FIRST WRITTEN STATEMENT OF RT HON JEREMY HUNT MP

Witness Name: Rt Hon Jeremy Hunt
Statement No: 1
Exhibits: JH/1 – JH/10
Dated: 4 April 2023

UK COVID-19 INQUIRY

FIRST WRITTEN STATEMENT OF THE RT HON JEREMY HUNT MP

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Section 0: Preface

I, Jeremy Hunt, will say as follows:

1. I make this statement pursuant to a Rule 9 request from the inquiry dated 8 February 2023. In responding, I draw primarily upon my experience
    a. as Secretary of State for Health between 6 September 2012 and 8 January 2018,
    b. as Secretary of State for Health and Social Care between 8 January 2018 and 9 July 2018, and

c. as Chair of the Health and Social Care Select Committee between 29 January 2020 and 17 October 2022[1].

2. I was appointed Chancellor of the Exchequer on 14 October 2022, a position I still currently hold. Between July 2018 and July 2019, I was appointed Secretary of State for Foreign and Commonwealth Affairs.

3. Dame Sally Davies was the Chief Medical Officer throughout my time as Secretary of State for Health and Secretary of State for Health and Social Care. Due to her involvement in many of the matters discussed in this statement, I asked that she review the statement in draft to check its factual accuracy. She did so, and confirmed that she had no comments on the statement and believed the facts in the statement to be correct. As such, no changes were made to this statement resulting from Dame Sally's review other than the addition of this paragraph.

Section 1: Introduction and opening comment

4. During my time as Secretary of State for Health, and Secretary of State for Health and Social Care, between 2012 and 2018 ("**Health Secretary**"), I held the overall responsibility for the work of the Department, including financial oversight and control of NHS delivery and performance and, from January 2018, oversight over social care policy.

5. During my time in charge of the Department, I prioritised a focus on the safety and quality of NHS care, following what I perceived to be a patient safety crisis which came to my attention largely because of the publication of the Mid Staffordshire NHS Foundation Trust Public Inquiry report on 6 February 2013, a few months after I had become Health Secretary. Other reports which I commissioned followed, a number of which were published after I left office, including the 2015 report into failures of clinical care at Morecambe Bay NHS Foundation Trust, the 2019 Gosport Report by Bishop James Jones, the 2020 Ockenden Report into maternity failings at Shewsbury and Telford and the First Do No Harm report by Baroness Cumberlege into the use of Sodium Valproate, Primodos and vaginal mesh. I also led the management of the Department's responses to major crises, which included a focus on health security.

[1] It should be noted that, given my previous role as Secretary of State, I recused myself from the sections of a report produced by the Committee in 2021 ('Coronavirus: lessons learned to date') dealing with pandemic preparedness.

Other priorities included dementia, mental health, maternity safety, technology and integration issues.

6. In this statement, I specifically address issues of emergency preparedness, resilience and planning for a pandemic which are the subject of Module 1 of the Public Inquiry. I will consider in turn the key decisions taken during my tenure, lessons from East Asia, funding and economic and workforce planning, before adding some general remarks.

7. I have been asked specifically for my views as developed in the capacity as Chair of the Health and Social Care Committee, and summarise those below.

8. I would like to add by way of opening remarks that in so far as I was Health Secretary for nearly six years, stepping down 18 months before the pandemic hit the UK, I take full responsibility for all the decisions that were taken or not taken on my watch. I also pay tribute to the efforts of frontline NHS and care staff during an incredibly challenging period that were nothing short of heroic. It goes without saying that we owe it to them, and to the many families who lost loved ones, to learn every possible lesson from what happened in preparation for future pandemics.

Section 2: Key decisions

2.1 Pandemic Preparedness

9. By way of relevant background, my tenure in office as Secretary of State for Health commenced just over three years after the outbreak of a novel influenza (influenza A (H1N1) "**the Swine flu**") in 2009. The Government's independent review of the UK's response to the pandemic had reported in July 2010.

