Witness Name:

Statement No.:

Exhibits:

Dated:

UK COVID-19 INQUIRY

DEPARTMENT OF HEALTH AND SOCIAL CARE

Module 2: First Witness statement of the Right Honourable Sajid Javid

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1. I, Sajid Javid, MP for Bromsgrove, will say as follows:

INTRODUCTION

2. I make this statement in response to a request from the UK COVID-19 Public Inquiry (the Inquiry) dated 10 July 2023 made under Rule 9 of the Inquiry Rules 2006 (the Request) asking for a personal witness statement for my recollection of some of the core political and administrative decisions made in respect of Covid 19 between 1 January 2020 and 24 February 2022 and my recollections and views in the role I played as Chancellor of the Exchequer and Secretary of State for Health and Social Care in such core decision making.

3. This statement covers the period set out above. Where it is necessary to refer to events outside that date range, I will make that clear and explain why I have referred to that event. This statement is to the best of my knowledge and belief accurate and complete at the time of signing. Notwithstanding this, it is the case that the Department of Health and Social Care (the Department) and the Treasury continues to prepare for their involvement in the Inquiry. As part of these preparations, it is possible that additional material will be discovered. In this eventuality the additional material will of course be provided to the Inquiry and a supplementary statement will be made if need be. I shall refer to parts of the corporate witness statements filed on behalf of the Department where appropriate and necessary.

Recollection/recall

4. I can remember some events which took place during this period but would identify that I have sought to look at contemporaneous material from my private office or from briefings and submissions to examine what decisions I made during this period of time. Much of my recollection of the detail of what happened and when has been obtained from that information, and in particular my official diary, and the notes taken by my private office. As can be imagined, I was undertaking a significant number of meetings in any one day. I did keep some notes at the time but only in a rough format. I have sought to find such notes as are in my possession and have exhibited them where relevant. I did not keep notes routinely. I have also consulted with a special adviser in my private office at that time (Samuel Coates) who was involved in the vast majority of meetings that I attended when drafting this statement.

5. Given the time constraints, the Department has not been able to conduct a full search of all potentially relevant documents but has sought to find relevant documents which highlight the essential issues which this witness statement raises. I have also been unable to go through all the documents I received during this period of time given the need to finalise this witness statement.

My method of working

6. During my time, at the DHSC (and in other Departments), my general rule was to try and see all submissions that were directly addressed to me. However, there was a system in place so that I may not have had sight of all submissions sent to me - as I authorised my special advisers and private office to exercise their discretion to ask that documents be resubmitted if they considered that they did not meet the brief or where there were gaps which needed to be answered before I could make a decision. There was a system devised so that all submissions would first be considered by my special advisers, who would be able to make comments or notes to me about them, then to my private office and finally to me who would do the same. My private office had discretion as to when submissions would be put into my ministerial box for me to consider. My box was split into three sections (1) a decision file containing submissions for my consideration (2) a correspondence file containing letters for signing and (3) a file for "information only" which was for matters which included studies and reports. I may therefore not have seen all submissions made on all topics during my time as Secretary of State but sought to read all submissions meant for me.

Career history / Ministerial appointments (Question 3 and 25)

7. I first became an MP in May 2010. Prior to this I had a career in investment banking over 18 years working in various roles in Chase Manhattan Bank and Deutsche Bank, including working in New York from 1992-1996 and Singapore from 2007 - 2009.

8. In November 2010, I was appointed a Parliamentary Private Secretary (PPS) to the Minister of State for Further Education in the Business, Innovation and Skills. This was my first government post. I then became PPS to George Osborne, who was then Chancellor of the Exchequer in October 2011. In September 2012, I became Economic Secretary to the Treasury and then in October 2013, became Financial Secretary to the Treasury. My first Cabinet role was Secretary of State for Culture Media and Sport, along with being Minister for Equalities from 9 April 2014. I was made a privy counsellor in April 2014. Following the general election of 2015, I was appointed Secretary of State for Business, Innovation and Skills. In July 2016, in Theresa May's first cabinet, I was appointed Secretary of State for Communities and Local Government. On 30 April 2018, I was appointed as Home Secretary. On 24 July 2019, following on from Theresa May's resignation and the subsequent election of Boris Johnson as leader of the Conservative Party and Prime Minister, I was appointed as Chancellor of the Exchequer.

9. I was Chancellor of the Exchequer until 13 February 2020, when I resigned. I did so because whilst the Prime Minister asked me to remain in post, he also asked me to dismiss all of my special advisers at the Treasury and replace them with No10 appointees. I made a personal statement in Parliament on 26 February 2020, setting out my reasons for resigning.

10. I then became a backbencher until 26 June 2021. During that time, I did not participate in any Select Committees; I did not join any MP groups, some of whom had formed various groupings to promote like-minded causes (for example, the Covid Recovery Group of MPs) and largely kept my counsel. I did not want to be seen as interfering from the back benches and was also aware of the complexity of decision making in crises, not all of which could be explained fully in public (because, for example, of national security considerations). I did my job as a constituency MP, and broadly supported the government on its programme in respect of Covid. I also led a project at Harvard looking at lessons from international governments for how to prevent and better manage future pandemics. I did not recall seeing the Prime Minister in person while I was a backbencher, except for one occasion in 11 July 2020 when I had lunch with him, and his wife in the garden at Chequers. This

was not a work event but of course work was discussed. I checked beforehand if this meeting complied with the rules in place at the time (which at that time permitted outdoor meetings of more than six people) before attending the event. I also saw the PM in his office in No. 10 on 1 December 2020.

11. On 26 June 2021, I was appointed as Secretary of State for Health and Social Care following the resignation of Matt Hancock. I resigned from this role on 5 July 2022. I am now a backbench MP and I am standing down at the next election. Prior to this point in time I had not been involved "behind the scenes" in working with Matt Hancock or in providing advice. I had a social breakfast with him (in a garden) on 7 May 2021.

12. I have agreed to be a Commissioner for the Institute for Government on its project called the "Commission on the Centre of Government" to examine how to improve the ways that No. 10, the Cabinet Office, and the Treasury work. As part of that I spoke at an event held on 3 July 2023[1] about the strengths and weaknesses of the centre of government. I consider that whilst this has not been entirely influenced by my experiences of the response to Covid 19, but by my entire ministerial career, that the Inquiry may find my recommendations to improve decision making to be helpful to their consideration of the issues raised by this Module of the Inquiry. I have therefore set out some of my observations during the course of this statement.

Chancellor of the Exchequer

13. I have been given a copy of the witness statement of Dan York Smith, the Director General for Tax and Welfare who provides a corporate witness statement on behalf of HM Treasury as well as the witness statement of Kate Joseph, Director, who provides a corporate statement on behalf of HM Treasury [SJ/1: INQ000215049 and SJ/2: INQ000215607]. I have used this chronology to seek to recollect my involvement as Chancellor of the Exchequer.

14. The Chancellor of the Exchequer has a very broad portfolio to manage the economic health of the government and the country. During my time in office from December 2019, my job would have been primarily to prepare for the Budget to be given in March 2020 and to identify how priorities from the manifesto should be funded. The Treasury is the only Department in government, which is responsible for not just spending money, but also identifying how much money can be raised from various taxes and other sources of

[1] https://www.instituteforgovernment.org.uk/event/sajid-javid

governmental income raising powers. It has a responsibility to set the Annual Budget which has to be passed by Parliament which sets out various fiscal commitments: it also has to identify and negotiate with each of the spending departments at a "spending review", which takes place every 2-3 years, how much money they will be allocated over that period of time. It therefore has a "bird's eye" view of what is happening across government and also a deep responsibility to examine not just what is going out of the coffers, but what may be coming into them as well.

Role as Chancellor in decision making about Covid 19 (Questions 11 and 16 - 24)

15. My involvement as Chancellor of the Exchequer with Covid 19 was limited to none, as my resignation took place before there were extensive cross governmental discussions about the response from the United Kingdom to Covid 19. I did not attend, nor do I recall being sent notes of, the COBR meetings which I understand took place in late January and early February 2020, chaired by the Secretary of State for Health. There may have been a Treasury official or minister present at those meetings, but I do not recall being asked to attend. The "usual" informal rule for COBR meetings was that the more senior the Secretary of State, the more likelihood that other Secretaries of State would attend. Otherwise, it was usual that officials or junior ministers would attend - as can be seen from this afternoon update as an example [SJ/3: **INQ000328748**].

16. I vaguely remember the Tuesday before my resignation (so the 12 February 2020) that Matt Hancock gave an update on the situation in respect of China at the Cabinet meeting held that day [SJ/4: **INQ000328747**]. I cannot remember that it was a significant part of the conversation, and I cannot remember exactly what was said. I do not remember there being any discussions about precautions, or pandemics or other major health risks at that Cabinet meeting. I cannot remember any other discussions or any major concern about this situation as it related to the risk to the UK. It was primarily a tone of reassurance.

