

A. Yes, obviously I believe I'm hearing from somebody that there is a problem with a genuine shortage of those particular masks, like I recall hearing at some point there was a genuine shortage with, was it aprons that

had completely run out? So, you know, I'm hearing things but I don't know the reasons of why I didn't get clear answers, no.

Q. Right. In relation to masks, can I ask you about ClearMask face masks, because clearly there was a concern that for those perhaps with hearing loss or other communication impairments, people who need and rely on reading of facial expressions and, indeed, lipreading, obviously a mask was an impediment to that. And I think you say that you recall in June 2020 it was recognised that people with those kinds of disabilities would require alternatives to the standard blue mask that we've been talking about and that NHS England had procured 250,000 ClearMask transparent face masks, and you said:

"I wanted to be able to distribute these masks to social care ... The recommendation was to use [the local resilience fora] for [that] immediate supply ..."

And then the portal for the longer-term supply of the masks.

A. Mm-hm.

Q. And do you know, did that in fact actually happen? Was there a supply of clear masks out to the adult social care sector?

A. So yes, we did a pilot on that. So for the reasons you

say, I recognised that there were difficulties in caring for people with the traditional face masks, particularly if you had somebody who was hard of hearing, both it's harder to hear somebody and you can't lipread clearly and other reasons why masks were a problem. So we looked at alternatives like the ClearMask approach. There was a pilot, though my recollection is they didn't actually prove very popular, so it didn't become a mainstream solution to the mask need.

Q. Do you know why they weren't very popular? Was that coming from those that were reading through them or from the care workers that were wearing them? Are you able to give us any --

A. I can't, I'm sorry, I can't remember, somewhere there will be an evaluation of that pilot but I haven't seen it. I can't remember what the reason was they weren't popular.

Q. Can I ask about the provision of free PPE, and in, I think, July 2020 it was proposed to introduce free distribution of PPE and you say it was because you wanted a more sustainable approach to distribution.

Can I ask you about your paragraph 251, please. You received a submission on free distribution:

"The submission noted that although we had previously maintained emergency supply of PPE to social

and primary care, there was now confidence in [the] inbound PPE supply. DHSC was authorised by [the] Treasury to purchase £14 billion worth of PPE to distribute across the health and social care system (to date, DHSC have distributed about £312 million worth of PPE to social and primary care)."

Can you put those figures in context. I don't want anyone to run away with any misunderstanding here. Clearly they're buying billions and billions of pounds' worth of PPE but it is actually a relatively small amount that has gone out to both the social and primary care sector. Is that because the rest of it was going to the healthcare sector?

A. I would need to see some analysis of whether -- it was -- whether it's that already a much larger amount had gone to the healthcare worker, or was it that -- I mean, that 14 billion, that was -- that supply lasted for a really long time. So -- yeah, that was used for many, many months going forward.

Q. You go on in your statement to say you weren't happy with the proposal that all PPE should be provided by a single central system. Your instinct was to fund care providers to cover their additional Covid PPE costs, allow them to source from their usual wholesalers. However, the budget had already been used up for

purchasing PPE centrally. Can you explain what you were talking about there and what the problem was?

A. I think from the initial experience with the national stockpile distribution, I was a bit sceptical about whether central distribution was the right way to meet social care's PPE needs. I -- yeah, I didn't come into this situation with a great deal of confidence that the national approach would work for social care. However, as it says there, the PPE had already been purchased centrally so de facto, that sort of decision had in essence been made and as I say, actually, I think the PPE portal, once it was up and running did work pretty well for social care and that's certainly what I've heard subsequently from the care sector and at the time once it was up and running.

So, actually, that was a good decision, in the end, that it was done centrally.

Q. What was the budget issue that you reference at the end of your paragraph 252?

A. So there was -- there's a -- I believe, and I am having to recollect here, that, you know, the Treasury had agreed to fund a substantial quantity of PPE but then that had already been spent on getting the PPE. So if I was going to do something separate for social care I would have had to have gone back to the Treasury and

asked for additional budget in addition to that 14 billion for more PPE for social care, and that, no doubt, would have been a delay and a difficult process. So the budget was there that way.

Q. Right. I think in due course there was decisions on extending free PPE extended into March 2022 in due course.

A. Yeah.

Q. Now, can I ask about PPE for unpaid carers.

A. Mm-hm.

Q. The initial advice from Public Health England and I think the DCMO in March 2020 was that unpaid carers should not use PPE, and it was based on three reasons, as I understand it: a concern that unpaid carers wouldn't be able to use the PPE properly without training; that it would be less effective for people living in the same household because they would share transmission; and there were concerns about the supply of PPE.

Do you think, Ms Whately, that the concern that unpaid carers wouldn't be able to use PPE properly without training was somewhat unfounded given that it was rolled out later that year and, in fact, it's not incredibly difficult to don and doff a mask in the scheme of the different types of PPE there are? Was

that, perhaps, reason being overstated in your opinion?
A. It is difficult for me as the recipient of advice like that to unpick -- I think, you know, the question is, was the advice, you know, genuinely that unpaid carers won't be able to use PPE or was someone somewhere behind the scenes worried about the supply and that was translated into advice which was: there isn't a need? That, on my part it was -- that would just be supposition. I don't have evidence that that was colouring the advice that I was given. The advice I was given was the concern that it would potentially do more harm than good. If you distributed PPE to unpaid carers, it might give a false sense of, I think, sort of safety, and it would be inappropriate.
Q. Clear reference was made there to PPE being less effective where unpaid carers are living in the same household. But was any thought given to the need for unpaid carers who were not living in the same household needing PPE, given they'd have to get themselves to the carer's house, they'd be going about their daily business? What thought was given to the non-resident unpaid carer?
A. So I think subsequently the policy we developed when the advice -- in future iterations of the advice -- and I think -- I know I particularly prompted this being

looked at again later on, because I say somewhere that I was still concerned that unpaid carers might be overlooked. So I asked for further advice on it. And then I know that there was a point at which the public health advice that then came out later on was particularly focused on unpaid carers who didn't live in the same household as the person they were caring for.
Q. The third reason for that initial March advice was said to be a concern about PPE supply.
A. Mm.
Q. Do you think if there had been no supply issue, unpaid carers would have been advised to use PPE in the same way that domiciliary carers were advised to use PPE?
A. I think that is probably a question you would need to put to the public health advisers who gave me the clinical advice on appropriate use of PPE.
Q. I understand why you say that, and we've heard from Susan Hopkins. I suppose what underpins that question is: was supply dictating the guidance here, rather than the science dictating the guidance? Can you help with that?
A. I mean, you tempt me to -- I don't have any reason to give you a sort of yes/no answer to that question, because I didn't have insight into what was going on behind the scenes before advice got presented to me and

whether there were discussions about, you know, should this colour the advice.
Q. All right. I don't want to tempt your speculate -- or ask you speculate either. All right.
In July 2020, though, you heard concerns -- at your paragraph 263 -- that unpaid carers were not being provided with PPE, and I think there was a recommendation that munch -- that month that, because transmission rates were lower, unpaid carers did not need PPE unless they were being advised to wear it by a healthcare professional.
And you said:
"264. Although I agreed with the recommendation, I was still concerned that in local situations unpaid carers might be overlooked."
What led you to have that fear that they might be overlooked?
A. It's hard for me to say, given the passing of time. I mean, I think there was in this area, like in many areas, sometimes a gap between, you know, a policy that was set and worked out at the national level and the interpretation of it around the country. So that could have been the reason and -- that, you know, whether it's some local authorities or some NHS areas would focus more on the needs of unpaid carers than others. That

may be what is going on there.
Q. Right. You said:
"I asked to see what the formal protocol was that local authorities would consider in the event of a locally raised COVID-19 rate. The Secretary of State supported my comments. I was told that specific recommendations on what local authorities were to consider in the event of a local outbreak were not within the current remit of the Adult Social Care Winter Plan and would be best dealt with by MHCLG or the Cabinet Office's COVID-19 team."
Were you satisfied with that response, Ms Whately?
A. **(Reads to self)**
Q. Yes, take a moment to read it to yourself if you need to.
(Pause)
A. It's a somewhat puzzling statement. Was I satisfied about -- in it or not? As I say, I can't remember the specific moment that was -- statement was put to me and did I do anything about it or not. I would again have to check the record.
I mean, I can try and -- go away separately from this and see what the next step was after this. I think in general, I wasn't -- if I wasn't satisfied about something, I did tend to do something about it. But

that is not something I can recall right now.
Q. No. I mean, we know in due course the infection rates did rise, particularly as we got to December 2020 and January 2021. But in the winter of 2020 there was the trial of free PPE for extra-resident carers that ended being rolled out nationally. And can I ask you about that.
A. Mm-hm.
Q. Can we have on screen, please, INQ000328012.
And this from a submission that went to you on 12 November 2020. I think the winter plan had come out that September, if I'm correct.
A. Mm-hm.
Q. And it summarises there:
"In the Winter Plan, the Government committed to free PPE for Covid-19 needs for Adult Social Care providers, including domiciliary care ... There isn't ... a national offer ... for unpaid carers ... [but] some [local authorities] have chosen to provide it, including in Liverpool and Birmingham."
And it makes the point that many unpaid carers are effectively doing the job of a domiciliary care worker. Reference to Carers UK's report, Caring Behind Closed Doors, and "unpaid carers have been providing even more care during the pandemic", and clearly an impact on them

because of local services closed and they were living in poverty.
So that was sort of the background to that submission.
If we go over the page to page 5, the submission noted the likely demand, and made the point that data on unpaid carers was essentially an estimate. At that stage, 7.7 million. We've also heard the census reference to, I think, just under 5 million. Some estimates are higher than that.
And paragraph 7 says:
"It is unclear how many unpaid carers would take up an offer of PPE. Currently, Liverpool regularly provide ... 8 unpaid carers with PPE, out of ... 52,000 ..."
And:
"In Birmingham, where [they] can apply ... PPE has been provided to 20 unpaid carers out of approximately 1500 who are ... on their database."
And they make the observation that Scotland and Wales are doing something not dissimilar and they've got far lower demand figures as well.
Do you -- do you know -- or when you were thinking about rolling out the pilot, did you ask why there was seemingly such low uptake of offers of free PPE to unpaid carers?

A. I expect so. I mean, a couple of things. One thing that I was certainly aware of at this time was that the records that existed about unpaid carers were not what you would have hoped. And although there had been some work before I became minister to try to improve the, sort of, records and awareness about unpaid carers through the Carers Action Plan that my predecessor, as Minister of State for Social Care, had done a lot of work on, that there was still a lot further to go on that. So limited knowledge of who unpaid carers are.
I know that at various points in the pandemic I wrote to local authorities. I think I specifically said: make sure you contact unpaid carers, find out who the unpaid carers are in your area and contact them to see whether they are coping.
From very many stories it appears that not much of that happened, although I can understand that local authorities had a lot of stuff on their plate and maybe that's why. And I know that unpaid carers often felt, you know, desperately unsupported during the pandemic and really struggled.
I think, in addition, and again from conversations with unpaid carers at the time or since, from reading the stories, we know a lot of people -- you know, they -- if they were a live -- unpaid carer who lived

with the person they were caring for, they would be shielding together with that person or they would be taking a lot of steps to try to actually reduce their own risk of getting Covid so they didn't pass it to somebody. So that was the scenario for a lot of unpaid carers, as opposed to those who you're describing who were more, sort of, in and out, being more like a domiciliary care worker.
Though of course, again, unless somebody actually was a care worker, if they were an unpaid carer who didn't live with the person they were caring for, they would be unlikely to be doing what a domiciliary care worker does, which is visit many people in one day.
Q. Yes, and I take that point, but they are still nonetheless having to transport themselves from their own household, maybe via public transport or not, to the person they're caring for, go to the shops and the like. So there is a transmission risk, although I take the point, perhaps not as much as going to ten different houses each day.
A. I think one of the -- you know, to the extent of silver linings, maybe, however you put -- should put it, that as part of the vaccine programme there was some success in building up the sort of register of unpaid carers amongst GPs records, so some increase in awareness about

who unpaid carers are. But that is, you know, work that still needs to be continued so that in this kind of scenario or others, there's a greater knowledge about who are the unpaid carers and -- so that they can be offered support.

Q. Fine.

We know in due course that there was a progress update given on the rollout in May 2021. By this stage it had become national. And again, the figures were relatively low.

There's no need to put it up on screen, but it includes, in Leeds, 137 orders in eight weeks only, and indeed, in Wiltshire, approximately 60 unpaid carers had requested PPE, and in Durham, 36 unpaid carers. So similar low numbers to that which the pilot had envisaged.

Do you know whether there was sufficient work done to promote the rollout of free PPE to unpaid carers? You told us you wrote the letter, but did you have any other --

A. I mean, what channels were used to try and -- I mean, I think -- so this was something where we looked to local authorities, who had, you know, the social care oversight in their area, including responsibilities relating to unpaid carers, so we'd look to local

authorities to communicate, through the channels that they had, to encourage uptake of the offer.

Q. Just finally on this, Mr Hancock spoke of the definitional challenges in determining who is or isn't an unpaid carer. Do you have any observations on if there's any way of making it easier to identify unpaid carers so that if, in the event of a future pandemic, we needed to get free PPE to them, we'd at least know who they were and then be able to communicate with them?

A. Yes. And, I mean, this is an area of work that I did more on in my second time as Minister for Social Care. You know, one is through GPs and their conversations with individual patients, whether it's the individual who's being cared for or, indeed, an unpaid carer is a patient themselves.

Another route is through schools, in trying to get schools to identify when you've got young carers. And there are a material numbers of young people who are caring for siblings or parents. It can have a huge impact on their schooling. And there is -- you know, some work going on with schools to get schools to identify unpaid carers and, clearly, local authorities where they have contact.

So I don't think there's a single answer on this. In part because not everyone will kind of necessarily

recognise that they're an unpaid carer.

Q. And you may be one only for a couple of weeks or for a couple of years or for a lifetime.

A. Lifetime, yeah.

Q. All right. Can I change topic then --

A. Before you do so, can I say, there's one more thing, and I think I put it in my lessons learned -- I was just looking forward to see if I could see it, but I couldn't -- which is on PPE, which is one of the conundrums for me is in the second wave, after we had the winter plan, we know that there was a -- you know, a substantial supply of PPE going out to care homes. We know that there was the training in place to support staff to know how to use it effectively. We had large amounts of testing going on. We had designated settings. And despite that, we saw social care -- we saw Covid get into many care homes during that second wave in the winter.

And to me, there is a question which -- and I asked at the time of public health advisers: what is going on, and how is it getting in there? And I think the record will show me asking questions like: is the PPE not working?

And I was assured at the time: no, this is the right PPE, we have the right PPE guidance.

But subsequently there has been work done which is particularly looked at hospitals and why is it that more healthcare staff got sick from Covid in, sort of, ordinary wards, shall we say, during the pandemic rather than intensive care, where they had a higher level of PPE? And one of the things I've seen from that research is that, you know, arguably the level of PPE that was being used in those everyday hospital wards, and similarly in social care, wasn't good enough in the light of the way Covid spread.

Now, I am not a clinician, I am not an expert on infectious diseases, but to me there is a question which should still be answered, which is: actually, is this the right level of PPE for this kind of disease? And, you know, for a future pandemic, what different sorts of potential infections might require different sorts of PPE?

And if it is something which is infectious in the way that Covid was, well, actually, do you need to be looking at distributing the higher level of PPE at -- and I recognise that could be enormously expensive and very hard to do, but that needs to be considered, to look at whether you actually needed a different level of PPE for this nature of infection.

Q. I can see her Ladyship nodding, because this will echo

with evidence we heard in Module 3 about the efficacy or otherwise of FFP3 masks versus the blue surgical masks, so thank you for adding that observation, Ms Whately.

But can I come on to another way that there were efforts made to try and limit the spread of infection in care homes, and look at the attempts made to restrict staff movement.

And you make the point in your statement that certainly evidence such as the Easter 6 study, which we're familiar with, showed that staff were a key vehicle of the spread of Covid-19. And indeed, by 15 May, the Covid-19 Care Home Support Package set out ways to try and limit movement, and the easiest way to look at that might be to show on screen your statement INQ000587788_39, and the bullets at the bottom go over to page 40.