10. The Board of the Pandemic Influenza Preparedness Programme ("**PIPP**"), the central DHSC-led programme of activity for the management of pandemic preparedness, had been in existence for three years at this stage and a UK Influenza Preparedness Strategy had been published in 2011. It updated a previous preparedness plan published in 2007. The strategy set out five different phases of detection, assessment, treatment, escalation and recovery.

11. I am also aware that the Department of Health undertook Exercise Winter Willow in 2007, which simulated the response to a flu-like pandemic. I understand that some of

the lessons from this exercise were of relevance to later simulations (discussed below), but this occurred significantly before my time as Secretary of State.

12. Just after my appointment, Middle East respiratory syndrome ("**MERS**") was first identified in Saudi Arabia, in September 2012. Most cases had been concentrated in the Arabian Peninsula, with cases spreading to the Middle East, Africa and South Asia.

13. In response to the MERS outbreak, a Public Health England risk assessment was published on 2 May 2014 and subsequently updated. The assessment of the risk to contacts of confirmed cases of MERS-CoV infection was assessed as low.

14. Following these outbreaks, in 2014 a new independent scientific advisory group was established called the New and Emerging Respiratory Virus Threats Advisory Group ("**NERVTAG**"). This group was established to provide scientific risk assessments and advice on all emerging viral threats to the UK, and was not limited to pandemic influenza. Although I was not Secretary of State for Health during the Covid-19 pandemic, it seems that NERVTAG would have provided some valuable warning and advice concerning Covid-19, and that establishment of this group is likely to have improved the UK's pandemic preparedness.

15. In 2014-2015, I chaired COBR emergency meetings concerned with the possibility of Ebola reaching the UK from West Africa, and the risk that UK aid and healthcare workers could bring the virus to the UK. In the course of these meetings, the crucial importance of more rapid vaccine development became clear. A UK vaccine network was set up ("**UKVN"**). Early funding was given from 2016 onwards to the University of Oxford to find a vaccine for Severe acute respiratory syndrome ("**SARS**") and MERS that would become the foundation of the Oxford/AstraZeneca vaccine. That programme of work was led by Professor Chris Whitty, at the time Chief Scientist at the then Department for International Development. I have little doubt that this funding and the incredible work which resulted from it, improved the UK's pandemic resilience.

16. We also took the issue of pandemic preparedness extremely seriously. I had no prior expertise but the benefit of advice from my excellent Chief Medical Officer Dame Sally Davies, whose advice I believe I always followed. On her suggestion, in 2018 I hosted a meeting of Health Ministers in London to discuss global health security. This meeting considered various aspects of pandemic preparedness (such as medical countermeasures, virus sequencing and public health communications) (JH/1 -

INQ000146025) and provided an international forum for discussion in this area. I also attended a similar meeting of Health Ministers at the 2015 G7 summit in Berlin, which considered relevant issues (JH/2 - INQ000146024). I recall having particularly close discussions with the then German Health Minister Hermann Gröhe.

17. During my time as Health Secretary the Chief Medical Officer decided to review the planning and resilience in place to respond to a large outbreak of MERS. An exercise was conducted on 15 February 2016 to explore the challenges that a large-scale outbreak of MERS could present to health partners in England ("**Exercise Alice**"). It was led by Public Health England's Emergency Response Department Exercise Team and had no Ministerial involvement. I understand that actions identified included the production of a briefing paper on the South Korean outbreak of MERS, with a view to considering the direct application of their experience and methods to the UK (which included the 17,000 quarantine cases and port of entry screening). The most controversial, wide ranging and unresolved discussions concerned the restriction of movement of symptomatic, exposed and asymptomatic patients. An options paper was to be produced using extant evidence and cost benefits for quarantine versus self-isolation for a range of contact types. More generally, this work within the Department led to the High Consequence Infectious Disease Programme (JH/3 - INQ000146026), which was published as I left office in 2018, and also fed into a separate classification for 'emerging infectious diseases' (as opposed to pandemic flu) within the 2017 National Risk Register (JH/4 - INQ000055869, p34).

18. I was not involved in Exercise Alice and neither the Department nor Chief Medical Officer believe any recommendations from it reached my desk. I am also now aware that there was some discussion at the DHSC Board concerning infectious diseases and pandemic preparedness at around this time. I was not involved in these discussions and, to my knowledge, I was not made aware of them.