17. I am reliant upon the documentation that the Treasury has found (and would ask the Inquiry to note the limitations to such searches set out in the Treasury witness statement [SJ/1: INQ000215049 at paras 8-10]. As the Chancellor, I was sent a vast array of submissions and other materials daily, some of which I would be asked by my private office to read, but much of which was dealt with directly by my private office. Private office officials, particularly for the Chancellor of the Exchequer, are exceptionally able civil servants, part of whose role it is to decide what I needed to see or react to and in what timescales. I would also be copied into hundreds of decisions made by other individuals within the

Treasury and other ministers but being copied in did not mean that I necessarily saw the decision or participated in decision making about it. Every evening I would work on my "boxes" which are a set of urgent decisions to be made overnight. I would often initial those boxes or make comments in manuscript hand upon them which would then be given back to my officials

18. I remember receiving a briefing about the impact of Covid 19 on the Chinese economy in early February 2020. I have been pointed to the briefing advice sent to me on 5 February 2020 [SJ/5: **INQ000328752**]. This identified that there would be a potential impact upon the global and UK economy from the shutting down and slowing of the Chinese economy because of the impact that the pandemic would have [SJ/6: INQ000088043]. I then wrote a letter setting this out to the Prime Minister [SJ/7: **INQ000328746**]. The advice I received was that the UK would only be "modestly affected" by this slowdown in China and that the UK banking sector should be able to withstand a global economic slowdown, although much depended upon the virulence of the virus [**SJ/3** **INQ000328748**]. I do not remember the Treasury providing me with any advice about the direct impact of NPIs or a pandemic upon the UK economy at that time.

19. I do remember raising concerns with the Treasury about the risk of pandemic spread, and the health impacts to the United Kingdom of Covid 19 in the week leading up to my resignation. On the Thursday or Friday prior to my resignation (so around 7 February) I was becoming concerned about the possible impact of Covid 19 beyond the economic impact upon a diminution of the Chinese economy and difficulties with supply chains and deliveries of goods from China to the UK. I was becoming annoyed that the Treasury advice was not including advice as to what the impact would be if the pandemic arrived in the UK. I also remember that the Cabinet Secretary was sent briefing advice from the Treasury about the potential economic impact on the UK of what was happening in China.

20. I was particularly concerned about the absence of any strict border controls in the UK from flights coming from China to the UK during this period. Part of this came into my consciousness because of a discussion I had with some friends whilst at a social occasion. One of them told me that he was concerned that the virus could spread and that many people would be vulnerable. I also remember these friends telling me that they had stopped attending events where they thought the virus may be spreading in the UK, and that a friend of a friend (who was an epidemiologist) had raised concerns as to why flights were not being stopped. This led me, along with my reading in the newspapers, to wish to raise concerns with other members of the Cabinet and the Treasury.

21. On the fringes of a regional Cabinet meeting on 31 January 2020, my concern was such that I spoke to the Secretary of State for Health, Matt Hancock and Dominic Raab, who was Foreign Secretary. I told them about my concerns - in particular why flights were still running freely between China and the UK. Dominic Raab agreed to look into it. Matt Hancock said he had already asked about this and had been told that stopping flights was not recommended. I have been pointed towards official advice which I received the following day from HMT (February 01), which I accepted. However, my concerns were raised again over the following days such that I asked for a phone call with the relevant officials on Monday 11 February involving Dominic Raab, Matt Hancock and myself [SJ/9: **INQ000328751**]. We met together in the FCDO building and spoke together with Sir Chris Whitty, the CMO. There may have been other scientific advisers there, but I remember this was the first time I had interacted with the CMO on the virus. I remember challenging Sir Chris Whitty as to why flights were not being stopped as a precaution from China, and Dominic Raab also asked that question. Sir Chris Whitty advised us the public health case for doing so was extremely limited, as it would make no meaningful difference to the spread of the virus. I kept challenging this on the call and was told that if the virus is coming, it would already be in the United Kingdom. We three ministers were a little unsure about the advice but recognised that he was the CMO and so was far better informed than us on this issue. I was left a bit bewildered but accepted the advice (not to stop flights from China to the UK).

22. Around the same time as the call with the CMO, I recall an internal HMT discussion on the situation in China that I had asked for. The Permanent Secretary Sir Tom Scholar said that flights should not be stopped or limited from China because of the possible economic damage that could do to the UK. [SJ/10: **INQ000328750**]. I was clear in my view that this was not important, as the alternative if the virus came to the UK could be much more serious than simply the effect of the loss of direct flights and along with it tourists and others coming to the UK. I remember that the advice of the Treasury was clearly not to interfere in any way with our economic relationship with China. The Treasury officials also thought it odd that I was asking about stopping flights, and I remember my private office relaying to me that Treasury officials could not understand why I was pushing it. I also remember asking what country had stopped flights with China and remember receiving the answer that Taiwan had. I remember thinking that if Taiwan was doing it, then they probably knew something that we did not.

23. My view is that the concern of Treasury officials about my wanting to know something beyond the economy - as the issue of controls at the border was not a directly economic

issue - reveals a concern I have about the Treasury and the way that it operates and sees things. Even though it has a wide-ranging impact across government, I found during my time occupying various roles within the Treasury that its focus was narrowly upon how the economy was performing. So, global events were only reported upon if they directly impacted the UK or global economy, and not otherwise.

24. By the time I became Chancellor of the Exchequer, I had been a Minister for nearly 10 years and had undertaken training in aspects of crisis management and decision making relating to national security during my time as Home Secretary. I had no training on crisis management in any other office of state, and there was, and still is, no general training on managing emergencies and leadership in a crisis that I can remember. I view this as a mistake. All ministers need to be able to deal with crises and manage them effectively. The vast majority of jobs undertaken outside Government do not require the same scale and range of decision making, and the speed of decision making. As I reflect upon further down in my evidence, if I had not had a decade's worth of experience as a Minister, I would have found my time as Secretary of State for Health and Social Care much more challenging and I am not sure that I would have been able to make some of the decisions that I was cautioned against, but which turned out to be the right ones.

25. I am asked about the impact that Operation Yellowhammer had upon HM Treasury capacity in January and February 2020. The answer was none. The election had been held upon Boris Johnson's proposed EU deal, so it was known by January 2020 that there would not be a "no deal". Given that, the Treasury were not working on Yellowhammer, although the Treasury were very focussed upon the details of the deal and were involved in negotiations with EU officials and others. I did notice - however - that some of the work I did on Yellowhammer seemed to have been usefully re-purposed as part of the pandemic economic response intervention (such as the furlough scheme + business support).

26. I did not see any modelling in respect of non-pharmaceutical interventions (NPIs), any economic plans in respect of Covid 19 response, any discussion about vulnerable or at-risk groups, or any financial packages to be provided to anyone during my time as Chancellor.

27. I do not think that the reshuffle of 13 February 2020 materially impacted upon the Covid 19 response. Whilst it would be flattering to think that I would have done a good job if I had remained, Rishi Sunak was already my very capable deputy at the Treasury and its response to the pandemic was in my opinion materially the same as if I had been Chancellor. I spoke with Rishi Sunak on one occasion after he became Chancellor as a

courtesy (but prior to the introduction of any stringent non pharmaceutical interventions) to discuss the contents of the Budget that I had been preparing when I resigned. I did not speak with the Chancellor, nor exchange messages with him, on the pandemic as I felt that if he needed me, he would contact me and I did not want to be seen as carping from the side-lines. I did, however, in March 2020 send the Chancellor and the PM an unsolicited short note of potential economic measures that could be taken during the national lockdown.

Decision making structures (Questions 4 - 11)

28. In my opinion, the "key" decisions which were taken during my time as the Secretary of State relevant to the Covid response (some of which involved No 10 and the Cabinet making the decision, and some did not) were:
    (a) Decisions on and about international travel - both those leaving the UK and for international travellers, involving placing various countries on the "traffic light system," and vaccine recognition for those vaccinated abroad. There were a significant number of decisions made about these issues throughout the summer and into the winter of 2021[For example: SJ/11: INQ000092045; SJ/12: INQ000092090].
    (b) The NHS Covid 19 pass and use of it [For example: SJ/13: INQ000237535; SJ/14: INQ000146802].
    (c) Domestic policy on the need for vaccination for entry to places within the UK.
    (d) Decisions on administering booster vaccinations and the prioritisation of such vaccines for ages 12 to 15 in the Autumn of 2021 [SJ/15: INQ000091995; SJ/16: INQ000092112].
    (e) "Step 4" decision to remove many restrictions on 19 July 2021 [SJ/17: INQ000088901; SJ/18: INQ000092214; SJ/19: INQ000088903; SJ/20: INQ000092034].
    (f) The decision to offer vaccination both to those aged 12-17 (made in July 2021) [SJ/21: INQ000092173] and those aged 5-11 [SJ/22: INQ000112226; SJ/23: INQ000074843] (made in February 2022).
    (g) The decision made to end the shielding programme and the policies in respect of those identified as "Clinically Extremely Vulnerable" (made in September 2021) [SJ/24: INQ000092105].
    (h) Changes made to self-isolation for those who were fully vaccinated [SJ/25: INQ000064021; SJ/26: INQ000092992].