But this is by mid-May, what the department asked care homes to try to do: to ensure members of staff work in only one care home wherever possible; to extend restrictions to agency staff, under the general principle that the fewer settings members of staff work in, the better; potentially cohorting staff into Covid-positive or green zones, red zones, call them what you will; recruiting staff to prevent the need for staff movement; and indeed, steps such as limiting the staff

public transport, and indeed, potentially providing accommodation for staff who chose to stay separate from their families.

And we know that accompanying this package was the Infection Control Fund, or the first set of funding, of 600 million. And you say in your statement that you wrote to council leaders to accompany the publication of this package, setting out the measures that the government was taking and asking all local authorities to review or put in place a care home support plan to be submitted by 29 May which should be made public.

What did you envisage the care plans would include or might say, and why were you asking for them to be made public?

A. So I know this time I felt like I wanted to, I guess, use the capacity and knowledge of local authorities, which is substantial, clearly, of their social care system. And I knew that some directors of adult social services and some local authorities were doing a lot with their care providers, but others, I was hearing from care homes saying, "We haven't heard anything from our local authority, nothing", so I'm trying to engage or enlist, sort of, more consistently leaning in from local authorities, and I want to kind of cascade, we're doing the national guidance and I want there to be

implementation of that at a local level, and I wanted to see something in writing that said how they were going to do it, because if they hadn't written down how they were going to do it, then how would I know that they had thought about how they were going to do it? And if what they wrote didn't add up then there would be an opportunity to go back and say do better --

Q. Did you ever see any local authority plans on restricting staff movement?

A. So I think there was a process of scrutinising those plans, but I don't recall seeing a plan at the time of the restrictions of staff movement.

Q. But was the idea behind making them public (a), to hopefully reassure care home residents, their loved ones, what was being done, but also to name and shame those that didn't make theirs public?

A. Yeah, I generally believe in making things public, and transparency, as a way of driving up standards.

Q. Clearly the bullet points that we just looked at very much focused on the care home and, indeed, the Care Home Support Package was focused on care home, but do you know, was any thought given to trying to restrict staff movement between people working in domiciliary care, and indeed, a similar package for the domiciliary care sector?

A. I think this was -- I mean, I think in general the funding went to care homes and domiciliary care, and if we, at some point, go into the infection prevention and control fund, and while the majority of that went to care homes there was also the 25% discretion intended to go to domiciliary care, kind of, reflecting the situation at the time which was the feeling that care homes were the hardest hit and had the greatest increase of costs, but yes, domiciliary care also had an increase in costs, and challenges.

I do think, you know, at this time, like the whole way through the pandemic, as soon as we became aware about the problem of staff movement, there was a set of activities being driven from the centre to try to fix that; on the one hand, by trying to build up the workforce through our, you know, recruitment efforts, training efforts, to sort of online training, free training thing that we did with trying to get people who were, say, furloughed from the hospitality sector to work in social care, so there was a strand of work to try to boost the supply of workforce.

And then there was a strand of work to try to get local authorities and care providers to take the steps they need to actually take to stop having staff going between care settings, including the work that I was

doing knowing that part of that was financial, and that if you're asking somebody to not work, say, for in two different settings, different places, you're going to need to address their loss of income as a result of that, and so I'm trying to make sure that that is addressed through the funding streams.

Q. Right. Well, I think indeed in the run-up to the package being announced there was a deep dive at which a number of ministers, secretaries, were present, and it was noted there that when discussing limiting the spread of infection, restricting staff movement was one of the ways to do that, and the financial consequences were noted for staff who were restricted. The provider sector -- has told -- was reported as saying that the adequate funding is a barrier to implementing the guidance more effectively.

Do you think it was abundantly clear that one of the biggest barriers to restricting staff movement was the funding issue and the loss of income for those people that couldn't work across multiple -- (overspeaking) --

A. There were a couple of barriers. One was the supply of staff, where we know when we went into the pandemic that there were already challenges to -- for social care providers to recruit and retain staff. I mean, it's a quite mixed picture, I mean, some care providers will

say they have absolutely no problem recruiting and retaining staff; others will have a high staff turnover. As a sector it's known for high staff turnover and relatively low pay.

One of the worries right at the beginning of the pandemic was that because of staff shortages, because of potentially staff being sick, because of staff being scared to work, and I have huge respect and gratefulness to staff who despite the risks to themselves did go to work but, you know, that was sometimes a problem, as well, that would we find that there just weren't enough staff turning up to care for people who needed caring? And we saw in, I think it was in Spain, early on examples of care homes just abandoned and people dying just because the staff didn't go into work.

So the supply of staff was a very early concern and we did work continuously through the pandemic to try to address that.

As you say, even with supply, the other hand of it was funding, and going from funding into, you know, paying staff, for instance, it's across sick pay and pay for isolation, and to not do other jobs. The various mechanisms to fund the sector that I put in place were intended to solve that problem where I didn't want money to be the barrier --

Q. Right.

A. -- to stopping staff movement, and that was the intention of the policies, for sure.

Q. Understood. In -- so that was in May 2020. In, I think, June 2020 the Vivaldi Study results became made available and that highlighted the risk factor where bank staff were regularly used as a vector of transmission, and indeed, I think Professor Shallcross gave evidence to us at the beginning of the hearing and she said that the survey provided evidence that care homes that did not pay full sick pay were more likely to have infections in residents and staff, and she'd reported that to the taskforce.

And I think, can you help me, in relation to the Infection Control Fund, one of the aims was that it would pay staff full wages if they needed to isolate, and the Inquiry is aware that at the end of July 2020, 66% of care homes, so two-thirds, were paying staff full wages but clearly a third that weren't. Do you know what efforts, if any, were made to try and ensure that the remaining third did do that which the fund was intended to do?

A. Yes, I've seen that and also I think one of the submissions, was it from Unison, to the Inquiry had some data on this, of despite the, both the funding and the

instruction going out, that staff should be paid full pay for isolating because they had Covid or, indeed, because they were a contact, and I think through various channels I had put out pretty robust communications saying, "This should happen." Still it is evident, in retrospect, and from that kind of data that that didn't happen.

I think one of the challenges is that obtaining the data that will tell us down to a care provider level where that wasn't happening. And clearly we had the Capacity Tracker and one of the things, the levers we put in place was that the Capacity Tracker had to be filled in in order for care providers to get funding, and we had local authorities meant to be doing due diligence on the distribution of funding but these are imperfect mechanisms.

And we also had the regional team that, you know, we put in place, me and Michelle Dyson together, in order to have more outreach, in order to have people in the department who could literally pick up the phone to a care provider if we heard a problem with their, sort of, compliance with one of these things. But that's not the same as having a, you know, comprehensive reporting system which is giving you data as to when a staff is off sick, are they getting their full pay or not? We

didn't have that kind of system.
Q. I mentioned there Vivaldi. Can I ask about this: were you aware of or asked to get involved with enabling PHE and NHS Digital data shared into the Vivaldi lake stream which I think was held in the NHS Foundry? Do you recall being asked to put ministerial pressure on to get that data shared?
A. So in general data -- so the data story is that we started off with very limited data at the beginning of the pandemic, it was a real struggle to get even data about deaths, what felt like a battle with PHE to get them to share deaths data with me. The development of the Capacity Tracker, which was very useful, the work to get that completed, and then the iteration from that into the Palantir dashboard, which was a fantastic tool, which I had access to, and was looking at. The first thing I did in the morning when I woke up, pretty much, was go and check that dashboard and see what was going on, because it gave me a good early warning system as to rates of Covid in care homes, particularly once we had the testing up and running.

So the data evolved. In general, other than I said that sort of early challenge with PHE trying to get deaths data, I don't think data was in general withheld from me. I think there might have been one problem

where I had an issue with a log-in, but that was an IT problem rather than anything more significant than that.
Q. We will look at data a little bit this afternoon but I was actually just trying to focus on Vivaldi data and whether you recall that you had to use some ministerial pressure to ensure that Vivaldi got the data they needed from Public Health England and NHS Digital. Does this ring any bells with you, Ms Whately?
A. No, I don't recall a problem with Vivaldi accessing data, no.
Q. And were you ever aware that Vivaldi findings were being reported to you in secret without other people at DHSC knowing about the Vivaldi findings?
A. No, I don't believe so. I was given presentations of submissions about Vivaldi through the normal channels.
Q. As far as you were made aware, were you ever alerted to a PHE or, indeed, the department being obstructive about either setting up Vivaldi or reporting on its findings?
A. No.
Q. Can we go back to limiting or efforts to limit staff movement and the Inquiry has already heard that there were a number of proposals running from, I think July 2020 onwards, to consider whether there could be legislation brought in to best -- to restrict staff movement, including in July 2020, I think David Pearson,

now Sir David Pearson, sent you a submission in which he noted 90% of care homes had put in place actions to restrict staff movement, and he recommended that consideration be given to legislative change.
A. Mm-hm.
Q. He also recommended regulation of agencies and advocated for a one-off bonus of £500 to be paid for social care workers. We'll look at legislation in a moment, but do you know if any work was done in relation to his recommendation about regulation of agencies?
A. I recall that staff movement restrictions were meant to apply to agency staff just as much as they would apply to, sort of, permanently employed staff employed directly by a care provider.
Q. And what about the recommendation for the one-off bonus payment to be paid to social care workers? Do you know what happened with that recommendation?
A. Yes, I remember us discussing how -- the bonuses and how we could reward the care staff but I cannot remember the outcome of that conversation but I could potentially look it up and try and get back to you on that one.
Q. I think in due course there wasn't any one-off bonus payment paid into the English adult social care sector, but maybe we'll come back to that if we need to follow that up with you.

A. Okay.
Q. Sticking with the legislation, though, I think there was number of issues that you were concerned about, and can we have up on screen, please, INQ000109792.

We are in September 2020 and one of the options, just to help you, Ms Whately, was an amendment potentially to Regulation 18 of the applicable regs which required providers to deploy enough suitably qualified and competent staff to meet the needs of their carers. It was about safe staffing levels.
A. Mm-hm.
Q. And whether that regulation could be amended to deal with the restrictions on staff movement, and you:

"[Secretary of State] is ... content for the team to address [the minister's] questions below on the further detail."

And you had raised the below questions:

"Does Capacity Tracker tell us that 91% of care homes are not confident staff are not moving, or that they are restricting movement (which is not the same)"?

Did you ever get an answer to what the tracker was actually telling you?
A. My recollection is what the tracker told us was the latter of those things, it was the -- I think the question was whether they were restricting movement or

not, and I don't think we necessarily had the answer to therefore -- (overspeaking) --

Q. But as you point out there, it's not the same as saying the staff are not moving.

A. Yeah.

Q. Yes. I won't go through all of them but the consequences of them not being compliant with the regulation, there was not to be prosecutions but there could be regulatory action if Regulation 18 is not enforced.

Various other points but can we go, thank you very much, to page 3. And you raise this issue:

"Given the risk flagged in para 14 that there may be a greater impact on women working part time / on zero hours contracts, can we have a mitigation on this. [You] would prefer to see this benefiting this group of people by giving them guaranteed minimum hours (or at least the option of guaranteed hours should they wish) in return for the commitment to only working in one place."

We're aware that there's a greater proportion of women in the adult social care sector, but can you help with what was the risk and why did you want there to be potentially a guaranteed minimum hours written into any legislation that might mandate against staff movement?

A. Well, because I'm thinking here about the reality of the social care workforce, which, as indicated here, often women, often from ethnic minority communities, often low pay. So you've got a group of people who, if the consequences of the policy is just loads of their income disappears, how are they going to keep paying the bills?

So I want, as part of this policy, for -- part of the policy to be that you make sure that people who lose out financially from the policy are, you know -- aren't left with not enough to live off.

Q. Ultimately, you indicated there you were minded to go with the recommendation to take the reg 18 route. Why were you minded to try to see if there could be legislation brought in to restrict staff movement?

A. Because from relatively early on in the pandemic, we have repeated, sort of, bits of evidence that tell us that where there is staff moving between multiple settings you've got a higher risk of outbreaks. And so repeatedly at various points we look into what can we do about this and, you know, by this point, we've given funding, we've put out pretty strongly-worded guidance saying that staff movement needs to stop, we've got local authorities to get involved to have plans to stop staff movement.

There was one piece of evidence, I think, as part of

the summer which was a spreadsheet I was presented with about recent outbreaks and every single one of those outbreaks was in a care home that still had staff movement.

So to me this is very, very serious, that all these efforts are being made, yet we've still got staff movement going on in, certainly, you know, the 9% of care homes, according to the Capacity Tracker that are not even restricting staff movement, but as I think I said, those that were restricting it weren't necessarily stopping it. So I'm, like, well, we have to -- where do we go next with this? You know, it's legislation. That is the next lever that you've got, hence where I am in the bit you've highlighted.

Q. Yes. Now, there was a consultation that autumn, I think, about the proposal to require the CQC-registered care homes to not deploy staff if they have or -- they are or have in the previous 14 days been carrying out a regulated activity. But there was an exception to that proposal, that if they needed to ensure there was enough staff available to care for residents safely, that then the providers could deploy this temporary exception.

A. Mm.

Q. And I think in due course, the consultation, there was

concern to you that limiting staff movement could lead to understaffing. Did you think -- take that to mean that if there was understaffing there would be a lower quality of care provided?

A. I mean, yes, a risk of understaffing is lower quality of care and potentially unsafe care. And, you know, if you don't have enough staff to look after people, then you've got somebody with dementia who may become dehydrated if they're not drinking enough -- you know, those sorts of things, there's risk to life as a result of that. So it's very serious if you're short of staff and unsafe care.

So -- and to me this was -- you know, this was a -- the battle on trying to stop staff movement versus me listening to the sector, and the sector telling me: there's a risk that this will be unsafe so you shouldn't do it.

Q. Can I ask you about actually some of the views of the sector, because in the middle of the consultation you held a teleconference with a number of adult social care providers, on 17 November.

Can we have a look at INQ000328021_3. Thank you very much.

Can we see there reference to Caroline Abrahams, who in fact gave evidence to the Inquiry earlier this week.

She was making the point on behalf of Age UK that when discussing whether to bring in restrictions on staff movement, she said:

"Why are we pressing ahead with this when we have such promising news about a vaccine?"

And you sort of take those points on board:

"... we are looking at the responses ..."

And:

"We will weigh up the options in [light] of new developments [like] the vaccine.

"However, the level of concern around this consultation is striking and makes me wonder how many staff are moving between settings. The guidance has been not to do this (except where unavoidable) for a long time."

Ie, since May of that year.

A. Mm.

Q. Then Mr Pearson gave some observations on the Vivaldi research showing that:

"... you're three times more likely have outbreaks amongst staff if there is movement ..."

And you said:

"I am confident about staff levels considering the exceptions in the guidance."

And then reference again to the vaccine not being

rolled out yet.

So clearly there was not unanimity about whether there was the need for legislation to come in.

A. Mm.

Q. Were there other concerns brought to your attention perhaps that were unrelated to potential vaccines? Clearly safety of the residents was one. What about --

A. I think it's summed up quite well here. I mean, Caroline Abrahams is somebody who is very informed and I would respect her view there. And, you know, that sets out this dilemma between, I want to say, unsafe staffing versus the very substantial risk, as David Pearson says there, that there's a materially greater likelihood of an outbreak if there is staff movement going on. The vaccine was on the way but it wasn't there yet and we didn't know how long it would take to roll it out.

And as I say, I think by this point I am extremely frustrated that the evidence is so clear of the risk of staff movement. The money has been going out there, you know, why is it still going on?

And as I say here, that if we'd done the legislation there were still exceptions in the guidance which was -- would mean that you felt you couldn't provide safe care with some staff movement, it still would enable it.

Q. All right. Just standing back for a moment, we know in due course that it wasn't possible to bring in legislation.

A. Mm.

Q. You set out in your statement that you argued that the staff movement restriction should be accompanied by furlough payments and/or some other financial support to compensate for loss of earnings, but make the point obviously that would require Treasury approval, and indeed Treasury rejected the proposals to compensate staff.

Just standing back for a moment, Ms Whately, what do you think now about whether there should be legislation and/or funding, and/or anything else, that might help ameliorate the risks that staff might unwittingly transfer Covid into care homes in the event that there was a pandemic which struck care homes in the way that this one did?