19. Between 18-20 October 2016, a pandemic flu preparation exercise was also held, over three days and involving 950 officials from central and local government ("**Exercise Cygnus**"). Participants took part in a simulation of an H2N2 virus that had come from Thailand, affected 50% of the UK population, and caused 400,000 deaths. My involvement in Exercise Cygnus was primarily on the last day when I chaired a meeting designed to test ministerial approaches to what is euphemistically called 'population triage' e.g. deciding who should live or die in resource-limited situations. I was asked

whether I was willing to close all intensive care beds leading to the likely death of many patients in order to release intensive care doctors and nurses to the community where they could save more lives, something I declined to do. I don't believe there is a right or wrong answer to such decisions and the point of the exercise was to try and understand how ministers might think when such impossible choices had to be made.

20. The major lessons from this exercise were the need for emergency powers, and for better ways to manage population triage, not least because of the resistance I had shown to taking the kind of decision with which I was confronted.

21. Insights from Exercise Cygnus and recommendations for taking these forward were presented to a meeting of the National Security Council (Threats, Hazards, Resilience and Contingencies) Subcommittee on 21 February 2017, chaired by the Prime Minister. A key recommendation, for the establishment of a cross-governmental pandemic planning oversight group, led to the formation of the Pandemic Flu Readiness Board ("**PFRB**") in 2017. Alongside the PIPP, this provided a governance structure underpinned by regular internal meetings on the Department's work continuing until 2019. I also believe further recommendations were implemented within a process supported by the then Chief Medical Officer Dame Sally Davies.

22. As a direct result of these lessons, a draft Pandemic Flu Bill was prepared between 2017 and 2019, with support from the Cabinet Office and Other Government Departments ("**OGDs**"). I understand that this Bill formed the initial basis for the Coronavirus Act 2020, and would therefore appear to have been of significant value. A Moral and Ethical Advisory Group was also established in 2019 by the DHSC, in response, to assist with the moral, ethical and faith considerations related to the kinds of incidents simulated in Exercise Cygnus.

23. Looking back, it is striking that the Cygnus recommendations did not mention testing once. Of course it was a pandemic flu exercise, so arguably testing was less relevant, and perhaps indicates a limitation of the exercise. But given it was by far the biggest exercise we did and failures in testing were to cost many lives, I think we need to consider why deeper thought was not given to the issue in either this or other exercises. That said, despite the obvious limitations inherent within artificial exercises such as this, I do consider that conducting them was likely to have been of some positive benefit towards pandemic preparedness planning.

24. Cygnus did also talk about the fragility of the social care system. I was not officially responsible for social care at the time. But I agreed that both the NHS and social care system were fragile and in need of more capacity. For that reason, I pushed hard inside government for a big increase in funding for the NHS and social care system in 2017 and 2018. I successfully secured a £20.5 billion increase in the NHS annual budget in June 2018, but not at the time for the social care system. I was able to remedy this at least in part as Chancellor, with a £4.7 billion increase for the social care system in the Autumn Statement of 2022.

2.2. Groupthink

25. As I have written elsewhere, I believe with the benefit of hindsight that our preparations, and specifically Exercise Cygnus, were affected by an element of "groupthink". By that I mean that the spread of many distinct types of virus could create a pandemic, yet our shared belief was that the most likely scenario was a pandemic flu. In consequence, resources were allocated to the preparation for that type of virus: the focus was upon the treatment and escalation phase of the pandemic response. The assessment and detection phases were not simulated, and particularly the risk of asymptomatic spread was not considered. The assumption was, fatalistically, that a pandemic virus was likely to spread to around 60% of the population at the initial, pre-vaccine stage. Hence, not a single recommendation was made about testing capacity with a view to preventing that initial spread.

26. I have contrasted this "groupthink" with the approach of East Asian countries which had direct experience of the discovery and spread of SARS in February 2003, with most cases occurring in China, Taiwan, Hong Kong and Singapore (see also Section 3 below).