(i) Additional money for the NHS to support it during the winter of 2021 and the "winter plan 2021" for the NHS (an additional £5.4 billion was allocated to the NHS to support the Covid 19 response)

(j) The Autumn and Winter response to Covid 19 - Plan published on 14 September 2021 [SJ/16: INQ000092112][2]

(k) The setting up of the UK Health Security Agency (UKHSA) and transfer of functions into UKHSA and from PHE to the Department, NHSE and NHS Digital, including the launch of the Office for Health Improvement and Disparities (OHID)

(l) The Omicron variant including (a) travel restrictions and (b) measures to contain the variant including whether or not mandatory restrictions should be reimposed, (c) the need for booster vaccinations for all those over the age of 18, and an additional dose for those who were immunosuppressed and (d) procurement of relevant anti-virals (where there were many and daily meetings from the end of November 2021 - February 2022) (Examples of major decisions include, for example: [SJ/27: INQ000092181; SJ/28 INQ000092199; SJ/29: INQ000092197; SJ/30: INQ000091584; SJ/31: INQ000091593]

(m) The Living with Covid Plan issued in February 2022 [SJ/32: INQ000086652][3]

Relationship with Cabinet Office and No 10

29. I have been asked a series of questions about decision making structures during the pandemic and my view as to their efficacy in respect of No. 10 and the Cabinet Office. Covid required a "whole government" response, and the place which co-ordinates that is the Cabinet Office and so use of that structure was right. I have said that the Prime Minister's Office is not as strong or as expert as it could or should be. Given the responsibilities which the Prime Minister has and the size of the other departments in central government, the team of officials and advisers around him are probably too small for him to be able to push the priorities and to stay on top of what is happening around him. That is the case in "peacetime". During Covid, that became particularly important.

30. Second, I would identify that one of the weaknesses of governing in this country is the difficulties in having effective cross governmental work. Many policies designed to improve the lives of the UK public require cross departmental policy-making and alignment of those priorities. For example, and as the Inquiry is aware, health inequalities are created in large

[2]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1020982/COVID-19-response-autumn-and-winter-plan-2021.pdf

[3]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1056229/COVID-19_Response_-_Living_with_COVID-19.pdf

measure by socio economic determinants relating to early years, such as housing and the environment. To tackle and improve the health of the nation, we therefore need good quality early years education, access to leisure facilities, encouragement of physical activity, to have a system which promotes healthy foodstuffs and discourages excessive alcohol consumption or smoking, to have good quality housing, to have clean air, and more). That needs to be delivered by a large number of government departments working together. My experience is that it is very difficult to make the machinery of government function in a way which is truly cohesive and coherent. I believe that there needs to be a change to the machinery of government to try and deliver these cross governmental programmes in a coherent way.

31. The machinery of government and reforms to it do not win elections, and can create short term disruption. They are not likely to feature at the centre of manifesto promises of any party, but I consider it to be essential to make changes to enable cross governmental working to become the norm, and not the exception.

32. I also consider that Covid showed us how flexible, radical, and innovative governing could be, and that this should be used to go forward when policy making and delivering services. There are often accusations that the executive is sclerotic and decision making is slow. There is also a view that the civil service is generally risk averse. But during the pandemic, to a large measure the "rule book" was thrown out of the window. To give an example, I cannot conceive that, absent a crisis, the Treasury would have funded the development of 8 or 9 vaccines as they did during Covid, knowing that many of them may not be successful or come to fruition. That crisis enabled the Treasury and others to take a riskier approach, knowing that not all of the funding would necessarily lead to a vaccine because the alternative was to prolong the pandemic. I would like to see that sort of radicalism become orthodox even where there is not a crisis.

33. I also consider that with climate change, and the threat of future pandemics alongside the current unstable political and economic situation across the world (and a war in Europe), it is necessary to prepare ministers and officials to deal with crisis as one of their core skills. The future will not be "business as usual" and it is essential that everyone has the training and preparation to deal with crisis.

34. My last general point, which refers to the role of the Cabinet Office/Prime Minister's Office and the Treasury is that when you are working in a spending department as Secretary of

State, your role is to work on the objectives of that Department and try and involve the centre as little as possible. That should change.

35. I was not involved in decision making about the response to Covid 19 on a day-to-day basis until June 2021, by which time the relevant decision-making structures had been operating for a considerable period of time. As someone who had been a minister in several departments, I had attended COBR based on emergencies on several occasions (for example, during the Grenfell Tower disaster). My experience of COBR was that it was effective in dealing with an emergency situation and that meetings could be convened quickly and actions were taken immediately (I remember that the screen at COBR set out in "real time" the actions to be taken whilst the meeting was ongoing so that they could take place immediately). I did attend Covid S meetings (ministerial meetings were Covid "S") but was not in post to attend the Ministerial implementation group or other meetings. I will speak of my interaction with those from the devolved nations later in this statement. I attended daily meetings internally within the DHSC, with other ministers and officials. I would also attend Cabinet.

36. I consider that it was appropriate to use the Cabinet Office structure and to have the "centre" to make decisions about Covid 19 because they were decisions which impacted the whole of society and needed to be taken centrally. Central government and the Cabinet Office were also needed to coordinate what was happening in different parts of the government and making sure that they all worked in concert. The Cabinet Office machinery for coordination was headed up by Michael Gove during the time that I was the Secretary of State for Health and Social Care. I consider that the Cabinet Office structures were broadly effective, but not always speedy.

37. I consider that the Cabinet that went into the pandemic had less experience of being in government or holding offices of state than many previous Cabinets. They were not a team who were well versed in the affairs of government outside of a crisis, and I can imagine that may have caused difficulties during the pandemic. My view is that the Cabinet was designed to place Dominic Cummings and the Prime Minister as the decision makers: the goal was to centralise power in No 10 with a preference for loyalty over experience.

The 8.30am decision making meeting

38. In respect of daily decision making, my experience of No. 10/the Cabinet Office was that most decisions about the Covid response were made at a daily meeting - which during my time in the Department was held with the PM and other key people involved in health at

8.30am - so that would be relevant ministers, and the Heads of the NHS (and others working in NHS England such as Steve Powis the National Clinical Director) the CMO, the CSA, Jenny Harries and Susan Hopkins of UKHSA. This was what I would call the "main meeting" at which decisions were made, for example, about NPIs. Other meetings would feed into this meeting. Those meetings were well structured, decisions were taken, and I found the "drumbeat" of having a daily meeting helpful.

39. I was also very impressed about the quality of the information that I would be given for this meeting. I had a daily Covid "sitrep" data pack which was printed out and on screen (provided by the Cabinet Office) which had all the data about the number of infections, how many patients in hospital with Covid, how many discharges, and the position in respect of other countries. It was very detailed but was also presented in a way that a non-scientist or expert could understand.

40. The meetings would involve everyone having a say about the decision to be reached. The Prime Minister wanted to listen to all the different views in the room, would ask questions and "test" the arguments and he would then make the decision. I felt my voice was heard, but also the other voices in the room.

41. Occasionally, a decision would be taken in this meeting, and it would then change without any explanation. Sometimes this would be on things which were not very important, but on other matters there were sometimes changes which had significant impacts (such as changing the date by which the vaccines were to be procured).

42. I recall two areas in particular where I considered that key decisions were being changed by the Prime Minister, firstly the wearing of masks and secondly the vaccine passports. The science was changing with greater information about the impact of mask wearing which would be discussed frequently with the UKHSA and the CMO/CSA in the 8.30 meetings, with debates as to what the science meant and where it led. But there was a lot of debate in Parliament about this and about what other countries were doing, and so this was the subject of much debate and discussion. Attitudes towards vaccine passports changed significantly in No10 during a time of political pressure.

43. My observation was that decisions were often made (from the centre) at the last minute because of lots of back and forth between departments which all had different views. For example, during my time at the Department there were decisions which had to be made about whether travel restrictions should be put into place for certain countries. I would be

advocating for restrictions on the basis of the risk to health, but if the Foreign Office wanted to improve diplomatic or trading relations with the country, or other financial investments, and knew that placing the country on a list would make it more difficult to enter the UK than it did for other countries, then it would advocate for a different course. The Department of Transport's concern about airlines and airports were the biggest source of resistance and backed up by HMT. I accept that it is the role of the Cabinet Office/Prime Minister to adjudicate between these competing considerations but consider that this sometimes meant that the decisions were only made very shortly before they needed to be implemented which caused confusion and problems with effective communication to the public and others.