A. So I think for a future pandemic, were it similar to this or these kind of scenarios, you need to have a plan by which you can stop staff moving between settings, because here it was clearly a material risk factor. You could have an even more infectious pathogen where it was an even greater risk factor. So you would need to have a plan to enable you to do that.

Clearly the big -- the biggest challenge was about the supply of staff. You need to both be able to make up for the incomes of those who lose income because of that, and so you need a system for doing that, and you need to have a greater supply of staff. And what was evident as that -- you know, we set up a bunch of things to increase supply of staff and recruitment and bringing people across from other sectors, but that was insufficient. So a future pandemic plan will need to work out how do you find a way to ramp up staffing further? Recognising that, while clearly social care requires material skills and that's something that experienced care workers bring to their work, it is something where you can, you know, train and support somebody to be able to take material part in a team, particularly in a, sort of, setting like a care home, where you've got multiple members of staff around.

So it should be possible to boost the supply, but I think that is something that would be worthy of advance thinking.

And the other thing is to, you know, build up the workforce in peacetime, so to speak, which is something that I spent significant time doing as my time as Social Care Minister, and developing what's called the Care Workforce [career] Pathway, which is exactly that:

making it worthwhile working in care so that people would pursue a career in care. And also the work that I was doing to get CQC to assess local authorities, and part of that assessment looks at how they're commissioning care, and part of that assessment is meant to look at whether they are commissioning care in a way that means that care providers are employing staff on proper contracts, with decent hours and decent pay and sick pay and all of those things. So looking at it through the commissioning route.

These are things which I kicked off as part of the reforms when I was Care Minister to try to put us in a better place in a future pandemic.

Q. Understood.

Can I ask about one discrete areas, which was designated settings policy, which was another way to try to prevent Covid entering the care homes.

And we're aware that each local authority was to identify sufficient accommodation to be able to care for Covid-19-positive patients being discharged from hospital, and the designated settings were identified.

And you deal with this at your paragraph 132 in your statement, if that helps you, Ms Whately, but you know that the Inquiry has asked you specifically why the designated settings guidance wasn't introduced earlier

in the pandemic and why there was an apparent delay in implementing it. Can you help us with those observations, please.

A. Yes. I mean, to some extent we may end up covering a bit of the territory we covered in the earlier conversation about discharge, but the plan and the policy in the early part of the pandemic -- was it from the mid-April discharge guidance? -- was that local authorities would set up essentially what became formally known as a "designated setting" to accommodate and care for people discharged from hospital when the care home they were due to go to wasn't able to effectively isolate and care for them.

So that was what was agreed in April as the approach. And my understanding was that that was something that local authorities were doing.

So that was the policy.

Then, in the period through the summer when the Covid rates went down and we set up the adult social care taskforce, led by Sir David Pearson, the objective of that taskforce was to say: what could we possibly do to help protect care homes and social care more broadly for the coming winter in the event that there is another wave of Covid? As indeed there was. What could we possibly put in place?

And one of the things that came out of that and as we were preparing, therefore, for the next winter, was having a more robust policy on this designated settings, on having a place to discharge people to from hospital.

And as the record shows, the policy that we then put in place, it did involve a lot of work. So, you know, material manhours put into setting up this policy so that it could really properly work and be overseen from the centre.

Q. Yes. We understand in your statement you set out the efforts that the CQC made to ensure that the designated settings were appropriate.

A. Mm-hm.

Q. Do I take it that you were therefore in favour of the designated settings policy?

A. Yes.

Q. And would you still be in favour of having it or an equivalent thereof in the event of a future pandemic?

A. Yes, I think -- I mean, clearly we have to always be careful of not preparing for the last pandemic, whatever it might be, so you need to prepare for a range of scenarios. But I think, you know, one of the scenarios is -- I mean, definitely from the experience we went through with this -- is: okay, if the NHS again needs to free up beds, and you don't want to discharge people

into care homes, well, where are you going to discharge them instead?

And it took some, you know, multiple weeks, even months, to -- it was still done pretty quickly -- to identify and set up and create designated settings that could do that. So much better to have them ready from the moment it looks like a pandemic is on the horizon, to be able to do that and to operate them pre-emptively.

You also might find a scenario where, if you've got a highly infectious pathogen and you believe somebody within a residential care setting has got that, you might decide you want to move them out of the care setting rather than try to care for them within it.

Now, we know that moving people who are frail and elderly, particularly, is difficult to do, and can be a risk to their own life indeed. However, you would have to -- you would be weighing that up versus what we see is -- something can go through a care home very quickly and it's very hard to quarantine within a care home setting, so you might want designated settings to do that as well.

Q. Yes, I was going to ask you about that, because Dame Jenny Harries gave evidence to the Chair, and she made the observation that there is a risk with the designated settings policy not only now putting all

of the infected people into one area, but equally the point you've just made: that moving elderly and frail increases their mortality, never mind the effect of isolating potentially in a wholly new setting that is alien to them.

A. Yes.

Q. Were these counterarguments put to you when you were devising the designated settings policy, and did they in any way change your view that you would still have one potentially in the event of a future pandemic?

A. I remember having discussions about that back in -- in the April time, when we were looking at the discharge process and whether somebody should be discharged from acute hospital to NHS step-down -- which then proved not where we ended up -- on the way to the care home, that -- that risk of moving somebody in an unfamiliar environment, particularly somebody, say, frail with dementia.

So I think that is a recognised risk. These are exactly the sort of risks that have to be weighed up. The risk to an individual of being in an unfamiliar setting and multiple moves versus if something's highly infectious. And if you can't isolate somebody within a care home effectively but -- you might have a care home with, you know, ten, 20, 50, 100, however

many people in it, if bringing somebody into that scenario who is infectious then means that everybody in that setting is going to get a potentially deadly illness -- these are the things, the difficult decisions that would have to be made.

Q. May I deal with one other topic, perhaps, before we take a lunch break, and you mentioned there preparations for another wave, and we know that there was particularly severe outbreaks in December into January 2021. And I think in January 2021 you received reports of care home staff continuing to work even after they'd tested positive for Covid-19 and I'm at your paragraph 172.

A. Thank you.

Q. You asked for the matter to be investigated, and can we show up on screen, please, INQ000565732, which is a draft letter but we know that the draft did in fact go to you, but it helps summarise the position.

We are here at 22 January 2021. It's a note that Ms Dyson was preparing for you, and, indeed, for Mr Hancock. And it was to alert you to the problem. And as at January '21 you're aware of six cases. Two of the cases are in care homes and one involves a care home in an area with a significant number of deaths that had been reported. They were letting you know that there was one case early in January, which was discussed, and

at that time it was believed to be a rogue case but now that regional assurance teams had found a further five cases making the six in total.

"It appears that in some cases the action has been signed off at a local level on the grounds there is a risk to safe staffing without [the] Covid positive staff continuing to work. A number of further requests have been made to our regional assurance team which have been turned down. So it is clear that we have a systemic risk."

Was that a request to allow positive staff to continue working that were turned down by the assurance team?

A. It looks like it. Though in general -- so when it says at a local level, it had been signed off, that wasn't a sign-off by the regional assurance team. Because our regional team would not have signed off anyone to do Covid-positive working, but that's implied by that sentence.

Q. No, Ms Dyson told us yesterday that there was never any departmental policy that it was acceptable to work in Covid positive -- when Covid-positive at all.

A. Correct.

Q. And I see you're in vehement agreement with that. Indeed, you then highlighted the problem to Mr Hancock

in a WhatsApp, describing it as:

[As read] "Note coming your way re positive staff working in care homes, shocking and totally unacceptable. We would not have known this if we hadn't set up the regional assurance team."

And, in fact, the numbers grew to 50 by 10 February and at least 94 by 13 April. Again, the -- I hesitate to use the word justification, but the reason given was because without the Covid-positive staff working there would be a risk to providing the care for the residents.

Do you know if it was even more widespread than the 94 by April 2021?

A. I don't have any data to indicate that it was more widespread but I think you've effectively expressed my -- I was shocked and furious to see this happening and I still find myself looking at it going: how was it completely impossible to find some staff who weren't Covid positive to cover those gaps? I still find that surprising and shocking.

Q. Do you know if this was an issue with Covid-positive working across domiciliary care?

A. I don't have that data.

Q. Did you hear any reports of it happening in -- on the domiciliary care side of --

A. The only reports I have are the things that you have

referred to there and, as I said, I think that was in care homes.

Q. Right. Did you ask for any investigation to be carried out as to whether there was any link between the Covid-positive staff and either an infection outbreak or worst still, a death in the care home?

A. I mean, I asked for these situations to be generally investigated, and I know that the police were involved in at least one occasion.

Q. Yeah, indeed, I think the CQC were asked to get involved, and potentially the police were asked to get involved.

Were you asked to put out any kind of statement or public announcement decrying the use of Covid-positive staff.

A. I think we did. I feel like we -- I mean, I recall having conversations saying how can we get this message out very loud and clear that this is completely unacceptable? Although I don't have in front of me what routes of communication we then did for that, but that was part of the conversation.

MS CAREY: Right.

My Lady, would that be a convenient place to stop? Because I'm moving on to a different topic.

LADY HALLETT: Certainly, and I understand that it will be

convenient to have a slightly longer lunch today; is that right?

MS CAREY: Yes, if possible, thank you.

LADY HALLETT: I shall return at 2.00.

MS CAREY: Thank you very much.

(12.43 pm)

(The Short Adjournment)

(2.00 pm)

LADY HALLETT: Ms Carey.

MS CAREY: My Lady, thank you.

Ms Whately, can I ask you please, briefly, about changes to the regulatory inspection regime. We know already, of course, that routine inspections were suspended in March of 2020, and I won't revisit that decision with you. And I think you certainly say in your statement that you recall receiving general updates on the Emergency Support Framework that was put in place as a way of trying to remotely monitor risk.

A. Mm-hm.

Q. And you were having updates in relation to that, and I'd like to jump forward, please, to the 1 July meeting you had with the CQC.

Before we go to the meeting, though, I think to help you, on 11 June there'd been an update saying that there had been over 5,000 emergency support framework calls

that had taken place.

A. Mm-hm.

Q. And you were recorded as stating that you didn't feel there was visibility on what interactions were being undertaken by the local authorities or the CQC to ensure that there was safe care going on. You said:

[As read] "I feel I've no intel, no idea what they found out. It's a black box or hole [to you]".

And you felt there were significant gaps in what you'd been seeing has been done.

You said that when you asked how sure that people hadn't died in care homes from neglect, you didn't have that assurance.

Now, that was on 11 June --

A. Mm-hm.

Q. -- so just a few weeks before the 1 July meeting.

And we're at your paragraph 396 onwards, Ms Whately, but it may be that an email I'm going to show you helps you with that meeting.

Could I have on screen, please, INQ000609960_2. Thank you very much.

The "KT" is a lady called Kate Terroni of the CQC. You were -- now, there's a number of things being discussed in this meeting; one is an issue about data and one is an issue about what was being done to ensure

that there wasn't abuse of residents in care homes, and I'll try and deal with both as we go through.

A. Mm-hm.

Q. Can you see the third bullet point down, or dash down, you asked about data and information from the provider discussions on specific issues.

Kate Terroni confirmed this was detailed data in each provider record but that its main themes were workforce, PPE, multitude of guidance, discharge, and the withdrawal of the health offer from community nursing by the clinical commissioning groups?

So was that things that had been raised with the CQC by providers as concerns or was it that you weren't getting the data about those concerns?

A. I think that was -- I think that was the concerns that they had gathered from their data.

Q. All right. And you noted then that:

"... insights sounded ... helpful but [you were] not confident that reports on these ... had been flagged with the department [and you] certainly did not see this at the time."

And then:

"Following the meeting, [you] ... asked whether this information [had been] received by the department, and whether [they'd] received anything other than data from

the Capacity Tracker? If it didn't come into us, was there a good reason for this, any particular barrier? [You were] not clear why CQC didn't share the intel they had from inspectors' contacts with care homes with [you] before, as we had asked for [it], and ... asked if this was due to not having a mechanism for getting this up to Kate?"

So that is just one issue.

A. Mm-hm.

Q. And I'll come back to it because it's copied -- or it's answered later in part by an email.

But as we could go towards the bottom of the page, you start to discuss there information in relation to what is being done to ensure people weren't being neglected.

And:

"[Ms Terroni] noted cautiously that whilst the right measures were taken ..."

And she gave an example of a care home that was closed because it lacked basic safety for residents.

In bold it says:

"... it is likely we will see an increase in no. of services that haven't been able to cope during [the] pandemic and therefore a spike of these cases being unveiled in [the] next ... [week]."

And:

"[You're] extremely concerned about this, [you're] flagging with [the] Comms colleagues ... in case we have any intel ...

"[Ms Terroni] stood by their decision to stop the routine inspections ..."

And you'd agreed.

"... but [it was] still likely to uncover bad cases in [the] next few weeks."

And you asked for more insight into CQC findings in terms of live intelligence, "especially where there are known alarming cases", and Ms Terroni agreed to take that forward and share any potential actions.

Can I just help you, did you in this meeting get any sense of the scale of the problem, about how many cases there were going to be unveiled that had been potentially either neglectful or abusive?

A. No.

Q. You clearly, though, were concerned by what Ms Terroni was telling you. Had you had any inkling, suspicion, or anything raised with you prior to 1 July to suggest there was going to be a problem once inspections started again and perhaps the abusive or neglectful cases were uncovered?

A. I don't believe so. I mean, it might be helpful to step

back a moment. So Kate Terroni was CQC chief inspector for adult social care, with whom I had a good working relationship with the pandemic. She had a background in social care. I think she was an extremely competent, capable person, and tended to be frank and straight in her dealings with me and the department, I believe -- that was certainly my impression.

I knew, and it was why -- sort of agreement -- or I was aware of the decision for CQC to stop their routine inspections going into care homes during the pandemic, for the obvious public health reason of the risk of taking an -- an inspector taking Covid into a care home, and they set up an alternative procedure to sort of keep an eye in the meantime.

I think the first thing that you have identified and shared here is the fact that they had done these 5,000 calls or so, had gathered lots of data about that, and I just thought that looked really useful data. And in a circumstance where all the way through the early part of the pandemic we're trying to get data and get better insights, in -- what you shared is my frustration that there was some data sitting there that -- why hadn't CQC been sharing it with us from the moment they were starting to collect it at any scale? Just that would have been useful.

Q. Can just pause you there, Ms Whately.

A. You can.

Q. Just simply because -- whilst we're on that point, could we have the top email on page 2, so there is no misunderstandings, because you've got the point there that: why wasn't this intel coming to us? We only had what was in the tracker.

And can you see the answer from Ros relating to that first point in red:

"... whilst we might not have received it formally, we certainly did receive ... this feedback through the weekly national Covid-19 [adult social care] calls ..."

Which Ros and someone called James Bullion had chaired.

"All of these issues featured heavily and shaped our policy [concern].

"So I don't quite understand [the minister's] concern -- this seems exactly what we were hearing from providers at the time."

Now, it may be that it's coming in from two different sources and you were still, nonetheless, keen to get the CQC data and not just hear it through the weekly national Covid calls, but was that -- does that -- do you recollect, sorry, that you were getting the same kind of concerns that the CQC were raising albeit

from a different route?
A. So yes, the concerns that were listed by the CQC were familiar things so it's true that I had been getting that and evidently, but I think what I -- no. To the extent that CQC had data which might have given us more colour on a geographical focus or particular type of care homes that were being affected or something which would give further insight, I would always rather have had the greater insight than just the rolled up summarised version, which might have been what I was therefore presented with.
Q. Can I take it there may be a comms issue here, because if there is this repository of data that the CQC have got and the department, indeed the minister would like it, something has fallen between those two stools, do you know was there any protocol or plan in place for the sharing of the data that the CQC were collecting other than that which went into the Capacity Tracker?
A. I don't know if there was a formal protocol. From the communications you've shared, clearly data was being shared, but as I say, I was then given a sort of summarised synopsis high-level view of it rather than something more granular, which I would have liked.
Q. I interrupted you when you were going to, I think, perhaps go on to deal with, after you told us that you

actually had a good working relationship with Ms Terroni, I asked you whether you had any inkling or suspicion that prior to 1 July there may be about to uncover a problem with abusive and neglectful cases and I think you were going to address that.
A. Yes, I think -- and this was -- explains my reaction in the content of sort of frustration, shock, however I articulated it, was that they'd been doing all these calls so why did it take until July to kind of notify me of cases of neglect? I recognised a risk of it, because as I said this morning, one of the biggest worries at the outset of the pandemic was that we would see what we saw in Spain of abandoned care homes, et cetera, and the risk of neglect, and I'd been trying to put in place early warning systems in the Capacity Tracker that would tell us if those sorts of things were going on.
So I knew that there was a risk of it happening, but I think this was the first time formally that I was told that they had identified cases of neglect, and given that we're talking about July, that feels really late, not, like, why didn't I get notifications in April, May, June, whenever they first identified it -- (overspeaking) --
Q. Did you ever find out the answer to why you weren't formally told before 1 July?