27. I have been asked to consider the causes of the "groupthink" I have identified, and whether I have any further institutional recommendations, which could guard against that risk. In terms of recommendations, I consider that plans for the future concerning pandemic preparedness should include greater learning and challenge based upon the experiences of practitioners from other countries in a wide range of disciplines (discussed further below).

28. As regards the causes of "groupthink" which over-focused on pandemic flu, in my view there was nothing deliberate about it or indeed unique to the UK. As far as I could tell,

it affected the scientific and medical establishment across Europe and North America, and seems likely to be rooted in our collective experiences.

29. Asian countries did prepare better for SARS-like viruses mainly because they experienced them more directly. But their response was not uniform: China successfully contained the virus but in a very draconian way; Taiwan and South Korea had superb test and trace systems running from the outset; and Japan pioneered backwards contact tracing. Overall, I would say that non-China Asian countries showed more curiosity and humility in their approach compared to here.

2.3 Wider and Structural preparedness

30. The balance in the UK between central processes and local processes generally stood the test of the pandemic, with advantages of central control including the ability for rapid decision making but with close cooperation on implementation with local authorities.

31. The standing capacity created by the funding and support provided for the UKVN (discussed above), permitted the UK to do better than many countries in terms of the rapid development of an effective and economic vaccine suitable for deployment. The UKVN directly led to funding the research on which the Oxford/AstraZeneca vaccine was based, a vaccine which is estimated to have saved six million lives globally.

32. The structural ability to increase NHS surge capacity, which included the redeployment of staff and return of clinicians who had recently retired, was based upon preparatory and planning measures which had been learnt and implemented previously, and proved to be prescient.

33. My view, informed by my time as Secretary of State is, however, that further lessons need to be learned with respect to overall NHS capacity. The NHS successfully made sure there were enough intensive care beds and ventilators for those who needed them, with resources such as the Nightingale hospitals stood up at great speed. But the capacity was delivered by switching off care pathways for many other conditions for which we are now paying the price with a large waiting list.

34. Linked to this, staff capacity within the system – availability of clinical staff – is also relevant to the question of structural preparedness. During the pandemic NHS staff

showed remarkable resilience but, as I have argued elsewhere (and consider further below), NHS workforce requirements have historically been considered in an ad hoc way, which has not always left the NHS with the staff it needs, and instead requires a long-term approach. Despite my best efforts during my period as Secretary of State, I acknowledge that the reforms I implemented did not materially increase the NHS workforce in time for the arrival of the pandemic.

35. In addition, it became clear during the pandemic that we were seeking to rely on extended supply chains in order to obtain vital supplies of Personal Protective Equipment ("**PPE**"), at precisely the time at which this became one of the most sought-after commodities globally. Therefore, one of the lessons learnt from the pandemic concerns the importance of establishing a domestic capacity for the production and distribution of PPE. Whilst I don't believe I ever rejected or ignored any recommendations to do this, it is clearly an important lesson that needed to be learned concerning wider pandemic preparedness. I understand that changes in this regard occurred both during and since the pandemic.

36. It also may be relevant to note that the UK's preparation for leaving the EU occurred in the run-up to the Covid-19 pandemic. I believe that such preparations took place after I left the DHSC (for instance, Operation Yellowhammer, which concerned 'no deal' Brexit preparation), so I am not in a position to comment on their effect on pandemic preparedness either way.

37. In 2019, the UK was rated one of the two countries best prepared for health emergencies by Johns Hopkins University (JH/5 - INQ000146027, p20). This is in part due to our focus on health security over many years, the expertise of our scientists and the fact we devoted considerable resources to exercises like Cygnus and Alice. This is not to justify the fact that there were gaps in our preparedness but simply to point out it was not a narrow British view that our preparations were good.

Section 3: Lessons from East Asia

38. As mentioned, one of the themes of pandemic planning in Europe and North America was that there was no recent experience of a responding to viruses with the wide reaching health security implications of the Ebola or SARS outbreaks. This may have led to the assumptions, which became part of a groupthink, that considered that the primary way to respond to a pandemic was the pandemic flu playbook.

39. By contrast, it is helpful to consider the response of South Korea in more detail. Recent experience of SARS in 2003, and of the largest MERS coronavirus outbreak outside the Middle East in 2015, informed their pandemic response.