Covid O and Covid S

44. I was involved in many decisions as part of the Covid "S" group which was a group which made decisions about key issues under the auspices of the "Covid Taskforce" whose role was to co-ordinate and harmonise decision making and implementation between departments and organisations. I would not attend Covid O meetings which I understood were attended by a larger group of people, but which would involve at times attendance of officials from the Department and also Junior Ministers. The Cabinet Office would set the agenda for the Covid S meetings and organise and arrange the papers for them. The Covid S group, for example, made decisions about international travel restrictions and the various lists which were in operation permitting, or not permitting, people to enter the UK, or to only enter if certain conditions were met (such as full vaccination). Whilst the Department's view would be given due prominence, and the CMO, Jenny Harries or other advisers from the UKHSA would often be present at the meeting to provide explanation and to give options and advice and to set out the scientific explanation, the meeting would be led by either Michael Gove or Steve Barclay (both of whom worked in the Cabinet Office at the time as Chancellor of the Duchy of Lancaster and the Minister for the Cabinet Office, respectively), and they would sum up the views and then it would be a joint decision between departments. The Department's view was not always the view that the other departments took and was not always followed. As a member of the Cabinet, I had to be mindful of the views of others, take their views into account and also to live with decisions which were not the preference of the Department.

45. I would note that the papers for these meetings would frequently only be supplied an hour or so before the meeting was to take place. This was problematic as it did not give me time to reflect on the views of others, or to discuss matters within the Department. Some of the

time it was necessary for these papers to only be disclosed shortly before a meeting because of the time implications within which decisions had to be taken. The Cabinet Office was also concerned about the leaks of information into the public domain before decisions were made (which had happened) and which could undermine public confidence and lead to unhelpful speculation within society so that the papers were only provided a short time before the meeting to lessen the likelihood of that happening. Whilst I understand the risk of leaks, I do consider that more time should be given as a general rule to ensure that decision making is not made "on the hoof" unless it absolutely needs to be. I also consider that sometimes, infrequently, papers were only circulated shortly before the meeting in order to ensure that a particular option was chosen and/or to prevent other options being put forward.

46. I also believe that some ministers wanted, for political reasons, to be seen as "anti non pharmaceutical interventions" i.e. NPIs and so would leak matters to the press if they received the briefing early. I cannot prove that this was the case but I certainly remember that very swiftly after Covid S meetings were finished, there would be material in the online media which described decision making within the meeting. I felt that this level of leaking was both inimical to good and open decision making and also deeply unhelpful in a situation where it was exceptionally important for there to be a clear and consistent message about the decisions to be taken. I felt it improper to seek to make political capital out of the differences of view given the need for collective responsibility (which is a *sina qua non* of Cabinet decision making). I also felt it was improper because this was a genuine health emergency, and it was important that some issues or matters did not go into the public domain for legitimate reasons and that decisions are made in the best interests of the UK - and not for political point scoring. I considered that there should have been more self-discipline amongst those who attended those meetings. I would also indicate that as political tensions increased about whether further restrictions were necessary (and as the leadership of the Prime Minister was put under pressure because of matters unrelated to Covid - namely the Owen Paterson affair which upset and caused problems with Conservative MPs) - I sensed and saw more and more leaking. For example, with the proposals about introducing more restrictions in response to Omicron, I noted that lots of ministers wanted to be hawkish and critical of NPIs and so the leaking became more and more common.

47. I would contrast my experience with Covid S - where the issues being discussed were potentially very injurious to the economy of the country or to diplomatic relationships (particularly around international travel), with that of my time on the national security

council where I was only ever aware of one leak which led to the minister being sacked. I consider that decisions taken in Covid S meetings should have been treated with equivalent seriousness and seen in the same way as national security issues. I favoured the importance of openness in a lot of pandemic communications - and was often open with people deliberately to get straight to the point. I do not know if the Inquiry may wish to explore whether such matters should be covered by the Official Secrets Acts or there should be some form of reprimand for leaking. I would, however, accept that there would be some legitimate concerns that could be raised about this suggestion: (a) The Official Secrets Act is often seen as allowing too much to be hidden which could be transparent (b) health emergencies and public health practitioners would see that maximum transparency and honesty is necessary for people to trust you and (c) it may mean that legitimate whistleblowing would be suppressed when that could be injurious to the health of the nation.

Advisers at No. 10

48. A large part of the role of some advisers in No. 10 is to deal with central government communications, in particular during the Covid 19 response when it was important that messages were made clear and were consistent between departments. No. 10 has a press room, provides press statements, and had a large media team. During my time in the Department, their job was to get the message across, to coordinate communications (for example, to suggest that I went on particular television shows to encourage vaccination or boosters), and to ensure that there was a clear line of what the government was saying and why it was saying it. The advisers who deal with these areas would speak regularly to me, to my Special Advisers and to the Departmental communications advisers and were very involved in the work on Covid 19 response.

49. I resigned in February 2020 before the pandemic in large measure because of the actions of the Prime Minister's Chief Adviser, Mr. Dominic Cummings, who was in post at the time. I would say that during my time as Chancellor, I considered that he sought to act as the Prime Minister in all but name, and he tried to make all key decisions within No. 10 - not the Prime Minister. I felt that the elected Prime Minister was not in charge of what was happening in his name and was largely content with Mr. Cummings running the government. I did not think that was right and that was why I ultimately resigned. On the day of my resignation, I told the Prime Minister that Mr. Cummings was "running rings around him" and "would not stop until he had burnt the house down".

50. Whilst I was not part of the front bench team, I did have occasional discussions with the Prime Minister before returning to government. The Prime Minister asked me in the summer of 2020 if I would come back and serve in government. I said that, given the crisis, I would help but only if Dominic Cummings was no longer part of his advisory team and that would be a condition of my return to the front bench.

51. Other than Mr. Cummings, about whom I have the views expressed above, I cannot remember having any significant concerns about other advisers in No. 10.

Spending review 2021

52. A spending review took place at the end of 2021. As health was the largest part of spending in this review, one of my roles upon taking office in the Department was to finalise this (it had been going on for some time when Matt Hancock was Secretary of State). During these discussions there would be the Chancellor, the Prime Minister and myself. None of us could have special advisers in these meetings. The Prime Minister's Chief of Staff would attend, and someone from the Cabinet Office to take minutes.

53. The money that the Treasury wanted to provide to the Department was significantly less than I, and the Department, considered justifiable to meet objectives. As part of the negotiations, the Permanent Secretary wrote to the Treasury to identify the concerns that the Department had with this spending review. From the DHSC's perspective, the health service had been stretched prior to the start of the pandemic, and the settlement proposed by the Treasury would not assist with the additional costs required to tackle the large waiting lists, to invest in the workforce on a longer-term basis and to invest in technology and diagnostics for the future. There was no dispute over the money needed to respond to Covid 19, but there was dispute over long term funding. This was also a period of time when the Prime Minister had made a pledge about the reform of social care by the introduction of a cap on the costs of such care and that also had to be funded. I was particularly concerned that the Treasury had not allocated any contingency for greater funding in case the unpredictable nature of Covid required more than was anticipated.

54. I knew that the settlement that the Treasury wanted to provide meant that I would have to find savings in the NHS budget, and I wanted to be sure that the Prime Minister and No. 10 would recognise that this was the case and be prepared to stand by and indicate that this was a collective decision. In the summer of 2021, I was concerned that the Prime Minister was seeking to avoid responsibility for the cuts that would be inevitable by stating

to me that it was "up to me what was to be cut". I knew that the settlement which the Treasury wanted to impose would mean that we would have to cut things like tobacco cessation programmes, sports programmes to encourage activity agreed with the Department for Education, and to delay decisions already taken in respect of health spending. I wanted to make sure that No. 10 would not then seek to backtrack and/or to disagree with those cuts at a later date, which would have led to the DHSC having an unbalanced budget [SJ/33: INQ000309460; SJ/34: INQ000309461; SJ/35: INQ000309459; SJ/36 INQ000309463; SJ/37: INQ000309521; SJ/38: INQ000309516].

Structures and advice within the DHSC

The background and experience of the Secretary of State

55. I am neither a scientist nor a clinician, and very few Secretaries of State have direct experience (other than as a patient, user of services or carer for others) of the health service or adult social care prior to becoming Secretary of State. I do not think it is a pre-requisite of running a health ministry or of making decisions which require clinical advice - such as all those made during Covid 19 to have the specialist expertise. What you need is to have good experts around you who can explain matters to you, and to be able to listen and respect their views. There needs to be good structures for the provision of advice from those experts and to have that advice tested. The Secretary of State should seek and rely upon a range of views.

56. The Secretary of State, and any decision maker in this situation, should be guided by the science, but that does not mean that all decisions will be made necessarily based on the option preferred by the scientist giving the advice. For example, during the summer of 2021, self-isolation when someone had Covid 19 was advised to last ten days. Employers, and others, were worried about the impact that was having upon economic productivity. Because of that I asked for advice as to the prospect of the transmission of the virus if the self-isolation time was reduced to 5 days rather than 10. A scientific team then ran the analysis on that. The scientific advice was that there was a need to maintain 10 days as that would avoid all infection, but I had to view the position in the light of the other factors including the likelihood of people complying with 10 days, the need for individuals to be back at work, the damage to the economy of such periods of isolation, the impact upon education of pupils and staff being off school for that time. I was told that there was a very slightly higher risk of infection if there was self-isolation for only 5 days of between 5-10%. It was my role as a Minister to look at the trade-offs that would be involved by changing the length of self-isolation, and the scientist's role was not to tell me what decision to make,

but to set out what the consequences of those decisions would be from a scientific perspective. I would describe my decision making as informed by science and based upon the science but not led by the science and not always making decisions which would involve no risk of transmission because of the non-medical consequences - to the economy or society and arguably in some cases possible mental health/isolation impacts.