A. I don't recall.
Q. Right. And then just to finish with this email thread, if we go to page 1, we've clearly looked at Ros's intervention explaining that the info may have been coming via a different route, and at page 1, the sender says that they have:
"... flagged with [the minister], but on the call Kate 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, she has asked:
"[one] Is there a way we can get them to expedite inspections?
"Can we get more formal information from CQC on where they are carrying out inspections ...
"Do we internally have a sense of what the scale of the issue is that may be about to erupt?
"She was ... really 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 comments today did not [reassure] her [or you] on this point."
So did you ever get any information about whether

there was a way to expedite inspections?
A. I'm trying to dig back in my memory. I think they did move or assured me that they moved as quickly as they could to restart inspections and get as close as back towards a normal way of working. The other thing we did at some point around this time was increase the focus on inspecting for IPC, for infection prevention and control compliance.
Q. Yes. It probably answers bullet 2, but -- and then, "Do we have a sense internally of what the scale is of the issue that is about to erupt?" Did you ever get any idea of what the scale was?
A. I don't recall getting that.
Q. Okay. Just to finish that, later that day, I think you WhatsApped Mr Hancock, and can we have up on screen INQ000274068_13. Thank you. And the entry at 12, I think, 45. Thank you very much.
You tell him:
"[Just] so you're aware -- CQC have at last shared with me info about what their inspectors did March-June. They have been in touch with many care homes & raised concerns with [local authorities]. However, they did not share their concerns with me (despite me requesting more info in regular meetings). There is also material risk -- now they are restarting inspections -- that they

will uncover cases of neglect. The processes put in place in March were meant to prevent that, but Kate Terroni is not confident. I have asked her to keep me updated so we are forewarned rather than seeing things in the media first."

And then he thanks you for that, and then:

"Sorry, it's more -- potentially -- bad news. But thought better you should be in the picture. I really pushed CQC to have a system in place that would pick up and stop neglect/poor care. It's frustrating that Kate could not assure me on this in my meeting with her today."

Can you help with what system did you push for to be in place? Was it the ESF or was it anything additional that you were asking the CQC to do once they stopped routine inspections?

A. Yes, so the CQC decided to stop routine inspections and as an independent regulator that it was up to them, but I was aware of that, and it was not unreasonable considering the pandemic and the need to reduce footfall. But as part of them advising me they were doing that, I said, well, how are you going to make sure that there aren't problems in care homes that you would otherwise be inspecting? I think the point they made was particularly they were suspending routine

inspections, so that wouldn't necessarily be the ones that were higher risk, it would just be the ones that were in the normal case of things be to identify whether -- to give a care home their CQC rating.

And then they put in place this Emergency Support Framework that was intended to be an effective way of remotely monitoring places that were higher risk and, at the time, I said, you know, is that going to work? How will you make sure? Given the increased risk of the event of the pandemic of neglect, how will you make sure that identifies that?

And I believe at the time of that conversation I was reassured, and then on, in July, late June/July, Kate Terroni is telling me, actually, there are going to be cases coming out that we haven't managed to pick up.

I mean, to be fair to her, she is at this point being straight with me and not attempting to cover up that. She's giving me advance notice that that's what's on the way but it was not very advanced, it felt quite late in the day and, as I say, I was then disappointed that the emergency approach hadn't succeeded in preventing that.

Q. Can I just stand back from the detail of that and just ask you this: you mentioned there, obviously, inspections are ending up going in, in particular, to

check that IPC measures were being implemented. Do you think perhaps that there is even more need in a pandemic, notwithstanding the transmission risk, for CQC inspections to continue to ensure that IPC is being properly implemented, given its importance, particularly if there might be an absence of testing, they might not have limited staff transmission, there might not be the amount of PPE that we would otherwise like?

A. Well, I can see the argument in future, as I was at the time, for the ones that -- the routine, which a care home or care provider was only going to be inspected every so often, anyway, to do their rating as to whether they are good or requires improvement, or whatever, and it might make sense in the future, as it did in this, to de-prioritise doing those because those aren't triggered by a particular concern about the care home and everything is going to be different probably in the care setting during a pandemic anyway, so are you even going to get a fair sense of how you should be rating a care provider in that circumstance?

However, what you do need is to have an effective way of identifying where a care home is not coping, is not doing proper infection prevention and control, where there is neglect, particularly, I mean, with the risk of, you know, staffing pressures and if it happened

again, if you ended up limiting visitors, I would hope that we'd find a better way in future, but you can't say never. And -- because visitors are another way of essentially ringing an alarm, sounding an alarm.

And so I think it is important to continue those kind of risk-based inspections, if you can possibly find a way that is, in essence, safe to do so, and you are going to encounter the question, does it make sense if you've got a highly infectious pathogen for somebody to be going from one care home to another care home to another care home to another care home as an inspector, you would clearly need testing, PPE, or whatever it is, to avoid them being a person who -- and I remember even people talking in the early days saying before the inspections were stopped, oh, that they, the CQC inspector would come and they'd blame the inspector for bringing Covid into the care home.

So that was a material and legitimate concern.

Q. Do you think now that the decision to suspend was still correct, and if you were asked in future, would you stand by that decision and, indeed, recommend it in the event of a future respiratory pandemic?

A. I don't think I have anything different to say to which I just said which is to some extent it's dependent on the circumstances, you know, the nature of the pathogen,

what are your options where you clearly do want to have a way of keeping eyes on. But, I mean, also in the future we might have different ways to do it, including being able to use technology more to keep a closer eye on it.

Q. A virtual inspection or --

A. Various. I would be open-minded about what might be possible in years to come.

Q. Running through that email that we just looked at was an issue about data, so can I turn to that as a sort of broader topic, please.

A. Yeah.

Q. And in your statement you say at your paragraph 66 that there was insufficient data at the start of the pandemic about who provided social care and in which settings and, indeed, data about Covid cases in social care settings.

And, Ms Whately, if it helps you, we've discussed data with a number of witnesses now throughout the public hearing, I dare say we'll continue to do so until it ends. You say there was initial lack of data, none of it in real time. And certainly by, I think, 27 March, no data on deaths, although there was sitrep data on care homes reporting suspected cases, and is that, broadly speaking, a fair summary of where we were

at the beginning of the pandemic?

A. Yeah, there was a terrible lack of data, including the department not having a dataset on care providers, CQC had a list of registered care providers, but obviously not unregistered, and the department didn't -- obviously didn't even have that. We relied on CQC for that. And it was incredibly frustrating in the early days where I was having -- receiving anecdotal reports of deaths in care homes and it was in the media, but had no reliable data coming through formal sources to me about the scale of the problem.

Q. Yeah, I think you described it in your statement as though you felt "we were operating in the dark" about the extent of the pandemic in the care homes.

A. Mm-hm.

Q. We do know that by 17 March when the NHS England discharge letter was sent out to the NHS trusts that there'd been 86 outbreaks reported or suspected outbreaks reported to Public Health England. Do you know whether data on outbreaks was factored into the discharge decision at all?

A. I do not know because I didn't even know about that discharge plan going out on 17 March. So, no. And I didn't know whether I had also -- whether I'd seen or was informed of that outbreak data --

Q. Fine.

A. -- either.

Q. All right.

Can I ask you about data about deaths in care homes. And I think you say at your paragraph 86, you received the first sitrep data slides for adult social care on 9 April 2020, which included a new slide on CQC death notification trends. And in particular, there was a distinction between the CQC notifying -- or being notified of deaths in total, which had to be done, but then being able to disaggregate it to work out what was a Covid or may have been a Covid-19 death?

A. Yes.

Q. Can we have a look at the sitrep data for 9 April.

It's INQ000565 -- thank you very much -- 864.

And there is a comment that puts the slide in context, which may be important.

"Deaths in care settings are not all reported to CQC on the day that they occur. This means that while most are reported quickly, it can take up to 10 days for a final figure ... We have now adjusted our data feed from CQC and our reporting to include deaths that are not reported to CQC immediately. [And it's] revealed an increase in deaths for most of the days in the last two weeks. Any apparent decrease in deaths on the last

few days on the graph are probably due to this delay in receiving notification ..."

And if we go to the next page in the slide, perhaps not hugely easy to read, but one would easily be able to identify the huge peaks. Yellow is 2020 data, and the other colours represent the preceding years.

And if we look at the box on the top left, the "Care home death notifications per day", in England, first hundred days since the start of the year -- so we're just at the end of March, thereabouts, we can see a significant spike in deaths in care home notifications, up to nearly 800 a day.

Thank you.

If we look at the bottom box, which deals with domiciliary care deaths, again, although the numbers are not as big, they're still approaching 100 deaths per day. Again, a significant spike on the preceding years.

Do I take it this was the first time you'd seen data coming to you in this format? And indeed in this level of detail?

A. I believe so.

Q. That's certainly the tenor of your statement.

A. Yeah.

Q. And if we can just screen out again, we can see it covers the different regions. I won't go through them

all, but if we look at the yellow lines, significant spikes, particularly in London. And again for both care homes and indeed domiciliary care deaths. And perhaps some spikes, but smaller ones nonetheless, at the bottom of the row. A relatively big one there in the north west, as well.

Thank you.

After you, having been seen -- or shown this sitrep data, I think you messaged Mr Hancock about it.

And can we have on screen INQ000274068, page 8, please. And at 21:20 that evening you say:

"I'm afraid [I've] been sent the first proper data on care homes deaths just now and it's not good. Speaking to [Public Health England], CQC and Ros [tomorrow] ... about it."

He says:

"Ok."

But it looks like he's doing a press conference on the afternoon of the 10th.

"... 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 data on deaths of residents in care homes but there is some double counting ..."

Because it may include people who have died in hospital and non-Cov.

"... it's complicated."

But it looks like this really is quite a significant day as far as understanding the death data that is now available.

Did -- can you remember whether the sitrep data, as it progressed, began to include the precise location of an outbreak, and perhaps the numbers of residents and staff who'd been infected? Clearly it didn't as at 9 April, but did it get more developed as the pandemic went on?

A. Significantly later on we had that kind of data. So, through the Capacity Tracker and the Palantir dashboard, I was able to see down to the level of a specific care home if it had an outbreak and how many people had died and staff and resident positive tests and things like that. So later on --

Q. The dashboard was rolled out on 1 October.

A. Yeah, exactly, so it was much later.

Q. Yes. Following the publication of this data, Matt Hancock's private secretary noted in the run-up to the action plan, which was on 15 April, he said it should include statistics on the spread of disease in care homes. And you'd had an exchange with him about death data again. And you are said to have been worried about knowing something that the public don't, and that

"our science isn't taking account of a higher rise in Covid deaths than reported".

In what way did you think the science wasn't taking account of a higher rise in Covid-related care home deaths than was reported?

A. That is hard for me to say. I mean, I know around about this time we were having a back and forth about asymptomatic transmission, and I'm concerned that there is such a thing as asymptomatic transmission, and I'm pushing for testing of people even though they're asymptomatic and being told the test doesn't work unless someone has symptoms.

So it may be that I'm drawing a link between what I was doing there and the deaths data, but I am -- that's a sort of -- me rationalising it rather than recalling it.

Q. You've mentioned now a number of times the Capacity Tracker, and I think clearly the data issues were well known across both the department and indeed other departments, but you said it did lead to the development of the Adult Social Care Capacity Tracker, which, as I understand it, was a tool that had been in use in some part of England and was adapted then for a wider rollout. Does that accord with your --

A. Yes. So around that time I'm talking to Ros and there

were -- had clearly enormous frustration around the lack of data. It was very frustrating that -- this back and forth about the deaths data, even, and it felt like I couldn't get reliable data from PHE, and the numbers kept, like, changing from hour to hour, to (unclear) got it shared. And that we didn't have -- like, things like geographical -- I mean, I did in those charts, but in general we just didn't know what was happening where and which care homes. It just seemed to be a complete gap.

And the other thing was the concern about care homes not having the workforce they needed, and being abandoned. So that was another thing I wanted to have data on, is how were they coping.

Q. Maybe we can bring some life to this by looking at a Capacity Tracker data.

Can I have on screen, please, INQ000327818.

This is Capacity Tracker data for 6 April 2020, at 18:40. And it might just need you to help talk us through it where it's not obvious, but if we look at the top box, "Care home ... Daily ... update".

The care homes that were registered with the tracker -- do I take it that not all care homes were necessarily registered with the tracker?

A. Sorry, and I failed to answer your last question, which was: yes, we -- I spoke to Ros about what were our

options, and the thing that was identified as the best option for providing data was an existing tool, I think developed in the -- by the NHS, in the north east maybe, that was being used already by some care homes to identify where they had vacancies for beds that people could be discharged into. Because that was already up and are running. The decision was kind of made to build on that and extend it. But I think it -- yeah, it took some time to, therefore, get all care homes filling it out.

Q. But looking at this now as it was in April 2020, is this showing us a national picture?

A. I think so, yes, yeah.

Q. So there's 71% of beds are occupied and then they can see how it's -- sorry, not occupied, registered.

Bed occupancy, 90%.

Vacant beds, there's 32,000-odd in tracker registered homes.

Then across all care homes, 45,000-odd.

So potentially there, looking at that, there is capacity within the system.

And if we could go out to the wider screen, we can see there a little bit of explanation:

"The ... Tracker is being rolled out to all care home providers. 71% are completing the data on

available beds, with around a third now completing [the red amber green] rating also."

Then there was other work in development.

And:

"Care providers will be offered an opportunity to flag if they have major concerns and need help instantly -- with the ability for CQC to act or flag back to [the] local authority."

If we just look at the RAG ratings, to use that terminology, "Admission Status", so just look at east of England, for example, over 80% of care homes were open, a relatively small number were partially closed, and the red indicating that there were some care homes closed. Clearly a bigger number closed in London, looking at that.

Can we go to the next RAG rating, "Overall Status". Do you remember, Ms Whately, what this was trying to indicate to you?

A. Mm ...

Q. Because the next one is "Workforce Status", then the next one is "PPE Status", and we've looked at "Admission Status", but I wasn't quite clear what "Overall Status" was.

A. I believe it's a combination of -- (overspeaking) -- brought together, but --

Q. All right.

A. -- I couldn't guarantee.

Q. If we go out and look at "Workforce Status", so the red is to indicate the number of homes that say they are really struggling with their workforce.

A. Yeah.

Q. And again, PPE, red again, care homes where they were really struggling with their PPE supplies. Bigger numbers, by the looks of things, in London and the north west.

So this was giving you -- that was the position as of 6 April. Were you able to go to the sort of next layer down and know which local authorities were having the particular problems? And in due course I think we were able to go down to which care homes were having the particular problems; is that right?

A. We were over time, and that was part of the reasons for building this out. And also, though, over time, building our capability to do something about it. Because one of the challenges in the early days was, even when we could get the data, for instance, to a local authority level, actually the department had very limited capacity, people who could -- whether it was contact local authorities or contact individual care homes, which was why we subsequently built that regional

team. And in between we boosted the operational sort of skill set within the department, to have people who would pick up the phone to find out what was going on. Because my view was, okay, data was helpful, but we need to be able to take action based on the data.

Q. One of the things you do say in your statement is you recall asking early on in the pandemic for data as to deaths related to Covid-19 in the workforce, but that was not available. And it was only later you could get them via looking at the number of people that had applied for the compensation scheme.