40. The lessons applied from those outbreaks included the development of excess bed capacity for hospitalisation and isolation, rooms with renal dialysis and ventilation capacity and a sophisticated network of public and private laboratories to enable the rapid scale up of testing. By January 2020, cases were detected and the response was put in place leading to rapid identification and isolation of potentially contagious carriers. The result was that South Korea avoided a national lockdown in 2020 with no more than forty Covid-19 deaths on any one day in 2020[2].

41. Taiwan was similarly able to deploy rapid scale up of testing due to this recent experience. In addition, I would also highlight the speed with which they were able to deploy targeted contact tracing using smart technology to identify those who may have been exposed to the virus within a few days. Although a much smaller country than the UK in terms of population, this meant that during the early stages of the pandemic the Taiwanese health authorities were very effective at identifying the source of coronavirus infections[3]. This, combined with early restrictions on international travel, effectively limited the spread of the virus by requiring those who may have been exposed to it to quarantine.

42. By way of further lesson, as a result of their experience during the SARS outbreak, all hospitals in Hong Kong were required to maintain 3 months' supply of PPE[4].

43. In the countries mentioned above, the focus was on surveillance and containment, community testing, contact tracing and isolation, and stockpiling PPE and ventilators. That approach contrasted with the UK's deprioritisation of community testing and isolation once the virus spread beyond a few cases from overseas.

44. I have also argued elsewhere that even if, in those early stages, the UK had not been willing to learn from East Asia, then the flaws of the UK's approach could have been

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[2] https://covid19.who.int/region/wpro/country/kr
[3] Po-Chang Lee et al, "What we can learn from Taiwan's response to the covid-19 epidemic" BMJ 21 July 2020 (JH/6 - INQ000146029).
[4] Wong ATY, Chen H, Liu S-H, et al, "From SARS to avian influenza preparedness in Hong Kong" Clin Infect Dis 2017;64:S98–104 (JH/7 - INQ000146030).

apparent from studies published in connection with the Spanish flu epidemic a century earlier: early and forceful measures, far from worsening the economic downturn, correlated with a faster recovery thereafter[5].

45. Had the UK followed such a strategy, then this stood to impact not merely upon the number of deaths in the first year of the pandemic, but also the prospects of avoiding national lockdowns.

46. These ambitious approaches can further be contrasted with the stopping of test and tracing in March 2020, and the late timing of the development of the UK "Test and Trace Scheme", instituted from a standing start only in April and May 2020.

47. The key lessons from countries such as South Korea and Taiwan were that by a combination of early border controls, localised rather than national lockdowns and strict testing/quarantining, the spread of a Coronavirus could be contained in the initial pre-vaccine phase.

48. However, it should also be noted that their response was found wanting in the later stages of the pandemic when some Asian countries (China being the most prominent example) found themselves unable to emerge back into normal life because they had failed to roll out an effective vaccine as quickly as the UK, Europe and the United States. Whilst there is much to be learned from their approach in the early stages of the pandemic, the opposite is the case later on.

Section 4: Funding and economic policy

49. My tenure as Secretary of State for Health coincided with the fiscal constraints of Government spending then in place. The budget of the National Health Service was protected from the most difficult elements of an austerity period. Unlike other government departments whose budget was cut (including my own Department of Culture, Media and Sport in 2010), the Government continued to increase health funding in real terms. I concluded early on, however, that the NHS required more funding, particularly after seeing poor care caused by short-staffing in Mid Staffordshire and other hospitals.

[5] Sergio Correia, et al, "Pandemics depress the economy, public health and interventions do not: evidence from the 1918 flu", SSRN, 5 June 2020 (JH/8 - INQ000146028).

50. At the same time, however, the NHS faced a rapidly rising demand for services from an aging population, an increase in the number of people living with multiple long-term conditions, and the continuing need to fund new technologies and drugs (JH/9 - INQ000146023 paras 2.33 to 2.42).

51. The Department's 2012-13 Annual Report records growth in cash funding set to increase by £12.7 billion by 2014, compared to 2010/11. The 2013 Spending Round, commenced in June 2013, resulted in a further £2.1 billion increase in real terms.