57. Another example of this was about when a whole class should be sent home if a child was infected with Covid in an educational setting. Because of the impact that this had upon the education of other students, we worked with the Department of Education to decide as to what the risks were of having further testing. Whilst there was some risk, there was a balance of risk exercise which I had to undertake as a Minister of some risk (but limited because of the availability of frequent lateral flow testing which although not perfect, did provide reasonably resilient results), so that not all children had to be sent home.

Intensity of decision making during Covid 19

58. I had been involved in Government for a long period of time when I became the Secretary of State for Health and Social Care and had been involved in crisis management (for example, I was Home Secretary dealing with the immediate aftermath of Windrush and the Salisbury poisonings and was the Secretary of State for Housing, Local Government and Communities when the Grenfell Tower fire happened). They involved having intense periods of focus, of making decisions in a crisis and of leading in that situation. I would describe this period as the most intense period of decision making and having to make the most difficult decisions of my political career, and I leant on my experience extensively. I consider that without this experience, both of the knowledge of other Departments and of the development of my own skills, I would have found it extremely difficult to have made some of the decisions that I did - particularly - as I describe later on - when I had to make decisions which were not agreed by other Departments or where I needed to seek to override their concerns.

59. There is currently no training for Ministers on how to do the job. There is also no training in most of the departments on how to deal with crisis. Because I had been Home Secretary, there is training and exercises on various aspects of crisis management which happen regularly and which I participated in, and which provided me with skills when I used when I came to be Health Secretary. There are other parts of Whitehall (for example, in the Ministry of Defence or parts of the FCDO or DCLG) where crisis training is given and provided. I would recommend that every Health Secretary (and others who may be

involved in response to civil emergencies) undertake and have training and participate in exercises to learn skills of crisis management. I also consider that there should be training for ministers upon induction on how to lead a Department and how to be a "good" Minister. Whilst there are some materials available for the Institute of Government, there is not a routine "induction" or set of training materials.

Meetings during my time as Secretary of State

60. When I arrived at the Department there was already a "rhythm" of regular meetings dealing with Covid response. I had a Gold meeting every week (as described in the corporate statements, these were myself, the CMO, Permanent Secretary, Clara Swinson (Director General for Global Health Director General for Global Health), and members of the UKHSA executive committee such as Jenny Harries (Chief Executive), Susan Hopkins (Chief Medical Advisor), Ed Wynne Evans (Director of Radiation, Chemical and Environmental Hazards). I also had a meeting with UKHSA on at least a weekly basis.

61. I would meet with my internal team, which would be my private office and my Special Advisers (commonly known as "SpAds") on a daily basis, to identify what was working well, and in particular what was happening with Parliament. My team of SpAds were essential for maintaining my situational awareness across the breadth of policy issues, as they could focus on different areas of my brief and spend more time on internal meetings, stakeholder engagement, and scrutiny of policy details. In doing so they could also ensure that my priorities and positions were reflected within the department and in discussions with No10 and other departments, and they assisted me in making difficult trade-off judgments that reflected the bigger picture.

62. I considered that the departmental team providing me with counsel on a day-to-day basis was strong. This includes the Permanent Secretary, the CMO, deputy CMO, the Head of NHS England - Amanda Pritchard - and the Director Generals, as well as those from UKHSA. I considered that they worked hard, were very professional, and provided me with good advice. In particular, I appreciated the advice from Susan Hopkins (Chief Medical Advisor to the UKHSA) who would lead meetings during the Omicron wave with which she was heavily involved, and I would have daily meetings with her and others involved in the "Gold" structure. I also considered that my private office was very effective.

63. I had daily "dashboard meetings" where relevant statistics were presented and where discussions would be held about daily input or decisions required.

64. Alongside daily meetings about the NHS, I also had daily meetings with the NHS Vaccine Delivery Team. This was as important as the meetings about whether individuals should be vaccinated or not, as it was essential that we could get everyone "boosted" and vaccines administered to those who had not had them during the autumn and winter of 2021.

65. With the arrival of the Omicron variant in November 2021, a series of meetings needed to be held daily to manage the risk of this, including making decisions about restrictions or NPIs, booster vaccination, workforce absence, hospital capacity, adult social care capacity and travel restrictions.

66. All these key decisions were discussed in formal meetings where civil servants were taking notes. Meetings involving myself, the Permanent Secretary and the CMO always had someone taking notes. I did not use my personal email to conduct any governmental business.

67. Before I announced key decisions on vaccination policy, I would speak with the Shadow Secretary of State for Health (during my time Jonathan Ashworth MP and Wes Streeting MP) to set out the decision I had taken and why, and to ask for their support. They did, in all cases, agree with the decisions I had taken and would support the government in respect of vaccination measures relating to Covid 19. I considered my relationship with them to be constructive and that their support for the vaccination measures we had to take was helpful both for public confidence and to ensure cross party support. When it came to vaccination policy, Her Majesty's Opposition rightly put the national interest first.

68. As part of the rhythm of decision making, WhatsApp and other informal messaging services, alongside phone calls and discussions would be used as a way to communicate decisions, or to discuss aspects of them, but not to make key decisions. So, for example, if I was attending a press conference, I would be sent the "key lines" by WhatsApp to remember. Or if a decision had been made, there would be WhatsApp groups to which the information may be disseminated quickly. For example, I had a daily dashboard meeting about Covid 19: if I was then in another meeting where I needed to have the data prepared for that meeting, I would ask for it on WhatsApp. I did not make policy decisions via WhatsApp groups.

69. I would also use WhatsApp to communicate with my Special Advisers and my Parliamentary Private Secretary ("PPS") who is an MP whose job it was to be my eyes and ears in Parliament. I would discuss matters with them, and they would convey information to me by way of WhatsApp. Due to the constant schedule of meetings, and 24/7 nature of media and political issues, this was often an efficient way to ensure my team and I were up to speed on latest developments.

Advice from the CMO and other scientific advisory groups

70. The CMO is the Chief Medical Officer for the Government but is based in the Department and is line managed by the Permanent Secretary of the DHSC. He does not therefore operate in a vacuum or separately to the work of the Department, and is integral to Departmental decision making, particularly in respect of the response to Covid 19. My experience of the CMO and his team was that they were excellent, hardworking and incredibly professional at all times. I relied upon him a lot, and always felt confident that he would provide you with information without any "sugar coating". If he did not know the answer, he would tell you as well. If it was not his area of expertise, he would tell me that and ask me to speak with either a member of the UKHSA or CMO team, or to find the relevant expert. His role was in part to gather and synthesize the views he had received from many individuals including those on SAGE, SPI-M-o, NERVTAG and JCVI. He was always available to me either in person or on the phone. He would also solicit different views so that I had a rounded view of the decision to be made.

71. I considered as Health Secretary, and as someone who was neither a clinician nor an epidemiologist or scientist, that on pharmaceutical and non-pharmaceutical interventions, I would accept the advice of the CMO or other clinical advisers unless there was some critical reason why I could not. The CMO would not usually formally advocate that something should be done or should not be done when it came to core decisions but provided options and explained the risks of the various options as well as the reasonably foreseeable consequences of the various options from a clinical perspective. They did not seek to usurp the role of the Minister or Prime Minister as the decision maker.

72. The CMO's role is largely as a "conduit" for information from other clinicians, groups or advisers. So, the CMO provided me with options from the Joint Committee on Vaccinations and Immunisations (JCVI) about vaccinations, which was one of the key decisions taken during my time as Secretary of State for Health and Social Care.

73. Even if a meeting was ostensibly about other matters - such as logistics or communications, I knew that I could always call one of the CMO team or the UKHSA team who would then join to discuss the medical implications of decisions. To give one example, during a vaccine delivery meeting there was a discussion in respect of how long people should stay following receipt of an mRNA vaccine. The advice was that they should remain in the building for 15 minutes after the vaccine had been administered to ensure no immediate side effects. The delivery team wanted to know if that timing could be reduced to 10 minutes as that would enable much more "throughput" of those needed to receive boosters. I called the CMO and the UKHSA team to ask for their advice and to get them to commission advice on this.

74. JCVI is a statutory advisory committee.[4] It has existed since the 1960s and its role is to advise the Secretary of State for Health on the provision of immunisation and vaccination, and to provide statutory advice to the Department both in England and Wales. Appointments to this committee are public appointments. Their terms of reference are to advise about the need for such immunisation, vaccine safety, and the cost effectiveness of vaccines, and how to implement the vaccinations, but also to advise on knowledge gaps relating to immunisation where further research or surveillance is required. During my period in office, I considered that I would follow their recommendations, as otherwise that would undermine public confidence in the system of advice, and because it was clear that they had significant expertise in respect of this subject. The JCVI wrote to me about their views on vaccination on a number of occasions [SJ/39: INQ000309438; SJ/40: **INQ000066868** SJ/41: INQ000309439; SJ/44: INQ000309502].