Do you know, as the pandemic progressed, whether there was any work done to get data about the deaths of the workforce from Covid-19?

A. I remember there being conversations about it, because I wanted it, and I wanted to know, you know, where members of the social care workforce had died, in specific providers, even to be able to, you know, offer support and in fact contact people to let them know about the compensation scheme when we set that up. But I don't believe it was possible to do that. I think we had to rely on a more, sort of, broadcast approach to communicating about that.

Q. All right.

Do you think there should be data kept about the

numbers of the workforce that die in the pandemic, particularly if they're the ones going out on the front line, putting themselves at risk?

A. So yes, I think there should be a much more substantial dataset about the social care workforce. You've got around one and a half million people looking after extremely vulnerable people, and at the moment we have a system where, in general, you know, we don't know who that workforce is, we have no way of contacting them, and we don't know what their qualifications are. And there are all sorts of reasons why it would be much better to have a system where -- in healthcare, you know, registered nurses, you know, there's a register of the nurses and what skills they have. You don't have that in social care.

It is one of the reforms that was in progress when I left as Social Care Minister, was to set up a digital register that people in the social care workforce could register their qualifications on and could become the foundation for having that kind of set of information.

Q. As we understand it, there is still no register for the social care workforce. Certainly Mr Hancock and indeed a number of other witnesses have commended that as a potential recommendation to her Ladyship.

Do you have any view on the utility or otherwise

that a register would have brought to the pandemic?

A. Yeah, I think it would have been extremely helpful. I mean, one of the uses, for instance, is -- it was concern -- it was raised with me the concern about whether social care staff had skills in infection prevention and control, and whether it was -- you know, PPE but also wider IPC measures. So we rolled out a training programme through the NHS to disseminate those skill sets. But I had no way of knowing whether all of the workforce at a particular care home had or hadn't had that training, for instance. So it would have been good to have, you know, a register in which it's noted somewhere, somehow: yes, So and So has completed the training. For instance.

And on a broader scale, as I said a moment ago, you've got somebody -- you've got people looking after other people who may be vulnerable, have quite complex health conditions. Many care workers are very skilled, but at the moment a family won't necessarily know the person looking after their relative, whether they do have a set of skills or not. So I can see a value outside the pandemic as well.

Q. Do you have any views as to who should compile the register and maintain it? Is that a new body? Someone we've already -- a body that's already in existence?

A. So I initiated work when I was a minister to build the infrastructure to do this and to enable it on a -- so the sort of online version of the register would exist and -- to be initiated on a voluntary basis for care workers to register, you know, their formal skills and qualifications.

So, if I recall right, I was working with Skills for Care on it, so there was a way of doing it envisaged that -- there are different ways you could do it, but achieve that outcome.

Q. Do you think the department should play a bigger role in trying to force this through, and indeed maybe even maintaining the register? Would it be feasible for the Department of Health and Social Care to act in that way?

A. I think I'd be open minded as to whether something should be done, you know, in-house or outsourced.

A government department isn't necessarily the right organisation to maintain something like this. If you look at the equivalence in healthcare, you know the Royal College of Nursing -- no, it's NMC, rather, that maintains ... NMC?

Q. Yes, Nursing and Midwifery Council --

A. Nursing and Midwifery Council, thank you, has a register for nurses and midwives. So it doesn't have to be in-house, but I think, you know, a respected

organisation, clearly, to do it.

And Wales already has a register for the social care workforce, so that's also a model to look at.

Q. I think a number of the DAs do in social care as well.

Just briefly about the dashboard. We know it was rolled out from 1 October, and in fact we looked at an example of it yesterday, and Ms Dyson looked at -- we looked at national, and she said if you click through you can essentially get down to care home level.

But in it's -- the run-up to it being rolled out, were you ever aware that you were being met with, in private, by people wanting to talk to you about the dashboard because there was some hesitance or reluctance for you to be given the dashboard data?

A. No. And I think I strayed into this this morning when I said I think there was a brief moment where I had some issues with a log-in because of a laptop or a tech -- a technical thing, but no, in general, I had good access to the dashboard and I looked at it at least daily.

Q. Were you being briefed without senior members of the DHSC adult social care team knowing that you were being briefed about the dashboard?

A. I don't recall that in general, no.

Q. Can I just ask about a few messages in October 2020, which build on questions about the dashboard.

And can we have up on screen, please, INQ000274068, thank you. And at 18:29, so 6.30 that evening, can we see at the top there, you've checked in about the dashboard:

"[The local directors of adult social care] get to see national top line data and local data ... I'm told the decision was made to give them the national picture as context ..."

And Mr Hancock said, "Not by me it wasn't" and you said, "Indeed, it didn't come up to you or me."

What was the problem or was there a problem with local authority directors getting to see the national and, indeed, local data?

A. I'm trying to think through, because what I am remembering from this time is wanting to give local authorities access to more data, because I felt we had, at the centre, access to a lot of data, and I felt it would be very informative for local authorities to have it, although I think there might have been some nervousness about local authorities seeing other local authorities' data down to the specific care home level, so that was an area that had to be worked through, but I can't remember more specifically what this is referring to.

Q. All right. You go on to say:

"I can find out feasibility of removing access to the national info -- although it would be a conspicuous change."

Mr Hancock said:

"Well, what do you think we should publish? If we do publish care home cases, no harm in putting it on the [local authority] dashboard".

And you said:

"I think we should publish weekly positive tests, with staff and residents breakdown, and death (Covid, and total). There may well be a bad initial reaction to '5,000 positive cases in care homes' but I reckon we have to ride that out -- and as it's mostly staff it makes the point that you have to keep community rates down ..."

And it looks like you linked to some other data that's available, including a French one and I think there were various other European ones. And you say:

"How quickly do you think we can get it published? I think ASAP so if possible ... before local authorities leak it."

He asks you to work it up.

Then towards the bottom of the page, you say:

"I'm" -- on the 28th:

"I'm chasing the [Adult Social Care] team for

a proposal to publish care home cases and deaths -- urgency driven by the fact that the dashboard rollout to [local authorities] is now well under way."

A. Yeah, sorry, so what you've just run through has reminded me. So one of the issues here was about --

Q. It's my fault, I didn't give you the whole -- (overspeaking) --

A. -- is about the tests and I was, indeed, monitoring what France was publishing because they had -- they were good on transparency I felt, on this. And so I was wanting us to share and publish the level of positive tests that were sort of happening in care homes, and then there was a debate, do you do it down to the local authority level, do you do it down to a specif care home level, and then a concern that if a care home, if you published down to care home level and then a member of the public could see that -- no, the care home there had got a very high number of positive tests. Well, might that deter the care home from testing?

So that's what's going on here, is a worry that if you're so transparent, would it mean that the care home would go, "Oh, we're going to stop testing our staff and residents because that's going to affect, you know -- be bad publicity for us?" So we're trying to think of the unintended consequences of the level of transparency.

So that's what's going on, on here.

Q. That makes sense, all right.

So in due course, though, did you ever get any sense that people were either not reporting Covid-positive tests because they were worried about adverse publicity or a bad reaction or was that just something you were concerned about but didn't actually materialise?

A. I -- the latter. I was concerned about it but I'm not aware of it actually materialising.

Q. Right.

A. And what I'm trying to remember now is did we end up publishing it down to care home level or it might have been that we published it not down to that level anyway, we ultimately published it down to local -- (overspeaking) --

Q. Local authority level. All right, thank you.

Can I ask you about data in respect of black and minority ethnic social care staff because I have to confess we're struggling to find good data on this. Do you have any observations on whether there was a good level of detail about the numbers of black and minority ethnic social care workforce and, indeed, of them, those that became infected?

A. So we knew and I knew a fair amount at a high level about the composition of the adult social care workforce

at the outset of the pandemic, including a significant proportion of members of the workforce from black and ethnic minority ethnicities. So we knew about that and we knew about the majority of the workforce being women, we knew about, broadly, age of the workforce. I think probably from Skills for Care data would be a good data set on that. So we knew those things. But we didn't know the deaths data in that way for the reasons I mentioned a moment ago, we just had very poor information about care worker deaths.

Q. Yeah. And given the disproportionate impact that we know that Covid did have on members of the black and minority ethnic communities, clearly, presumably, you'd advocate for more data on the ethnic minority workforce.

Can I just ask you about this though, we've seen that you had a number of meetings with the NHS Chief People Officer --

A. Yes.

Q. -- in -- at various stages, and I just want to be clear that it didn't mention adult social care in those meetings. Is that deliberate because that wasn't the remit of those meetings or was it an oversight that the adult social care sector wasn't mentioned in those meetings?

A. So I would have met Prerana Issar as the NHS Chief

People Officer in my role as minister for the NHS workforce, so we worked together significantly during the pandemic on support for the NHS workforce, for instance on the mental health side, amongst others. And one of the things I worked with her on was the concern about the risk to black and ethnic minority workers in the NHS, and the rolling out of the risk assessment -- risk assurance framework?

Q. There's a risk reduction -- (overspeaking) --

A. -- (overspeaking) -- framework -- (overspeaking) -- so that started first in the NHS and across the health workforce. I mean, in part because of just the -- there is the structure in place to do stuff for the NHS and health workforce at greater pace, basically more people working, essentially, on that. And then I took the decision for us to piggyback on that and roll out something similar for the social care workforce saying, well, if we can do that for the NHS, let's do that for social care.

Whether I formally talked to Prerana about that, I can't recall, but she certainly would have been somebody who'd be helpful about thinking more broadly about the social care workforce.

Q. You mentioned the social care risk reduction framework which was published on 19 June 2020, and there are

certainly concerns from a number of the Core Participants that this may have been too late. Do you know why it wasn't published before mid- June?

A. So the sequencing I remember is -- no, the -- the awareness of which staff were -- people who would be at greater risk, then the NHS taking the lead on this because they, you know, not least because they had people to work on that sort of thing and then, as I say, us developing it, adapting it for social care, and then rolling it out for social care as quickly as we could. So it -- the timing just is a consequence of that sequencing.

Q. I think, in the sequencing it may have come out after the NHS one, as you've just alluded to. I don't want to be unfair, but is that another example of potentially being social care lagging behind decisions that are made for the healthcare sector? Is there a particular reason for that?

A. I mean, it's factually lagging evidently, self-evidently. That's a consequence, I think, of the resources that the different sides of the system have. So the NHS had a Chief People Officer, then. Social care didn't have a, you know, social care didn't have a national HR function in the same way. So it's a resource -- (overspeaking) --

Q. May I briefly touch on the topic of testing, and I know you've given some evidence about testing before, but just can I go to your paragraph 183, please, Ms Whately, and on 7 April, so this is just before the action plan comes out, you received a submission on the prioritisation of tests, and the submission proposed that during April while capacity was being scaled up, tests should be prioritised for frontline NHS staff.

And if we look at the top of the page in your statement this actually -- can we go back out, please. Thank you.

There you are, the paragraph that begins "15", it actually repeats what's in your submission, all right? And it says there:

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

Essentially, what it meant was that "frontline" was the NHS across all settings, and social care workers to get testing where capacity allows.

Now, I think you had some concerns about that priority and if we look at an email that you sent on 8 April, at INQ000327822, and if we just look at your top email there:

"Apologies for the delay. [The minister] reviewed the submission and is fine with the overall text. However, she is concerned it appears we will prioritise NHS staff over social care staff, rather than prioritising based on the risk to care of staff absences."

Why were you making that observation that "we are prioritising NHS staff over social care staff"? What was your worry?

A. Why was I worried about social care staff being lower priority?

Q. Yes.

A. Well, the biggest worry at that time was very large number of staff absences and, therefore, neglect and loss of life due to neglect in care homes, and the testing that was -- and one reason why the NHS was testing so much, if I recall, was in order to identify if people didn't have Covid if they had, sort of, a cold or something else, that they could still go into work. Well, the same applied in social care. If you were worried that people were not going into work because of

some other symptoms and, actually, it wasn't Covid, well -- and I was really worried about social care staffing, so I thought the prioritisation should be where you had the greatest sort of vulnerability of services to staff absence rather than a sort of NHS then social care prioritisation.

Q. Yes, although I think, in fact, your argument didn't win out, if I can put it like that, and it was the priority given to NHS staff until later that month, in April, there was sufficient capacity to test all.

A. Mm-hm.

Q. All right. Can I ask you about asymptomatic testing of domiciliary care. In your statement you say it was introduced on 23 November 2020, but the Inquiry has heard evidence from Jane Townson that although it was introduced in November 2020, it wasn't available in practice until January 2021. Were you aware there was a time lag, for want of a better phrase, between it being introduced but actually in practice, homecare workers being able to access asymptomatic tests?

A. I would have to look up what I knew about that between November and January.

Q. All right.

A. I can do so and let you know subsequently.

Q. Thank you very much. All right.

Can we come on to visiting restrictions. And the arguments for and against, I suppose, to put it like that, are well known to her Ladyship. And you, indeed, touched on them this morning Ms Whately, when I asked you about some of the things that went well, and didn't go so well.

One of the things you do say in your statement was, at paragraph 278, is that you obviously were worried about the visiting restrictions leading to social isolation and the effect of mental health on residents, and you commissioned research into this area.

Are you able to tell us the outcome of that research and when it was commissioned and what it informed you?

A. So I commissioned it and actually what happened was a review of existing research rather than, kind of, fresh research, I believe. And it looked particularly at examples from the Netherlands and I think the US where there was evidence of visiting restrictions being to the detriment of the wellbeing of care home residents. That was the upshot of the research.

Q. Right. Did it help inform how the restrictions policy or the visiting guidance developed thereafter? I mean, there was always the tension between trying to protect the residents from the infection but equally acknowledging the deep harm that was done to them and

indeed their loved ones who couldn't see them, but did it make any material difference to how the visiting guidance developed?

A. Yeah, I mean, it contributed to the argument because up to that point all the data had been about, you know, the risk of Covid and deaths from Covid and the direct, sort of, Covid impact, the disease impact, and there was no data on the other side and therefore, on that basis, sort of, no visiting at all would be where you might go. So I was looking for an evidence base to balance against that weight of evidence, which is, but hold on, there is actually a harm in stopping visiting to care homes and so that -- it contributed to the conversation about that, albeit that there are various points, particularly during the winter during the sort of second wave of the pandemic, when there were greater restrictions on visiting and I came under a huge amount of pressure, including from the Prime Minister who felt very strongly about stopping visiting --

Q. I was going to ask you about that, actually.

I didn't mean to interrupt you but if it makes sense to deal with that now, can we have up on screen, please, INQ0002740268. This is in October 2020 where you wrote a series of WhatsApp messages to Mr Hancock on the subject of visiting, and it's page 27, sorry. And the

message is at 18:23, top message, thank you very much:

"[You were due] to talk to someone called Wade next week ... But overall -- we really need to enable Covid-secure visiting. I think our restrictions now mean too many care homes are allowing too little/no visiting. Nadine [presuming Nadine Dorries] had a meeting with the [Prime Minister] last night and a family who recently lost both parents in a care home without being able to see the Dad. She has told me the PM wants us to 'follow the approach in the Netherlands' which is much more visitor-friendly."

And you say:

"I have asked my PO to check if that really is PM position, check with you, check with Jenny Harries ... but meanwhile I don't think we should publish the new more restrictive visiting guidance which was basically driven by No. 10 'ban visiting' steer, and DCMO has been consistently against."

Matt Hancock says, effectively, that he agrees with you.

So can you just help unpick that because it sounds like there's two messages coming through here. There is the Number 10 that there should be more restrictions but then if one reads the message that references Nadine Dorries, potentially an approach which is more

visiting friendly. Can you help unpack that for us, Ms Whately?

A. Yes. So Number 10 was up until that point very strong on "let's ban visiting", and at some point earlier on, in the winter, when we see the numbers going up, I think the Prime Minister sends a message, I think it's in some of the records of, you know, "Stop visiting". And I have an argument with him about why there is a case to continue to have some visiting in controlled, you know, in a controlled way. Because I was very aware of, I think, the harm of stopping visiting was doing.

And also, because, you know, there are circumstances and ways in which you could do visiting in a way that, you know, very much, you know, reduced a risk of a visitor bringing in infection and the evidence has showed us, you know, that the infection was much more driven by -- to do with staff unwittingly bringing the infection in.