52. In the Spending Review of November 2015, I secured an increase in the overall settlement for the NHS of £10 billion in real terms, with £3.8 billion of this increase provided to the NHS in 2016-2017. The additional money was to enable investment in the NHS England's Five Year Forward View. The settlement increase was earmarked for NHS England and frontline NHS services, and coupled with a requirement from the Treasury for me to make real cuts in other areas part of the Department of Health budget. This included funding for bodies such as Public Health England.

53. In 2018, after protracted negotiations led my myself and Lord (Simon) Stevens, the NHS received an agreement for an additional 3.4% increase in real terms funding for each of the following five years equating to an increase of £20.5 billion in its annual budget.

54. More specifically in relation to pandemic preparedness, funding for global health security increased after 2015, including (but not limited to) the UKVN already mentioned. Since the 2015 Spending Review, the DHSC has committed over £300 million in this area.

55. I have been critical elsewhere of the rather random process by which such funding increases are achieved, and have advocated a more rigorous and logical process for the estimation of the amounts needed. Improvement in this regard would undoubtedly have a positive impact on the UK's ability to ensure that it is adequately resourced in terms of pandemic preparedness.

56. In addition, I am of the view that a corresponding exercise needs to be conducted with respect to the planning and funding of social care. One of the regrets of my time as

Secretary of State for Health, and Health and Social Care, is that I was unable to secure a longer term funding settlement for social care approximating that secured as part of the NHS funding deal in 2018. The establishment of a long term plan to relieve pressures and iniquities in the provision of social care to patients and their families. As mentioned earlier, I was able to mitigate this somewhat with the money I found for social care as Chancellor in the Autumn Statement of 2022.

57. I have asked myself whether there were any key decisions on economic policy and the funding of public services which should have been taken differently. I think it is difficult to approach this without understanding the context of the coalition government that was formed in 2010 with the immediate responsibility to tackle an enormous deficit resulting from the 2008 financial crisis. Our clear advice was that failure to do so would lead to a potential collapse of the pound and confidence in the UK by international markets. I supported then and still support the broad approach taken by that government.

58. In this context, I have been asked for my perspective as the current Chancellor of the Exchequer. Following the funding increases of 2018 and during the pandemic, the NHS is now funded at similar levels to other peer countries as a proportion of GDP. But that does not necessarily mean within the envelope of NHS funding that the right balance of funding decisions are being made with respect to pandemic preparations.

59. In response to the global financial crisis of 2008/9, the Treasury reformed its operational and organisational procedures (JH/10 - INQ000146022). One such change was to implement alteration to organisational structures to enable faster allocation of resources in a crisis-response, which was of particular importance during the Covid-19 pandemic.

60. During the pandemic itself, the Treasury also increased the frequency of meetings of the key economic management boards to allow more regular and in-depth discussions of risk management and implemented significant changes to the Spending Control Framework to allow the decisions to be taken at speed.

61. Since the pandemic, attendance at the Treasury's Economic Risk Group has been extended to a wider range of teams, to ensure that economic and financial stability risks are better factored into the department's wider processes for risk management. Lessons have also been learned in how government manages fraud risk specifically.

The Public Sector Fraud Authority was launched in August 2022, with an additional £24.7 million over 3 years to turn the existing Government counter-fraud function into a new Public Sector Fraud Authority.

62. I have been asked specifically for my views with respect to the funding of localised contract tracing capacity, domestic PPE production, domestic vaccine research and production, and their establishment within the UK. I believe that all health systems should prioritise appropriate pandemic preparations within the funding they receive including making sure they have the capacity to stand up PPE production and testing capacity quickly. I also think we need to develop the capability to speed up vaccine discovery and production within a much shorter timespan.

Section 5: Workforce planning

63. The prediction of how many doctors and nurses the NHS needs is, inevitably, difficult given new discoveries in bioscience and medicine. That difficulty is compounded by the fact that it typically takes seven years to train a doctor, and three years to train a nurse; and by a global shortage of medically trained professionals. This all leads to high vacancy rates within the NHS. Poor workforce planning has resulted in an increase of expenditure spent upon locum doctors and temporary/agency staff to fill gaps.