75. When the JCVI would write to me, their letters would become public, but I would see them just before this stage. I recognised that to keep public confidence I would firstly speak with the Devolved Administrations. Scotland and Northern Ireland did not have to follow the JCVI advice but would receive it as they had representatives on the committee. I would either discuss this with the Health Ministers of those administrations during our usual weekly meeting or would call a special meeting to take them through the decision and to try and see if we could all agree about the course of action to take. In every case, all four nations agreed to the same approach in respect of vaccination. We worked well together, all coming from the same point of view and recognising the need to have a common view

[4] NHS (Standing Advisory Committees) Order 1981 (SI 1981/597). Its terms of reference and Code of Practice are found here:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/224864/JCVI_Code_of_Practice_revision_2013_-_final.pdf

on this important issue. The second thing is that I would speak with the Shadow Secretaries of State for Health to explain the decision and ask them to support me. In every case concerning vaccination they did so and were very positive in their approach.

76. The Medicines and Healthcare products Regulatory Agency (MHRA) was also essential as it was the body that approved the vaccines. I only met the head of the MHRA, Dame June Raine, on a couple of occasions to discuss her budget, but never met her to discuss the licensing of drugs as that would not be my role. I was, however, extremely impressed that the MHRA set up a system to swiftly approve antivirals and vaccinations. Some other countries vaccinated people without it always being formally approved by the relevant regulator. We decided that we would not vaccinate anyone without MHRA approval, and that approval also had to be for the right age group so that there was MHRA approval of the vaccinations to be administered to those under 18 before they were rolled out. I considered the role of the MHRA to be vital to provide the level of independent, expert assessment of the safety and efficacy of vaccines and other treatments.

Discussions with the devolved administrations.

77. I set up a weekly meeting with my counterparts in the Devolved Administrations. I understood that this was not something my predecessor did on a regular basis. [SJ/43: INQ000279851; SJ/44: INQ000279853; SJ/45: INQ000309495 ; SJ/46: INQ000309515]. Every Thursday or Friday we would speak together, to ensure that decision making was as consensual as possible and also to seek their views. We also had informal conversations and had a good level of trust [SJ/47: INQ000309526; SJ/48: INQ000309504]. I also know that officials from all the Devolved nations met regularly and seemed to get on well (including the CMO group). As identified earlier, on vaccination the four nations acted in concert. There were some differences in our approach to NPIs. I suspect, although I am not certain, that had we reimposed NPIs during the winter of 2021 then the other nations would also have done so.

78. I recall one time when I had concern with the behaviour of the Devolved Administration was about the vaccination of those aged 5-11. It was particularly important to have a common and consistent message about vaccination of this age group and steps had been taken to have central communications. I heard (via backchannels) that Nicola Sturgeon wanted to announce this policy prior to it being fully ready for a four nation rollout, with relevant scientists, information sheets and communications all being in place. I phoned up Humza Yousaf (who is now the First Minister of Scotland: but at the time was the Health Minister) to indicate that this was not acceptable, and that if this happened, the trust would

be lost with his office and that therefore in the future I would have to deal with Ms. Sturgeon's office. Mr Yousaf acted swiftly and resolved the issue, and the matter was announced in concert.

Relationships with International counterparts

79. I would also have regular meetings with European Health ministers. For some time, we had an almost weekly video conference with the Health Ministers of France, Germany, Italy, Switzerland, Portugal, Spain and a couple of others to discuss the pandemic and to share ideas. Health Ministers also had more formal consultations via the G7 and G20. The informal group emerged from a G20 meeting (the UK had the presidency during 2021/2022) in Rome where we all met formally and got on well so agreed to stay in touch and have informal discussions [SJ/49: INQ000309528, SJ/50: INQ000309527, SJ/51: INQ000309510, SJ/52: **INQ000112247**]. I was interested in learning from them and in hearing their views. First, in the summer of 2021, many of the European countries had more restrictions in place than the UK had during this period, and we exchanged views on this. Second, when the Omicron wave happened, these countries also took a different route in respect of Omicron by imposing significant non pharmaceutical interventions, whereas we did not. There was an active debate as to which approach was the most appropriate, and we were able to discuss the different approaches and the rates of booster vaccinations. The other European countries felt that our approach in winter 2021 was riskier than theirs, but they accepted that they had lower vaccination rates and were impressed by the high numbers we had already for booster vaccinations. Other European countries had more difficulties than we did convincing their populations to have booster vaccines (or vaccines in the first place). The impression I had was that they were impressed by our action and ability to distribute antivirals, operate a booster campaign and have testing across the board, which some of them considered was not open to them. A number of them sought advice from us about how they should handle Omicron, as the UK was seen as having dealt with it effectively despite being affected it by it earlier than others.

Meetings about the NHS

80. I would speak with senior individuals within the NHS and have meetings with them weekly, and small group meetings with Amanda Pritchard and others about the NHS more regularly than that. Often, I would meet with the NHS team daily to discuss delayed discharges and waiting lists. I would also have meetings where required with individual hospitals where I was having concerns about their performance.

Adult social care

81. I would also have regular meetings with my Ministers and others about adult social care during my time as Secretary of State for Health and Social Care. In these meetings we discussed funding proposals to go to Treasury and areas of reform for adult social care [SJ/53: INQ000309446 ; SJ/54: INQ000309451]; issues with bed capacity and care home vaccinations [SJ/55: INQ000309462]; winter planning [SJ/56: INQ000309464] and publication of the Winter Plan for adult social care [SJ/57: INQ000309458]; preparation and contingency planning for Omicron [SJ/58: INQ000309479]; the Department's bid for £530m to address workforce challenges in the adult social care sector in December 2021 [SJ/59: INQ000309489]; and the strengthening of the asymptomatic staff testing regime in care homes [SJ/61: INQ000309509].

Behavioural science, decision making and vaccination

82. Vaccination was an area where I feel it would be useful to have more input and advice from behavioural scientists in the future. The take up rate for vaccination amongst those under 25 was nowhere near as high as for those over 50, and I remember us having debates about how we could incentivise young people to become vaccinated. I remember that some other countries sought to give young people cash when they were vaccinated, and we looked at this. I felt that more behavioural science work on this would have been useful in seeking to devise "nudges" so that there was greater take up. I also felt that further expertise and advice was needed about ensuring better take up from those from ethnic minorities. We knew that black citizens, particularly men, had lower take up rates than others. I had a number of meetings internally and externally about this and also undertook a round of media engagements to talk about this and to encourage greater take up. I would have found it helpful to have had further behavioural analysis and research as to what would have encouraged people from various minority groups. I would advise that in the future that behavioural analysis and understanding should be essential to any future pandemic decision making where there is a necessity for vaccination or administration of any other form of drugs. I also consider that work needs to be done to try and encourage trust by those from minority groups in the NHS and social care advice, who have historically felt discriminated against and excluded from healthcare. I would like there to be direct work undertaken by OHID to seek to encourage vaccination uptake and to seek to provide reassurance and to understand why people feel mistrustful of medical advice, particularly from certain minority communities.

Inequalities and healthcare - pre and during the pandemic

83. I am the son of Pakistani immigrants. My mother did not speak English fluently when I was a child and I remember visiting the GP with her to translate. Both before my time as Health Secretary and during it, dealing with health inequalities, access to treatment, in diagnosis and in managing illness which particularly affects those from certain minority ethnic groups, was a central concern of mine.

84. When I became Health Secretary, I asked for meetings with the CMO and others to try and understand why a disproportionate number of people (particularly men) from certain minority ethnic communities had died from Covid, and worked on a white paper on health disparities[SJ/61:INQ000309457;SJ/62:INQ000309454;SJ/63:INQ000309494;SJ/64: INQ000309453;SJ/65: INQ000309441]. This was due to be launched in the week after I resigned, however, the government announced on 24 January 2023 that the white paper was not going to be published.[5]

85. Some other steps I took whilst I was Health Secretary was to commission a review about inequalities in respect of the efficacy of medical equipment on the grounds of race, which was chaired by Professor Dame Margaret Whitehead [SJ/66:INQ000309485, SJ/67:INQ000309486,SJ/68:INQ000309507,SJ/69:INQ000309508,SJ/70:**INQ000309511**, SJ/71:INQ000309512,SJ/72:INQ000309517,SJ/73:INQ000309519,SJ/74: INQ000309518 , SJ/75: INQ000309520; SJ/76: INQ000309465]. This consultation ran between August 2022 and October 2022, and I understand the panel of the independent review were to provide advice to the government by June 2023.[6] I had read that pulse oximeters gave incorrect readings on darker skin and asked about why this was the case. I found out that this was because such oximeters were tested upon white skin because they are seen as the biggest global market by the manufacturers of such equipment. I talked about this publicly, which helped to raise awareness of these issues within the NHS. The main policy proposal that I thought of to tackle this was that if the US and the UK - who are the two biggest purchasers of medical equipment in the world insisted that it would only purchase products which had been tested in all races, then global manufacturers would do so. I discussed these matters with my US counterpart, but it did not come to fruition because I resigned as Health Secretary. I still consider that the UK should consider making this a requirement of procurement of medical equipment.