So the Number 10 position, and I think it reflected the having seen the awful deaths in care homes during the first wave, Number 10 was understandably, you know, very, very cautious, let's do everything, while I had this, I guess, more, you know, nuanced position, having spoken more and heard more from families, particularly as well as staff.

However, Nadine Dorries had, you know, been to see the Prime Minister and involved the family who brought a very personal story to the Prime Minister and, actually, that I think shifted his view on it. So I then hear in this message that his view has shifted and he's more open to allowing some continued visiting, but then, in my message of therefore, sort of, 18:25 I was saying, well, can we really check because I wanted to know what the official Prime Minister's position was rather than just sort of hearing it word of mouth.

Q. I think in due course in that winter of 2020 there was a huge spike in infections, and I think the Prime Minister wanted to stop visiting again by that winter of 2020.

A. Mm-hm.

Q. Can I just ask you though, you spoke there, obviously, about the desire to prevent the infections coming in, and then what you've learnt from your discussions with the families and the loved ones, but the Inquiry I think disclosed to you a witness statement from an English care home, dealing with the care home's perspective on the visiting restrictions.

Can I, through you, just ask you about INQ000587678_4. It'll just take a moment to come up on the screen.

And this care home made the decision to pre-emptively lock down. You can see there at paragraph 5.3:

"It must be said that the ban on visitors impacted significantly more on family members than it did our residents."

Because in fact this was:

"... a residential care home for adults of all ages with a learning disability and ... [a] lack of capacity, [so] they ... did not understand the significance of what was going on."

But if we go down to paragraph 5.4, they say that -- the care home -- the only way they could facilitate contact with family members was by Skype and phone. The family members found this distressing, and the process of scheduling the calls, the video calls, was extremely onerous on a weekly basis for the 65 residents.

And indeed, if you go on again to paragraph 5.5, there was then window visits in the autumn, around November. The risk assessment was prepared, and they were allowed to use a closed area in reception. It was approved. And it said:

"... [they'd] provided the same if not greater challenges to staff as it was different to schedule and due to the number of residents we had. It ... took

staff away from routine care tasks. This [manner] of visiting continued for [many] months into 2021."

And indeed, can we just briefly go on to 5.7 and 5.8, the care home said they spent a substantial amount of money on adapting a specific room that was a way for residents to allow and had access for visitors. That was approved.

And as we'd moved on in time and there's clearly testing now available, the process was that visitors would attend 30 minutes prior to their scheduled visit, they'd be met by staff in a designated testing area and provide a lateral flow test.

So, again, clearly taking staff away to be able to facilitate the tests.

And can you tell me, were you aware of the impact that the changes to the guidance were practically having on the ground where care homes were doing their best to try to facilitate visiting? And if you were aware, what were you trying to do to help ameliorate this position with the care homes?

A. So yes, I was aware. I was hearing from care homes about how difficult they were finding -- I mean, I was hearing from care homes who were finding it very distressing that their residents weren't receiving normal visits and that staff were having to work very

hard to maintain the morale of residents who were really upset that they -- and, you know, confused that they weren't getting their normal visits. So that was one of the things I heard from care homes.

And then I also heard, yeah, the difficulty of complying with -- with testing requirements or, you know, meeting window visits or other things.

And I know care homes made significant investment in facilities to try to enable some of that sort of Covid-safe visiting, and one of the things we did is that -- one of the allowed uses of some of the tranches of the Infection Control Fund was to fund extra staffing costs or extra facilities for visiting. So that was, yeah, one of the allowed uses of both that and the testing fund, I think.

So these were significant amounts of money that were distributed to care homes to help them with the extra costs of visiting.

Q. One of the other aspects of the visiting restrictions I'd just like to ask you about is potentially restrictions on healthcare professionals entering care homes to provide care.

Now, I think -- is this the position: there was no blanket ban on GPs or other healthcare professionals attending care homes where it was necessary for them to

provide a visit; is that correct?

A. Correct. I don't believe there was a blanket ban. And it was something I looked into because I heard quite a range of stories on this. I heard from care homes who were distraught that they felt they couldn't get any attention from healthcare professionals, they couldn't get a GP to come in, they weren't getting the district nurse coming in, and staff were really struggling with sick residents and without getting healthcare help.

And then I heard from another care home whose GP, they said, was absolutely brilliant, and was giving a huge amount of support to the care home, whether that was -- and I can't recall at that particular time whether that was in person or through fantastic video calls. But, you know, either of those could actually work. You can do quite a lot by a GP who was very readily available doing video calls.

So there was this great difference in the level of support that social care got from the NHS. And that was one reason why there was a very specific intervention I did, involving Simon Stevens -- I think involving the Prime Minister -- to get NHS England to commit to expediting enhanced healthcare in care homes and this model of very focused attention from GPs and every care home to have a named clinical lead that they could call

on. And the NHS committed to delivering that.

Q. Well, what you just said there echoes a number of contributors to Every Story Matters records, and I just want to put up two very brief examples.

Can I have on screen INQ000587565_153.

But on the positive side of the coin, we can see there that one care home worker from England said:

"The GP was there to give advice and guidance from the beginning. We didn't see them really in person, but they were there on the phone and they really supported us through it, to be honest."

A positive account there, but if we go to page 154:

[As read] "Staff working in care homes told us that in-person GP visits were very infrequent."

And look there, just two quotes:

"Our GP, I did a lot of video calls with them, it was hard to get them to come out."

And then the next quote:

[As read] "As soon as the Covid hit and we went into lockdown, we really struggled to get any doctors or it's mostly the doctors that would not come into the care home. They quickly started giving instructions over the phone and giving us more and more responsibilities in terms of how we needed to manage the residents."

Do you know whether the Enhanced Health in Care

Homes programme did in fact ensure that the care homes had access to a GP? I think it was a named GP.

A. Yeah. I mean, it was intended to, and Simon Stevens and NHS England committed to delivering it.

I think in practice -- and I've seen some reports saying that didn't make a difference with some care homes, so I don't -- so I suspect that there was variability in how it was implemented.

I think there's also a bigger question here, is like, what happened here? Like, why?

And I find myself asking, you know: why, if you're a GP that -- you know you've got a care home that's within your catchment area and you usually look after the residents in that care home and you know that they're having a really hard time because of Covid, why aren't you there for them? Why aren't you making sure that either you go in person? Or even -- if you feel you can't do that, maybe you're, you know, a GP who has some vulnerability, you're worried -- albeit, clearly, staff -- care home staff were going in, why aren't you in touch with them?

As I say, I know there was some great practice, but why was that not the rule, is an important question to ask and try to get an answer to.

Q. Can I ask you about DNACPRs, please, Ms Whately.

A. Yes.

Q. I'm not going to go over the CQC interim or indeed final reports. We're familiar with that. But in your paragraph 384, you say:

"On 25 April ... [your] private office sent an email to ask individuals within the Department to investigate an article [you'd] read ..."

Which reported:

"... an 'unprecedented' number of ... (DNAR) orders were being sought for people with learning disabilities."

And you:

"... asked for contact to be made with Turning Point within the next 24 hours to find out what was happening ..."

Can you just help us about what you learnt when you, I think, spoke with Turning Point a little while later on, and indeed maybe I think had a meeting with them?

A. Yes, so they had evidence that there had been a substantial rise in the number of DNACPR decisions made, and I think they said -- and it's paragraph 386 in my evidence -- that they'd seen about 13 decisions made in the last three years for the people they support but in contrast they'd seen 13 in the last week where no best interests test had been undertaken.

So we're clearly going in a dramatic increase in numbers from 13 across three years to 13 in one week. So, evidence that was happening.

I think also, there's another one where your Every Story Matters document is helpful, and one of the bereaved family members there, I see, says that the priority for -- of the GP for care home was to move all residents on to DNACPRs, in one example.

So there clearly were examples that come clear retrospectively and some evidence at the time of this significant increase in DNACPRs.

Q. Did you ever, in your role as minister, come to learn about why there had been such an increase? Because we know that there -- it wasn't any guidance that went out, and we know it certainly weren't approved by the BMA and the RCGP and all the other organisations that firmly deprecated this, and indeed had done for many years, but did you or the department ever really understand why there had been such an increase, particularly in March and April, of DNACPR orders being imposed?

A. I didn't receive evidence that would tell me why. I can hypothesise, but I've got nothing which is like "This is the explanation for why that happened."

Q. Finally this, I know we've covered a number of topics with you, Ms Whately, and indeed in your addendum you

provide a lengthy statement setting out your observations, reflections and lessons learned. I'm not going to ask you to repeat that, but is there any other reflection that you would like to give or any lessons learned that you think would genuinely help address some of the problems that we've identified in the response to the adult social care sector?

A. Yes, and thank you for asking me.

I mean, I think -- so -- I mean, I'll just run through a few, if that's all right.

So, firstly, there is a job to do to, you know, understand properly, sort of clinically, what happened with this pandemic in social care. And I say "this" because -- recognising that other pandemics may well be different, but alternatively they might be similar.

As I said earlier, I think we still don't understand whether the right PPE was being used for social care or not. And, you know, fundamentally, how come when -- yeah, we had the PPE, we had the testing, we had designated settings, we had put in place -- short of completely banning staff movement, but restricting it, you know, a lot of things that should have protected care homes from Covid outbreaks in the second wave, but still there were a huge number of outbreaks. And it still feels to me like that work hasn't been done to

really get to the bottom of it.

You know, there are care homes that had either no outbreak or very few outbreaks through the whole of the pandemic. What were they doing that was so different from the ones that did have multiple outbreaks? I mean, obviously size was a factor, but you could look at care homes of a similar size. I think there is still work to be done to get to the bottom of what the, you know, what protected some versus others.

Ultimately -- (overspeaking) --

Q. Who do you think or how do you think that work could, should be done?

A. We have, is it the UK HRA? Health Research --

Q. The Research -- NIHR, I think it is.

A. Yes, I combined it, so we have UKHSA on the one hand and NIHR, which can do health research. So their remit includes social care, so that would be one avenue.

I think -- I mean, obviously, I think there's a role for UKHSA, UKHSA, in this as well, and there's something about, you know, building up greater research capacity in social care like we have for healthcare. I mean, for instance, I did actually look at the UKHSA strategic plan recently, and that mentions the NHS 52 times, but social care is only mentioned four times and it's only mentioned in the context of the Department of Health and

Social Care.

So why is that organisation not seeing social care as something that, given what happens in the pandemic, why is social care not a feature in their strategic plan?

So there's getting to the bottom of what happened and building up that research capability and oversight of infectious disease management in social care.

There's, going back to sort of kind of where we started today, there's proper pandemic planning and, clearly, when the pandemic starts, it's too late to make a plan when your pandemic has already started. And in fact, we know from looking through the data that, you know, deaths were occurring in care homes almost certainly from Covid from mid-March onwards. So it was there, but the planning was, you know, hadn't -- was -- came subsequent to that, really.

So you do need a proper plan that goes through all the things like PPE and the discharge process and what you'll do about funding and visiting and vaccination policies and the various scenarios. So that needs to take place.

There's this point about having some greater level of capability and infrastructure at the centre to be able to do a coordinated response. It took time to

build that up. We went from having I think less than 100 people in the Social Care part of the Department of Health and Social Care to 300, you know, we have built it up, but there was the time it took to do that.

And similarly, local authorities needing to have the capability, and care homes themselves having the capability to respond to a pandemic. And like all those levels, need to be in place.

On the staffing side, and we have talked about that a bit, you know, the need for, you know, recognising staff, you know, professionalising, recognising the status and skills of staff, making sure staff do have a formal set of skills and giving as much attention to the supply of social care staff as we do for other staff across health and social care. I think that is very important, and I'm not confident that it's happening.

There's the status and representation of social care in government and also the relationship between the NHS and social care sectors. So we've talked quite a lot about what happened with the discharge process and how that happened and the NHS sort of saying "social care needs" or "requires" or "will take" people. As I say, I understand the NHS lens on that, but why didn't NHS leaders say, or think about the impact of that on people living in care homes and the health of those people? It

was almost as if what matters was hospitals and not the health of the whole population, including those living in social care. What would it take for your, you know, at the time the chief executive of NHS England, and okay, NHS England has been disbanded but the leadership of the NHS to be thinking about the health of the whole population, including those who receive social care? And I think that is worthy of thinking, work on.

And then I'll say -- so one more thing just to reflect on is, as part of pandemic planning or being ready, is thinking about how you prepare and support the leaders of your system, that's both civil servants and other people in positions of responsibility and, indeed, ministers themselves to be able to respond and do a good job in an extremely unusual situation. Because, you know, providing leadership through a pandemic is very different from almost anything else you're ever going to experience.

And I know I thought about it at the time, as like, what do I need to do to make sure that I am making good judgements, that I'm getting the right balance between absorbing huge amounts of information and keeping my head clear to make the right calls, to ask the right questions, or to make sure stuff is happening?

Sometimes you've asked me questions about, well, you

know, that was a policy, did it actually happen? Like, how are you making the judgements about how you spend your time? So all of that, I think it would be worth in a peacetime, outside a pandemic, as to thinking how would you make sure that those people who are doing leadership roles at a time like that, are, you know, best supported to do the best possible job in what is going to be, in almost any circumstances, however well prepared you are for it, to do as well as it could be done.

MS CAREY: Ms Whately, no doubt great food for her Ladyship's thought, some of it may be a little beyond the terms of reference of this Inquiry, but nonetheless, they are all the questions I have for you. Thank you very much.

And my Lady, would that be a convenient moment for the afternoon break?

LADY HALLETT: It would indeed. I shall return at 3.35.

Last furlong, Ms Whately.

THE WITNESS: Thank you.

(3.18 pm)

(A short break)

(3.35 pm)

LADY HALLETT: Ms Morris. Can you hear me?

MS MORRIS: I can, my Lady.

Questions from MS MORRIS KC

MS MORRIS: Good afternoon, Ms Whately. I ask questions on behalf of the Covid Bereaved Families for Justice UK, and I've got four topics to ask you to expand and clarify on, please.

The first topic is hospital discharge policy. And in particular, I want to ask you about your views about the success of that policy, because at a Healthcare Ministerial Implementation Group, on 7 April, the minutes record that you said:

"Discharges from hospital into the community to increase NHS capacity had been hugely successful."

And you observed that non-Covid bed occupancy had reduced by nearly 40,000 patients since 2 March against the target of 30,000.

So my question is, was the success of the policy only measured by unoccupied NHS beds? And I ask you that because, based on what you said in evidence this afternoon, I'd anticipate you'd agree with the perspective of the bereaved that I represent, this is about lives and not about bed numbers?

A. Yes, and I think the minutes to which you're referring is probably where I'm there as a -- the ministerial representative across the Department of Health and Social Care, and therefore sort of giving a broad update

on a perspective and from the NHS side of the department, the policy was -- they would have seen that as a success because they managed to discharge lots of people and free up lots of hospital beds.

Clearly for me looking at it as a former Social Care Minister, I have a different perspective on it, which is that I have a concern that it was one of the sources of infection into care homes at that stage and, in any event, also put care homes in a very difficult position where they felt they were sort of required, made to take people -- admit people discharged from hospital that they were very worried about doing so.

So that gives it a less good verdict, shall we say, as a policy.

I still think there is a gap in the work that could and should be done to look into the impact of that policy where it was well known there are various reports done about what was the main cause of infection going into care homes, and those reports tend to look at the period for which we had significant test results and identified that the vast majority of outbreaks were seeded from, sort of, the wider community rather than due to hospital discharges.

But still, I think it is unknown about the early period of the pandemic and to what extent infections

went into care homes during that early period, from, you know, community, for instance, staff and visitors versus the discharges. And the rates of excess deaths started to increase in care homes in, sort of, mid-March-ish, sort of, maybe around 18, 20 March, that sort of time implying that you were beginning to see Covid deaths at that time even though there wasn't the testing to prove that.

And I think there could still be, I would envisage, a piece of work done to say to what extent were those increased -- where those deaths occurred, were those in care homes which had taken discharges from hospital versus not? I believe that could be investigated but I haven't seen that done.