64. I also found to my cost that the best intentions of ministers can be thwarted by unexpected changes in working patterns. I promised an extra 5000 GPs in 2015. By 2018 when I left the Department of Health we had only increased the full time equivalent by a few hundred. That was not because we did not increase the flow into general practice from medical schools but because there was an unexpected increase in the number of doctors working part time upon completion of their studies.

65. In 2016, the then Prime Minister accepted my recommendation to increase the number of doctors trained in the UK by a quarter. Five new medical schools opened. There was an equivalent increase in the number of nurses and midwives. Unfortunately, because of the time take to train new doctors, no additional doctors arrived ahead of the pandemic as a result of this decision. I acknowledge that general workforce pressures caused by issues such as this are likely to have had an effect on the resilience of the public health sector, but I believe changes have been put in place to ensure that this picture continues to improve over time.

66. As I have written elsewhere, one of the things I learned in my time as Health Secretary and wish I had understood better at the outset was the importance of workforce planning. This was not something I implemented while Secretary of State because it took me some time to appreciate the full picture. I was also not advised to place more emphasis on this because the NHS had a longstanding habit of relying on immigration to fill any gaps. However, with a two million shortage of doctors globally according to the World Health Organisation, this was not a sustainable position in the long term.

67. I believe we needed to go further. The consideration of the number of doctors and nurses which the UK needs to train has not historically received the priority it deserves. Rather than being subject to short-term consideration in negotiations between the Department of Health and the Treasury around spending reviews, it requires a longer term, strategic, view.

68. I have previously advocated a change in this system so that independently verified estimates are published of the number of doctors and nurses likely to be needed. Although I have previously suggested that this role could be undertaken by some form of independent body, I have in fact been able to bring about some important change more quickly since becoming Chancellor of the Exchequer. Following my Autumn Statement of 2022, publication of independently verified NHS workforce estimates is now Government policy, and is subject to the same democratic scrutiny as any other such policy. I hope that such an approach will help to ensure that the NHS has the resources it needs to face the challenges of the future, including any pandemic to come.

Section 6: Key lessons learned

69. I understand that the Inquiry will be interested in my own views as concerns the key lessons and conclusions concerning planning, preparedness and resilience to be drawn from our experience in the pandemic.

70. As I have set out above, I share the view that a greater diversity of expertise and challenge – including from practitioners from other countries (including countries with recent experience of SARS and/or MERS outbreaks) – would have assisted the framing of plans emanating from the exercises I have outlined above. To minimise the risk of groupthink materialising, I consider that the furtherance of transparency, the

fostering of and encouragement of "contrarian" views (for example, by way of 'red team/blue team' exercises, in which a team is deliberately set up to challenge a planned way forward) and the avoidance of hierarchical structures would assist. In my view these are cultural changes that would increase the resilience of the Department with respect to future pandemics.

71. We needed to consider (and improve) our capacity for running ongoing care and operations, in a virus clean environment, during the course of a pandemic. The solution to this is clearly connected to the wider issue of workforce planning.

72. More generally, I also consider that more expansion of the NHS workforce, and consequently of its surge capacity, would have assisted in the preparation for and early stages of the pandemic. As I have stated above, I think that we have taken steps to improve NHS workforce planning.

73. In summary, I consider that the UK's pandemic planning was too narrowly and inflexibly based on the flu model and that NHS capacity responded strongly, but at the cost of more routine treatment areas, and should be the subject of more long-term planning. I have explained the reasons why I consider these to be important above.

Section 7: General reflections

74. I don't think there was any deliberate decision not to prepare for a pandemic: quite the opposite. Extensive preparations were made. They were just not always up to the task of responding to a virus as dangerous as Covid-19. I believe the biggest failing was not to be more open-minded about the kind of virus we were likely to face in an age of international travel.

75. We should also remember our successes and the remarkable dedication shown by those working within the NHS and beyond. The UK has punched well above its weight in terms of helping the world find a solution to the challenges of the pandemic.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Personal Data

Signed: ______________________________

Dated: ________20/04/2023______________