[5] Written questions and answers - Written questions, answers and statements - UK Parliament
[6] https://www.gov.uk/government/consultations/equity-in-medical-devices-independent-review-call-for-evidence; and https://www.gov.uk/government/groups/equity-in-medical-devices-independent-review

86. The Department of Health works with the FCDO and has a global health team, part of whose role is to use our development aid on health projects in other countries. When I was Secretary of State for Health, I sought to allocate monies to projects which focussed upon illnesses which historically would be more likely to impact black and minority ethnic communities. For example, we funded a collaboration between the University of Manchester and Kenyatta University in Nairobi to work upon skin cancers which only appear in the black community.

87. I have been asked questions about seeing equality impact assessments when examining NPIs. Equality impact assessments are carried out routinely for all legislation, and also for policy proposals. The Department has filed a witness statement dealing with equalities. We did consider the issues around unequal impact of NPIs on different communities when reaching decisions, but that may not have had a formal "impact assessment" attached to it.

Decision making and advice - June 2021 - February 2022 (Questions 26 - 40).

88. I have already answered some questions in respect of decision making in the sections above, including what I considered to be the "key decisions" during my time in Office, and the process by which decisions were made.

Lifting of restrictions - Summer 2021

89. I was obviously involved in discussions around the lifting of restrictions in the summer of 2021 and attended the Covid S and Prime Ministerial meetings where this was discussed [SJ/77: INQ000309442; SJ/78: INQ000309450; SJ/79: INQ000309440]. Until June 2021, whilst the country was not in a strict "stay at home" policy, it was the case that there were restrictions in place. There was a general view in government that these restrictions could not last forever. There would be a need to relax restrictions at some point, and the view was that it was less risky to do this in the summer than going into the autumn. There was a general feeling at that time that the worst outbreaks were behind us. We recognised that case rates would go up with relaxation but given the level of vaccination, this would prevent serious illness in the population to a significant degree.

90. By the summer of 2021, the public's freedom of movement and restrictions on liberty had been going on for well over a year. Restrictions should only be kept in place if they were strictly necessary - not as a default. I was of the view that there needed to be a review of

what was proportionate at the time in question. I asked the CMO and the CSA what the risks would be to ease restrictions if there was significant uptake in testing and the ability of individuals to test daily if needed, and what would be the appropriate tests to adopt when deciding if restrictions should be relaxed. I was informed that whilst there was never a risk-free option, relaxation in the summer was more logical than waiting for winter. It is worth noting that a considerable majority of the public were against coming out of lockdown at this point, so if it was not successful I would have come under extreme scrutiny. As it turned out, the political and media focus shifted within just a couple of days onto scrutinising the measures that enabled these greater freedoms - such as the Covid app 'pings', and the cost of tests.

91. One of the reasons that the restrictions were lifted was to try and get back to normal. That did involve seeking to have the NHS return to dealing with its day-to-day business, including seeking to reduce, as far as possible, the waiting times for elective surgery and other interventions. The relaxation was not undertaken to make the NHS do such, but part of the side effect of fewer people being very unwell with Covid in hospital settings was the ability to have other patients treated and to try and release more capacity in the NHS.

Vaccination of children and young people - summer and into winter 2021

92. Many other European countries, and other international partners, were vaccinating children and young people once the vaccination came into place. Until the summer of 2021, the vaccination programme was only generally open to those over the age of 18, those who were considered clinically extremely vulnerable or those with underlying health conditions[7]. In the summer of 2021, JCVI was asked to provide information and evidence as to whether vaccination should be extended as a matter of routine, first to those aged between 12-17 [SJ/80: INQ000309443; SJ/81: INQ000309444; SJ/82: **INQ000061276**], and then to those aged 5-11 [SJ/83: INQ000309496; SJ/84: INQ000309497; SJ/85: INQ000309498]. This was an important decision. The JCVI were neutral about its efficacy. As was known by this point in time, children and young people rarely had significant ill health from catching Covid but were significant transmitters of the disease. The JCVI advice was not to actively recommend the need for it on clinical grounds, but to identify that the risks of it were not sufficient to advise that it should not happen.

[7] https://www.gov.uk/government/publications/priority-groups-for-coronavirus-covid-19-vaccination-advice-from-the-jcvi-30-december-2020/joint-committee-on-vaccination-and-immunisation-advice-on-priority-groups-for-covid-19-vaccination-30-december-2020#vaccine-priority-groups-advice-on-30-december-2020

93. As the JCVI advice was equivocal, I consulted with the four CMOs and asked for their advice to be put into writing so that it could be published prior to the governments deciding as to whether to offer such [SJ/86: INQ000309448; SJ/82: INQ000061276 SJ/88: INQ000066869 SJ/89: INQ000111538]. This decision was also made with No.10 and it was decided that vaccination should be recommended but [8] not with the same priority as adult recommendation. The UK has never had a recommended vaccination programme for children (unlike many other European countries), and we considered that it would be wholly in appropriate to impose one at this time, in circumstances where the reason for vaccination was primarily to address the fact that children and young people were very effective transmitters of the virus.

94. At all times, the four nations discussed this matter together (with all four Health Ministers and their CMOs) and sought to reach a general agreement, both as to the policy to be adopted but also how it was to be communicated by all four nations to create a coherent message which had maximum chance of success of being accepted by the public. It was particularly important as parents were naturally concerned about the impact of vaccination on their child.

Covid Response Plan: Autumn and Winter 2021 (INQ000137065)

95. This plan was issued by the Cabinet Office and not the Department. The Department would have fed into this plan and provided public health input into it. I would have seen the plan and would have accepted it. On 14 September 2021 I made a statement to Parliament announcing the plan[9], and the *'Covid-19 Response: Autumn and Winter Plan'* was published that same day[10]. The purpose of the plan was to try and set out what contingency measures should remain in place, which could be relaxed and the tests which would be adopted if there was a new variant in place and the steps to be taken if that were to happen. The idea behind the plan was to try and remove most of the NPIs as far as possible, but not to indicate that they would never return. I cannot remember any significant disagreements between myself and any other part of the government about the contents of the plan or the necessity for contingency planning.

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[8] https://hansard.parliament.uk/commons/2021-09-13/debates/18DE57E4-A4ED-4852-95D6-8DE445AC44FE/Covid-19Vaccinations12To15-Year-Olds

[9] https://hansard.parliament.uk/commons/2021-09-14/debates/DC215883-A118-4E79-B329-3012F3A5F5BD/Covid-19Update

[10] https://www.gov.uk/government/publications/covid-19-response-autumn-and-winter-plan-2021

The Omicron variant November 2021 onwards

96. As identified in the Department's corporate witness statement at paragraph 63, the Omicron variant was first identified in November 2021 in South Africa, after Hong Kong uploaded a sequence of the variant to the international genomic database. My first recollection of being told about it was over a weekend in November 2021 when the CMO and Jenny Harries of the UKHSA asked to speak with me, and for this to take place in the Department's offices. A meeting was then convened involving myself, my Special Advisers, private office, the CMO, Jenny Harries, Susan Hopkins, Sir Christopher Wormald [SJ/90: INQ000309469; SJ/91: INQ000309472] when they told me about the Omicron variant but said that they knew very little about both the variant and the possible impact of this upon the UK (and elsewhere). I was told that the variant had been identified as one of concern from the international database, GISAID, [SJ/92: **INQ000257119** ;SJ/93: INQ000309467] by one of the advisers to SPI-M-O who was very worried as it was potentially highly infectious, and it was not clear whether or not the current vaccines would be effective against it. I understood that we were the first group of scientists to have identified this variant and to alert international partners. I remember Susan Hopkins in particular being worried about the number of spike protein mutations.

97. I asked a lot of questions at that meetings and the scientists did not have all the answers but were not afraid of informing me about this uncertainty. I remember the CMO telling me that the vaccines were very effective (around 95%) on the current variants. If the Omicron variant reduced the efficacy by 5%, that would involve 5 more people in every 100 potentially becoming unwell and millions more people becoming infected. The meeting agreed that this variant should be monitored and that international epidemiologists and those working in Southern Africa should be contacted to get more information on this variant.

98. I also remember a discussion about whether this variant had emerged from South Africa, and the implications of this. I was aware that the hospitalisation rate amongst younger people was high in South Africa in the summer and autumn of 2021, and if this was the Omicron variant then that was a particular concern. I was also aware, however, that South Africa's vaccination rates were very low.

99. From that day onwards, seeking to combat the new variant became the number one priority in the Department, and I asked that the Department became focussed upon this.

100. So, for example, within a day I had met with the vaccine and anti-virals procurement teams and asked them to [SJ/94:INQ000309477;SJ/95:INQ000309481;SJ/96: INQ000309483] procure further vaccines and make sure that we could deploy more vaccinators and seek to roll out the campaign of booster vaccinations as quickly as possible. I also worked with the NHS to ensure that there was adequate surge capacity. I also told the Prime Minister about this at the 8.30 meeting held the next day. He demonstrated concern.