Q. Thank you.

My second topic is around testing for domiciliary care workers. In a submission on testing in care homes dated 9 May 2020, you're recorded as saying that the UK Government should:

[As read] "... in parallel be piloting the blanket testing of domiciliary care workers in order to understand whether there are widespread asymptomatic carriers among them."

And on 19 May you say that you agreed that PHE should conduct a quick study of blanket testing with one

or two domiciliary care providers to identify whether there were, in fact, domiciliary care workers with asymptomatic Covid and associated Covid amongst the people they were caring for.

And the Inquiry has seen on 26 June, you sent a WhatsApp to Matt Hancock referring to an earlier meeting which said:

[As read] "Very helpful meeting. Thank you, glad I badgered PHE many times to do a dom care testing pilot."

So I wanted to ask you, was your recommendation of 9 May 2020 taken up and if not, why not?

A. So from what you've just outlined there was a smaller-scale study. What I don't have in front of me is what the results were of that study, which would then have informed the subsequent policy, I believe, but I don't have those results with me.

Q. All right. Why did you have to badger PHE to do a pilot?

A. I'm trying to think back to what the conversations were at the time, and I can't -- I mean, evidently from me saying that, I was obviously having to push for the work to be done. What the reasons were, again, I could hypothesise whether it was they were busy doing other things, concerned about testing volumes, but I'm not

sure, I'm sorry.

Q. I was just trying to get at whether this is an example of, kind of, your, and in this case, important steer being ignored by those who have the power to put things into place?

A. I mean, in general, to your question about domiciliary care, and I think the record will show it, is that on multiple occasions I'm making sure that we're thinking about care homes, both older people and people of working age, in fact, and domiciliary care services, and there were situations in which people tended to focus on the care home situation because that was where the headlines were. But I was always also thinking about well, what about domiciliary care? I know that from the point of view of lots of clinical advice that I got, that there were greater concerns about Covid in care homes because of the nature of the environment in care homes where it was so difficult to control the spread of infection around all the residents in any facility, whereas dom care was more likely to be one person receiving care into a different form of setting.

Q. Can you help with whether a quick study was completed later on in May, and if so, what its findings were?

A. So that's where, if -- PHE agreed to conduct it and my WhatsApp exchange indicates that it happened, but I

don't recall what the findings are.

Q. All right. Thank you.

My third topic, the Inquiry has seen emails around 21 April 2020 in which it seems that you were asking for advice on the introduction of what you've referred to as a carer's wage. I wanted to ask you whether you'd received advice on that and what that advice was?

A. I believe I received advice. There certainly have been many conversations about that and whether you could raise, sort of, specifically higher minimum wage for care workers --

Q. Is that what you were sort of identifying --

A. That was one of the things that I looked at and, in fact, from that email exchange you can see that clearly it's something that had been looked at before, I was not the first minister to ask it. In fact, where I, subsequently, as a care minister, took the view that what needed to happen for -- to improve the supply of care workers was particularly career progression, and that while somebody might start off at the lower end of a pay scale the particular problem, I believe, with social care is that it's very hard to progress up a scale and that there's plenty of evidence around, Skills for Care amongst others, that even if you worked in social care for, like, 20 years and got a huge amount

of experience and expertise, you will get little or no extra pay to reflect your extra expertise. So I want to see a situation where people can actually build their expertise and be recognised for the extra responsibility and work they are doing; hence the work I did to try and build a career path with people in social care.

Q. But why wasn't it ultimately introduced, can you help?

A. Why hasn't a care worker's wage been introduced? I think it's looking at the -- I mean, there's realistically the funding challenge that to achieve a material uplift in pay for over a million -- there's 1.5 million people working in social care, you're looking at a lot of cost. Is that the right way to do it versus, as I say, actually having better pay progression?

We now have a new government. We'll see what they do. They're talking about a carer's wage but I haven't seen them commit any funding whatsoever to it.

Q. Thank you.

My final topic is returning back to looking at DNACPRs, please. And at paragraph 380 of your statement you say you recall being told about the inappropriate use of DNACPRs, but can't be certain how you first learned of that concern. The Inquiry has already seen an email from Professor Vic Rayner of 3 April 2020,

directly emailed to you, to escalate the -- the -- amongst other things, the PPE concerns that one provider has and to alert you to the practice of once CCG who was reporting issuing blanket DNACPRs to care home residents. It contained a reference to a CCG in Birmingham, Solihull.

So I wanted to ask you, on receipt of that email, what immediate action did you take to investigate whether there was, in fact, such a practice at the CCG?

A. So, I don't know the specific email you're referring to, when you say directly to me, unless it was to my personal email address, it won't have been one that I directly opened and -- when I say it's, you know, I have a private email address my family contact me on, but an MP ministerial email address will not come directly to me, so --

Q. It's your office, to your Private Secretary --

A. Yes, okay, so to my office, so therefore, I won't have necessarily, sort of, seen that or read that. And I don't recall being told that there was a specific CCG where this was happening. As I said in my witness statement, what I recall is learning that there were issues with DNACPRs being put on people inappropriately and investigating them, and then there was a whole set of communications that went out to say that this

practice was unacceptable.

I also subsequently triggered a review of patient records, I think, to try and go through and identify where people had had a DNACPR put on them that they hadn't consented to, and to try to undo that. And that was a concern later on, as well.

MS MORRIS: Thank you.

Those are my questions. Thank you very much, Ms Whately.

Thank you, my Lady.

LADY HALLETT: Thank you Ms Morris.

Ms Weston. Ms Weston should be across the hearing room down to your right, I think.

MS WESTON: Thank you, my Lady.

LADY HALLETT: I'm sorry, it's hard giving directions when you are miles away.

MS WESTON: It certainly is.

LADY HALLETT: Sorry, Ms Weston, I knew where you were.

Questions from MS WESTON KC

MS WESTON: Good to know. Thank you.

Good afternoon, Ms Whately. I'm asking questions on behalf of the Frontline Migrant Health Workers Group representing the interests of migrant social care workers.

My question concerns the Infection Control Fund.

You have already made reference today to the concerns expressed to you by UNISON that ICF wasn't making its way to the care workers themselves and in June 2020 you wrote to UNISON stating that local councils would allocate ICF on the condition that they were used as stipulated and that councils would use reasonable means of recouping wrongly allocated funds.

However, a survey of UNISON members in July 2020, found that more than half of care workers, 52% in fact, said their employer, the care provider, was still paying less than £100 a week, or nothing at all, if they needed to shield or self-isolate.

And my question is this: do you agree now that the enforcement of the use of funds under the ICF was wholly inadequate?

A. So yes. So you refer to the system we set up to try and get the money directly to care providers. In fact, the Infection Control Fund was introduced in part because the original, I think it was around 6 billion funding given to local authorities, which was intended to support, amongst other things, social care, I got response back from the care sector that they really weren't seeing a material amount of that. So I said, okay, let's do something directly. I created the Infection Control Fund, which was a very novel approach,

but we had no way existing to play -- pay providers directly, so it had to go through local authorities, and rely on local authorities in doing a level of due diligence to make sure that it was spent as it should be. And also, for local authorities to do the due diligence that staff were, you know, receiving pay that they should be.

I mean, clearly what's evident from that survey, from other stories, that there's a very mixed picture and some care homes did pay staff full pay for isolating, and others didn't.

To me, that's one of the, you know, lessons, and to be better prepared for a future pandemic, is, you need a system, you know, to make sure that when you have a policy like sick pay from day 1, well, that is actually implemented. We didn't have the systems in place to be able to go down to individual care provider level to make sure that was happening.

I mean, and the other thing that relates to it is, I, many times as a care minister, subsequent to the pandemic, was trying to push for better terms and conditions for care providers, addressing the stories of care -- sorry, for care workers, addressing the stories of not being paid for travel time for instance, and, you know, unfair contracts.

Q. Yes, I understand all that but are you able to point to any material that shows that local authorities were identifying where funds were not being used for the intended purpose and recouping them? What were you doing to monitor that?

A. So I got reporting back about the fact that local authorities were scrutinising, and I got a dataset that said -- that even broke down, oh, well, this percentage has been spent on stopping staff movement and this percentage has been spent on individual or testing, I can't remember the -- but I hard a breakdown of the percentage of funds that were being spent. So clearly the local authorities were reporting up the way the money was being spent. And in fact I got complaints that my process was too bureaucratic and that I was demanding too much reporting. In fact one of the, you know, pushbacks from the whole system was we needed to distribute funds without such an onerous requirement on reporting.

Now, I'm quite robust on this, and I say if you're structuring large quantities of taxpayers' money for certain purpose, I think it's perfectly reasonable to demand reports about it. But local authorities and care providers themselves said we were asking for far too much reporting.

So I stand by it. I mean, as you are indicating, if anything, we should have required more specific reporting --

Q. Well --

A. -- of are you doing this and that for your staff down to the individual care home level.

Q. Indeed, and you express frustration that, although there was -- the evidence was clear that the risk of staff movement was absolutely essential to be recognised, and you say that: the money's been going out there, so why is it still going on?

But would you agree that it's clear that one reason was because the ICF money wasn't being used to compensate workers for self-isolating?

A. No, there -- so I think you're -- you know, your hypothesis is perfectly reasonable. There's a point at which the money isn't doing what it could do to -- exactly -- make sure that people have sick pay when they're isolating, or, you know, the costs are covered if they stop doing hours in one setting in order to only work in another setting. If those things aren't being done, well, you're less likely to stop your staff movement.

So, you know, I think that we -- you know, in retrospect, you know, could -- could've -- could we have

pushed for more specific reporting? As I say, I did my best to listen to the sector. One of the complaints I got from the sector, as I say -- and I don't want to be negative, care providers did an amazing job during the pandemic and I know went -- many, many organisations went the extra mile, but, you know, I -- there was a view that we didn't listen enough at the early stages. We worked really heard with the adult social care taskforce to set up lots of engagement. One of the things I heard was there's too much reporting, too much bureaucracy. But, you know, the argument you're making is actually, you know, you need that and, if anything, need more reporting to know that money is being spent the way you want it to be and that there is compliance with those kind of requirements.

MS WESTON: That's fair.

Those are my questions, my Lady.

LADY HALLETT: Thank you, Ms Weston.

Straight ahead for Ms Peacock, Ms Whately.

Questions from MS PEACOCK

MS PEACOCK: Thank you, my Lady.

Good afternoon. I ask questions on behalf of the Trades Union Congress.

My first topic is also around the Infection Control Fund. This has been touched on already, but in relation

to the proposed regulations to restrict movement of staff between care homes and the related need to reimburse care workers, you describe in your statement at paragraph 167:

"On 18 December 2020 HM Treasury rejected the proposals to compensate staff through the furlough scheme but said they would consider extending the Infection Control Fund ..."

You go on to say:

"I responded the next day saying I did not want to go ahead without furlough payments being made ..."

And indeed you had received an advice on that decision which referred to the difficulty of proceeding with regulations to restrict movement of staff without a robust compensation mechanism.

And that's at INQ000328026, at page 4.

Why did you refuse to go ahead with the regulations without furlough payments being made? And you've already touched on some of the limitations of the Infection Control Fund, but why was the ICF not sufficient in that case?

A. I'm -- so I'm -- I'm having to join the dots on what was going on here to recollect what was going -- I mean -- so, as best as I can reconstruct in my head, so I'm wanting to regulate on staff movement because I'm

frustrated it's still going on, but take the view that there needs to be proper compensation for staff. I'm therefore in a form of negotiation with the Treasury to try to secure that. The Treasury is, you know, pushing back on my proposal. So, you know, that is a negotiation in progress.

What I recollect then is various things happen, one is which there then becomes much greater staff shortages. So actually we've then got to a point where I'm then told that basically the exception -- the unsafe staffing exception is going to end up being used so much, if we implement it then, that it's not going to have any impact. And then I think we move on to the vaccination programme.

So I think it was -- those -- those events then happened probably while there was -- the negotiation was in progress to try to address the pay question.

Q. And in your statement, of course, you quite closely link that decision not to go ahead unless it's with furlough payments.

And just, perhaps, to help with your recollection, you received that advice which I referred to on 18 December 2020, and at paragraph 4, the issue of the Infection Control Fund is described. It says:

"We have considered whether we can make the ICF do

this job adequately. But even if money was added to make it sufficient, it is an unsuitable mechanism. Unlike the furlough, we cannot know whether providers pass funds on to employees ... To date, we have not found evidence of the providers having used the ICF to compensate lost hours."

Is that an accurate summary of the reason you didn't want to proceed with the regulations with the ICF and without furlough?

A. Well, I'm confident that, as you've described, it was a factor in the reason why I was having this negotiation with the Treasury to try to get them to do something which was more targeted, like a furlough scheme.

As I've said, I think the main reason for ultimately not proceeding, though, was -- was particularly to do with the problems of lack of supply of staff, because the economy was reopening and we had higher Covid rates, and therefore that the unsafe staffing exemption would make the legislation ineffective. That was what then really got in the way.

Q. Thank you.

Turning to awareness of this issue with the ICF within government, minutes of a Covid-O meeting on 22 December 2020, at which Michael Gove and Matt Hancock were present, record that you explained that the

challenge with the ICF was that there was no way of knowing whether the money had reached individuals.

And the minutes of points made in discussion, although they don't ascribe them to an individual, record that:

[As read] "On staff movement, the ICF was designed to support this policy but its weak processes meant that fund was not reaching those that needed it most. The furlough was a well tested mechanism for ensuring that funding reached under-represented groups and was fair."

Is it right, then, that the weak processes of the ICF were known within the department, and indeed more widely within government, in part as a result of you raising it?

A. I mean, it's likely. I think that -- you know, that reflects -- what you've just read out reflects what I've been saying here in the conversation in general, which is that we knew that we could gather evidence through local authorities of broadly the buckets in which the money was being spent, but you couldn't trace it down to individual staff members getting paid for -- to compensate them for lost hours, for instance. So it couldn't do that, and we had no way of getting it to do that.

Q. And then turning to some of the reasons behind these

challenges and the efficacy of the ICF in respect of providing full sick pay to care workers, which we -- we've already discussed some of the challenges in quite a bit of detail, and the data by Unison has been mentioned, and you've referred to a mixed picture.

By way of example, in August 2020, a survey suggested that at that stage, so three months after the ICF was introduced, only 25% of employers were paying staff who needed to self-isolate their full wages.

And that data is at INQ000119075, at page 3.

Then the suggestion recorded by Unison at that time was that care workers were not being paid by providers because not doing so placed more pressure on workers who tested positive to continue to work.

Then in October 2020, minutes from a DHSC testing meeting, which I think was a tripartite meeting, Unison attended it, state that:

[As read] "Some homes have refused to sign up to the ICF because they're worried it will mean they will have to accept the principle of paying staff in full for all future forms of sickness."

So a concern about setting a precedent expressed there.

To what extent were these challenges and the

potential reasons payments weren't being made known by you and more widely within the department?

A. So I don't recall knowing either those two bits of data that you have just shared. On the Covid-positive point, it's similar but different. I did know about one area of the country being very reluctant to roll out testing because they thought it would reveal that they had lots of people who were Covid positive and that they would therefore stop working, and intervening in that case to make the testing go ahead so that they could identify they had Covid-positive staff and those staff not work.

But clearly that's a different scenario.

Like I said, I don't think I saw the data before that you have just described there. But I do think what you're talking about, though, reflects a bigger problem about the importance of -- given that you have social care workers who are looking after people who are vulnerable to infection, you need to have a, you know, stronger cultural ethos of there being sick pay so that somebody who is on a relatively low income doesn't find they have to go to work, even though they may have an infectious illness, and that could be flu, for instance, which we know kills people in care homes every winter, because otherwise they can't afford to put food on the table.

I can understand the concern of some care providers that: hold on, if we give people sick pay, well, you know, they'll say they're sick and won't come in. And I have heard from care providers who tell me their frustration, some of them, that their staff, you know, they're expecting staff to come in and they don't for all sorts of reasons -- that is a bigger question about how do you manage your workforce, it shouldn't be a reason not to pay sick pay. I think it should be paid in a sector, as I say, where people who may be vulnerable to infection, are working.

Q. Thank you. I'll just move now to my second topic which is around vaccine confidence in the social care workforce.

You refer in your statement at paragraph 363 to a letter sent to the Secretary of State in February 2021 which set out that:

"An extensive programme of work was under way to address fears about vaccination. This included webinars for the care sector, educational materials sent to providers, and broader work to build trust amongst hesitant communities."

Given what's been discussed about the complexity of the sector and the lack of operational reach into the sector by the department, do you know to what extent

this programme and information was reaching care workers?

A. Sorry, I was trying to look up the paragraph you mentioned but I didn't -- did you say 363?

Q. Yes.

A. Oh yes, a letter. So to what extent was that information receiving -- reaching care workers?

Q. That programme and that information.

A. Yes, I mean, we wouldn't have had -- and as we talked about during this session, I didn't have a register of care workers, I had no way of knowing, you know, on a tick-box basis, had every care worker received information or not, so the approach was taken about communication of the vaccinations was a sort of broadcast look through, down multiple channels. This is something we worked very closely with the NHS on to try and reach all different communities. We worked a lot with care sector representatives, trying to work through registered managers in care homes who often had, clearly, a strong relationship with their workforce, worked with GPs. So one potential source of guidance on getting vaccinated would be somebody's GP and GPs would literally talk through somebody, you know, what their worries would be about getting vaccinated, so it was kind of a multiple channel approach going on.

Q. Sir Sajid Javid, during his evidence on Monday, was asked about his evidence before the Inquiry that many care workers felt they did not receive enough information and support about the vaccines and he agreed it would be worth considering a more centralised way to distribute information to care staff in any future pandemic rather than indirectly via providers. Do you agree?

A. So yes, and again I think, you know, compared to say, through -- to reach the nursing workforce, you have channels to do it because nurses are registered and you have contact details through that. With social care staff, you know, we tried many ways, like, and I remember saying, you know, how can I reach care workers? We created an app for staff but it didn't have particularly great take-up. So -- and as I'm sure you'll know, considering the organisation you're representing, it's not a particularly unionised workforce. So although I had conversations with the unions at several occasions during the pandemic, there was only a small proportion of the care workforce who were actually members and that would be a channel of communication.

So, I think it would be a good thing to have a better way to communicate directly with this

workforce, yes.
Q. So is a fair summary that registration would be a step in the right direction and potentially also more mechanisms to discuss with care workers and their representatives these types of issues and, in particular, to give them information about vaccines? Is that fair?
A. Yes, I'm broadly supportive of that. I mean, there's a-- I can see a counterargument which is oh, red tape, and requiring everyone to be registered and cost and all of that, but I think to weigh that in the balance, when you have a workforce who are looking after a really vulnerable group of people, and, you know, taking significant responsibility to do that, it's not an inappropriate thing to put in place.
MS PEACOCK: Thank you.
Thank you, my Lady, those are my questions.
LADY HALLETT: Thank you, Ms Peacock.
Mr Straw.
Mr Straw should be behind Ms Peacock.

Questions from MR STRAW KC

MR STRAW: Good afternoon. I represent John's Campaign, The Patients Association and Care Rights UK.
In your addendum you appear to accept that the concerns about the adverse impact of visiting

restrictions, isolation, and so on, that had been raised by people drawing on care and their supporters, weren't heard by some in government, and that this was partly because they weren't, as it were, in the room.
In your 2023 witness statement you also welcome, and I quote:
"... the emergence during and since the pandemic of groups specifically representing care home residents and their families -- like Rights for Residents ... who helped raise awareness of the importance of visiting."
Do you agree that those groups and others like them should have been better listened to by decision makers during the pandemic?
A. So I think, as you just allude to in that question, one of the challenges is that there was just limited groups in existence representing particularly -- and Rights for Residents emerged, if I recall right, during the pandemic, and became a very effective advocate on visiting.
The department and me personally had sort of care user groups that we did regular sessions with, whether it was in-person meetings in non-pandemic times or lots of remote calls, and those groups included family members of people who receive care, they included people who were, sort of -- who were, you know, carers, unpaid

carers. They included people who themselves were -- drew on social care support.
So I did have points of contact.
And TLAP would be an organisation to think about in this as well.
But those were more likely to be -- particularly I think people -- that was particularly people who, for instance, were receiving care at home. There wasn't such a strong voice from residents of care homes, is my recollection. And that is something which Rights for Residents particularly provided.
And, you know, they were one of the, sort of, ports of call for getting that view as the pandemic went on, and in fact subsequently leading to the legislation which I introduced to count visiting as a fundamental standard of care, now as one of the things that the CQC inspects on.
Q. You've mentioned Rights for Residents. They were -- you met with them at one -- at least at one point, if not more. And they considered that although you listened to them, their recommendations weren't ultimately implemented.
So, to take an example, they favoured the right to an essential carer and explained how that could, for example, reduce the need for highly dangerous staff

movement. But although that was listened to, it wasn't ultimately implemented.
Would you accept that, and if you know -- and if so, can you give any explanation as to why?
A. Yes, so the debate about visiting is, you know, you get pulled in two directions on this. On the one hand you've got those who are concerned about visiting, both care homes who are worried that visitors will bring in infection and in fact some of the families receiving care who want the care home in which, say, their relatively is living in to have a very strict 'no visitor' policy. And on the other side you'll have, for instance, families like the Rights for Residents campaigners who want a much more open visiting policy. And some people will say, "I'll be prepared to take the risk that my family member might get Covid but it's more important to me that I get to visit them."
So you've got both of those viewpoints happening at the same time, arguments going -- pulled in both directions.
And I understand from the point of view of a care home themselves, you know, they've literally got families on the one hand saying, "Please stop visiting, it's not safe", on the other hand saying, "Let us in to visit our family."

So those are difficult.

Then you've clearly got the context that we were dealing with in government of a lot of people have died in care homes, and -- you know, the public health advice I was given, which was very strongly on the side of infection control and minimising footfall, and the record shows me having quite -- back and forths with public health advisers on this, saying, "Well, hold on, you know, surely we can at least allow window visiting? That's not going to be a risk to residents of care homes."

And actually having to have an argument with public health advisers, saying, like, "Really, really, I can't see how window visiting increases risk of infection to care home residents."

I mean, in fact, there was a point at which that became the policy, and I remember campaigners being disappointed because of the level of restriction that was imposing on visiting. It was actually something that I fought for, to even allow that.

So you get these tensions going on behind the scenes. And indeed a lot of back and forth about the essential care model, which I was a supporter of, but, you know, ultimately in the policy-developing process I clearly am having to take clinical advice, and advice

in general, on both what's seen as clinically safe and also what is seen as manageable by the -- for the care providers themselves.

Q. Just very briefly, looking to the future, would you agree that these -- the views of stakeholders like the ones I've mentioned, that they are well placed to try to help you make the best decisions, and it would be helpful for there to be a better mechanism to ensure their views are fed up?

A. So, yes, I think the views -- it's very important to take the input of a wide range of views of stakeholders. It's something I did a lot of work on myself to try to make sure I was reaching out. And I think it was very helpful of the emergence of new groups.

I think also, and I'm just going to pick up on one of the things you said I had said in my statement, about the importance of people who were in the room, because one of the things I think is worth thinking of in the event of a future pandemic is making sure that you have enough people in decision-making positions beyond the individual Minister for Social Care, who have a good understanding of social care, and -- and including, for instance, what makes a difference for the wellbeing of people who receive social care.

And while in the room there was often a lot of

people from the NHS -- and pretty much, you know, everybody has some experience of the NHS, not everybody has experience and understanding of social care. So I think that is something to be thought about for a future pandemic.

MR STRAW: Thank you very much.

LADY HALLETT: Thank you, Mr Straw.

Ms Beattie, who is probably just behind Mr Straw.

Questions from MS BEATTIE

MS BEATTIE: Good afternoon, Ms Whately. I ask questions on behalf of Disabled People's Organisations.

We know that from an early stage in the pandemic you expressed concern about deaths in domiciliary care. And you said in evidence this morning that your most vivid recollection from the series of home visits that you did pre-pandemic was how isolated many of the people were that the care worker who took you around was looking after.

You saw the sitrep on the 9 April 2020 which you messaged Mr Hancock about because it showed stark rises in mortality rates in care homes and in domiciliary care; is that right?

A. Yes.

Q. At that stage, did the stark rise in deaths of domiciliary care recipients reinforce the need for

further investigation of whether those deaths were Covid related and hence relevant to issues such as testing, staff movement, PPE, and bespoke guidance?

A. I mean, on the testing, because at that early stage we were very limited in the number of tests but I think the record will show that I pushed for tests to be used, you know, across social care in care homes as well as domiciliary care, albeit that the prioritisation of how tests were used was a clinical decision, in essence. So that was what's -- what dictated how tests were distributed.

Q. But you would want to know whether those deaths were Covid related or related to something else, would you?

A. I think it's important information to have in general, to try to have about deaths, yes.

Q. The ONS data then published, on 15 May 2020, then again confirmed a very significant increase in deaths of domiciliary care recipients of 2.7 times the previous average. Now, those figures only included deaths reported to the CQC, so I presume you would have appreciated that that -- they were likely to be incomplete; is that right?

A. So I believe, by that point in the pandemic, I was receiving data which would have given me the full picture of deaths in social care, because by that point

I believe that -- well, the double-counting concern that had originally been to do with hospitals and social care had, I think, been ironed out. So I would expect that I would be given the full picture on deaths, unless there was some reason why the reports given to me that -- unless there was some reason why, I guess, Public Health England wouldn't have known of all deaths, but I believe I was receiving the full picture.

Q. Yes, I think the ONS statistics themselves explained that for domiciliary care providers were only required to notify the CQC of a death where the person died while a regulated activity was being provided, or where the death may have been a result of the regulated activity or how it was provided. So it may have provided a limited picture of the true number of deaths in domiciliary care.

A. I would need to take a -- I would need to look at that rather than just having it presented to me like this.

Q. Okay. Well, that ONS data showed that the proportion of the increased deaths in domiciliary care recipients which involved Covid was lower than the proportion for care home residents.

A. Okay.

Q. Bearing in mind the extent of isolation which you knew pre-pandemic that people might live in, as you've said

earlier, did the fact of a lower proportion of domiciliary care deaths which involved Covid itself require further investigation of whether the increase in deaths might be due to other factors? So not or not only to Covid infection, but to indirect impacts of the pandemic or the pandemic response, including, for instance, people dying from a lack of basic food or hydration?

A. I mean, I'm trying to think back to that time, and, you know, to what extent, because it feels to me like there's potentially an overlap between what you're asking me and the work that was done through the shielding programme, and also the other work that was done to try and support people who, for instance, were lonely and isolated. The shielding programme was a substantial programme to try and make sure basic supplies went to people who were unable to leave their homes. I also did quite a lot of work through my sort of -- part of my remit was to do with volunteering and setting up the NHS responders, and some of that was to do outbound calling, which I indeed did myself as part of this, to people who were identified as isolated and, you know, in need of just some contact and to find out whether they needed any support.

So that was one of the things that was put in place

to try to support people who were isolated and home alone.

I think, though, there's, you know, the reality is, and we know from the many stories that the pandemic was an incredibly tough time for people who were isolated, particularly living alone at home and particularly if they were shielding or unable to leave home for any reason. There's no getting away from the fact that the pandemic was a terrible, terrible time for people in those situations.

Q. So in addition to those initiatives that you've mentioned, did it require additional focus on what, if any, guidance or change in guidance was needed to address the impact on domiciliary care recipients?

A. I think I would have to -- if you will forgive me, it being five years ago now -- I would have to look back at the record to see what was done in response to the data you're describing.

Q. And I have a further question about easements --

A. Yes.

Q. -- under the Care Act. You refer in your statement to the aspect of easements whereby local authorities were not doing assessments and reviews. Did you understand that local authorities could invoke easements to seek to justify withdrawal of actual services contained in

a care and support plan? So for instance, cutting a home care visit or the number and frequency of home care visits to assist someone with hygiene or with toileting?

A. So if -- it would be helpful, probably, if I take a step back, at the point at which the decision was made to allow local authorities to turn on Care Act easements, the view taken there was that we were expecting a lot of people to potentially become sick with Covid and we knew that a significant number of care workers might well be sick with Covid or isolating and unable to work.

So in a scenario where you have a much reduced workforce, what are local authorities going to do, because they probably are not, I mean, they are certainly not going to be able to continue to provide their normal levels of care to all the people they usually care for. Like, that is an obvious risk or fact that's going to happen. If you've got a lot of your staff off sick, you're not going to be able to provide your full care to the full number of people who usually receive it.

So the idea of Care Act easements was to have a controlled system which would involve local authorities notifying, if I recall right, the Chief Social Worker, that they were going to have to limit and

make some restrictions on care, and to enable them to decide to prioritise care based on those who were in most desperate need, particularly those who, if the care was not provided, would for instance not survive, so to enable those kinds of decisions to be made by local authorities, but by doing it through a formal process with the Care Act easements so that it was, you know, communicated to the department so that it could be monitored, so that there could be, you know, questions asked if that was continued for a very long time.

That's what the Care Act easements were about.

Q. So do I understand your evidence is that all those cuts and changes should have been reported through the easement process; is that right?

A. So my -- so the reason why I approved the Care Act easements was because that was a managed process. Now, what I understand, and I know because I watched some of Michelle Dyson's evidence yesterday, was in practice -- and we know from the records that only a limited number of local authorities turned on the easements, and that some potentially used what you'd call flexibilities to -- which involved them therefore providing less care to people.

What I found particularly startling from one of the reports I've read, it might have been in the Every Story

Matters document, was that there seemed to be little in the way of consequences observed where local authorities didn't do the easements but did reduce their care for people. So rather than following the proper process, there's a lack of consequences, which I do think reflects a problem which is the lack of, essentially, oversight and accountability for whether -- and this applies outside a pandemic as well as during -- to whether local authorities really are delivering on their Care Act obligations.

It is one reason why I launched the CQC assurance of local authorities delivery of their Care Act obligations, because I did not think there was enough scrutiny of whether they're doing that or not.

Clearly the way that local authorities are held to account is through local elections, by the members of the public in the geography of a local council voting for whether they want that council to continue to be controlled by whichever political party or not, but I don't believe that that election process is very good at holding local authorities to account on their delivery of their social care obligations.

There are many reasons why people vote as they vote in local elections, and that's one reason why I put in place the CQC process: to provide more transparency and

accountability, and actually recognise when local authorities do a really good job in social care, as well as shining a light on those that were not doing such a good job.

LADY HALLETT: Thank you very much.

MS BEATTIE: Thank you.

LADY HALLETT: Thank you, Ms Beattie.

That completes all the questions we have for you, Ms Whately. I'm sure it's been a very long and tiring day.

Whatever findings I make about the response of the department in which you're a minister, you personally were obviously highly alert to so many of the issues we've been investigating during the course of this module, so may I thank you for all that you tried to do and for the way you promoted the cause of social care.

And thank you very much for all the help that you've given to the Inquiry. You've obviously prepared very carefully and answered all the questions very carefully. We're really grateful.

THE WITNESS: Thank you very much.

MS CAREY: Thank you.

My Lady, before we conclude, may I just ask one matter of you, please.

During the course of preparation for Module 6, as

your Ladyship knows, a number of Rule 9 requests were made of myriad witnesses, and can I invite you today, please, to publish 64 statements. They include -- and I won't read them all out, but I think up on screen is going to be put a list of the 64, including the name of the witness and their organisation, their unique Relativity number, and a description of who -- they have given evidence before.

But in short, my Lady, it includes the statistics agencies, government departments and other agencies, social care sector providers, representative groups and interest groups, impact witnesses from our Core Participant groups, and indeed, statements taken from care homes across the UK.

And I'd be very grateful if all 64, with your consent, could be published later today.

LADY HALLETT: They can, thank you very much, and obviously to remind everybody that I'll be bearing those statements very much in mind as well as the oral evidence when I come to make my findings and recommendations.

MS CAREY: Thank you, my Lady.

LADY HALLETT: Thank you.

Very well, we shall return, I think it's -- is it 26 July, is it?

MS CAREY: 21st.
LADY HALLETT: 21st. Can't read my own handwriting.
21 July, when I shall be back in person at 10.30.
MS CAREY: Thank you, my Lady.
(4.26 pm)
(The hearing adjourned until 10.30 on Monday, 21 July 2025)

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