101. Within three or four days of learning of the existence of the variant, I had discussed with the CMO whether to stop flights from southern Africa to England to limit its spread. He considered that it was a good idea but that it was likely to already be too late (the variant was likely to have been present in South Africa for a period of time). I agreed with the Prime Minister that this should take place, and that both South Africa and other countries in Southern Africa should be placed on the red list. Eleven countries were added to the UK red list to slow the seeding of the UK with the Omicron variant. Six countries were placed on the red list on 26 November (South Africa, Botswana, Lesotho, Eswatini, Namibia and Zimbabwe), four countries were added on 28 November (Malawi, Mozambique, Zambia and Angola), and Nigeria was added on the 6 December [SJ/97: INQ000309468; SJ/98: INQ000309482; SJ/99: **INQ000074422**; SJ/100: INQ000309492].

102. At the same time as stopping flights, the UKHSA was trying to grow the culture of the variant in its laboratory to try and examine how it may operate and impact on the vaccine and therapeutics.

103. On 27 November 2021, it became clear that the variant was in the United Kingdom and it was circulating beyond those who had travelled from southern Africa and within the general population [SJ/101: INQ000309471; SJ/91: NQ000309472].

104. The backdrop to the decisions made about NPIs during this period is important. In the late autumn and early winter of 2021, many people felt that the pandemic was over, and that social restrictions should not be reimposed. This included some MPs. Furthermore, there was widespread concern, and I remember fielding several media interviews at the time that "Christmas would not be cancelled" after the situation in 2020. I remember being told that there was evidence that people were becoming tired of restrictions and were taking more risks with the social restrictions in place (especially those under the age of 30) particularly when vaccination was providing people with what could be false levels of

comfort. Those living in residential care settings were also able, because they had been fully vaccinated, to see more of their friends and family than had been the case for the past 18 - 20 months. My view was that there was a feeling of exhaustion at the idea of yet further restrictions by the public.

105. At the same time as the Omicron variant was emerging, Conservative MPs in Parliament had their confidence in the Prime Minister damaged as a result of the request that MPs vote to refuse to sanction Owen Paterson MP despite the conclusions of the Parliamentary Commissioner on Standards, which vote was due to take place on 3 November 2021.[11] I, along with other MPs, had been told by the Chief Whip that we should vote for a new committee (to replace the current Standards Committee), thus in effect putting Mr. Paterson's sanction into abeyance. I reluctantly supported the Government amendment.[12] Several senior MPs, including the former chief whip Mark Harper voted against this amendment, while former PM Theresa May abstained, and it caused considerable rancour within the Conservative Party as many MPs considered that the investigation by the Parliamentary Commissioner on Standards had been fair and that Mr. Paterson had not behaved in line with the Code of Conduct set on propriety. It was known that the Prime Minister was the person who (amongst others) considered that Mr. Paterson had been treated unfairly and some MPs described being put under significant pressure to vote for the change despite having concerns about it. This whole affair was deeply damaging to the Prime Minister within the Conservative Party.

106. There were also other events which damaged the credibility of the government, and in particular the operation within No. 10 and the Cabinet Office, namely what became known as "Partygate". On 30 November 2021, the Daily Mirror stated that there had been Downing Street staff gatherings in breach of the rules during Christmas 2020. On 7 December 2021, a video was leaked the press showing Allegra Stratton, who was then the Press Secretary for the Prime Minister joking in a rehearsal for a press conference about events taking place in No 10 that may have broken rules. She then resigned. Lord Bailey, London Assembly Member (then Shaun Bailey), resigned as Chair of the London Assembly's Police and Crime Committee after evidence emerged that he had attended a gathering where Covid Regulations were broken on 14 December 2020. On 8 December 2021, the Prime Minister announced a Cabinet Office inquiry into such breaches of rules.

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[11] https://hansard.parliament.uk/commons/2021-11-03/debates/EA7E30B2-F0D0-4FC8-A608-9845CE43CF28/CommitteeOnStandards

[12] https://hansard.parliament.uk/Commons/2021-11-03/division/7278BB12-7F87-4287-B8A9-C0125CE357E2/CommitteeOnStandards?outputType=Names

107. As a result of these events, I considered that the political incentives of the Prime Minister in respect of non-pharmaceutical interventions may have been impacted. My experience of him prior to the winter of 2021 was that he was very cautious about Covid and not laissez faire at all. He had, for example, strongly advocated and pushed the decision made in the autumn of 2021 that there should be a requirement to be vaccinated to work in the health service. Part of this was realpolitik - you cannot introduce measures which your MPs will not vote for, as you cannot rely upon the Opposition supporting you in any vote even if they are sympathetic privately as they will wish to make political capital if they can. There was a concern that the vaccination condition of deployment legislation and the regular bi-monthly Coronavirus Act renewals may not pass a parliamentary vote. I would describe the handling of MPs and Parliamentary business as becoming significantly more problematic over this period. This meant that it took much longer to persuade colleagues about measures to be taken, including measures concerning health protection and the pandemic. I was steering the Health and Social Care Bill (which was to make changes to the structure of NHS organisations and to create the "Integrated Care Boards" of both health and social care to try and lead to greater integration of services), a measure informed by the pandemic, and it became more difficult to steer this through the House of Commons. I would describe the waters as becoming more choppy because of Conservative MPs' unhappiness with the government more widely rather than concerns about my Bill. I was also undertaking work to introduce a cap on the payment of monies by way of fees for social care services for those adults who required it which again was contested by some MPs not because they opposed this but because they were unhappy about aspects of the pandemic response - for example vaccines as a condition of deployment or mask wearing.

Omicron and consideration of NPIs and Christmas 2021

108. As was set out in the "winter plan", it was envisaged that there would need to be introduction of some NPIs by way of "Plan/Step B". This was implemented on 8 December 2021. It involved face masks becoming compulsory in most public indoor venues other than hospitality, the NHS Covid Pass becoming mandatory in nightclubs and settings where large crowds gather, and people being asked to work from home if they could. The number of cases in the UK in early December with the Omicron variant showed high levels of community transmission, and there was still doubt at that time if the vaccine would be effective against this variant. I was aware by this stage that there had been modelling of transmission undertaken by various expert advisers (I did not meet with SPI-M-O or others tasked with modelling the transmission - the CMO or Ms. Hopkins from UKHSA would

present the information from the modelling to me). I was aware that someone from the London School of Hygiene and Tropical Medicine had done some work modelling this variant. Various modelling showed the potential for exponential growth of the variant and therefore the potential for exponential growth in the need for hospital places. Due to the grave risks posed by that potential scenario I met with the CEO of NHS England and her team to ensure that it could cope with a surge in Covid bed spaces and the consequent ill health of the NHS workforce [SJ/58: INQ000309479].

109. As a result of this modelling, and the unpredictable nature of a variant that we did not yet have much experience with, advice from a number of clinicians and officials was that significant restrictions would likely be needed as each day of exponential growth would be very difficult to cope with and reverse. The public were already increasingly taking their own precautions ahead of Christmas beyond what was required of Plan B restrictions. I was not in favour of returning to some of the stricter approaches from earlier periods but I did recommend to the Prime Minister that we should consider some time-limited NPIs to minimise the worst case scenarios, to reduce the unsustainable rate of hospitalisation and potentially help to ensure that Christmas plans could go ahead.

110. I understood (not directly from the Prime Minister but through the respective private office officials and Special Advisers) that the Prime Minister did not want to see the imposition of further NPIs and wanted to find an alternative. We considered a riskier alternative which was (a) booster vaccinations and (b) anti-viral drugs (there would need to be more drugs than we currently had in stock, and they would need to be provided to all those most at risk of serious ill health through Covid) and (c) mass, regular testing so that it became a daily function. I was told by No. 10 that this should be the focus.

111. The decision made about what steps to take in response to the Omicron variant was not just a decision for the Department, but as it would impact everyone (in particular over the Christmas period where many families were looking forward to spending time together), the Prime Minister decided that it should be a Cabinet decision. There was a Cabinet meeting held on 10 December 2021 [SJ/102: INQ000309490,SJ/103: INQ000309491]. At the meeting, the CSA and CMO gave their advice which was for further NPIs. I emphasised the potential risks identified by the CSA and CMO. Michael Gove, the Secretary of State for Housing, Communities and Local Government, and Simon Clarke, Chief Secretary to the Treasury, spoke in favour of further measures. The majority of voices were in favour of taking the risk of maintaining the status quo, so it was decided that there should not be any further NPIs beyond “Step B” in the winter plan. The Prime

Minister summed up the mood of the meeting at the end and did not say his view [SJ/104: INQ000083832, SJ/105: INQ000083834, SJ/106: INQ000083848, SJ/107: INQ000083854, SJ/108: INQ000083833, SJ/109: INQ000083831].

Vaccination and Omicron

112. As a result of that decision, it was then my role to ensure that there was sufficient uptake and deployment of booster vaccinations - and that all of those who needed it obtained one - or obtained the first or second vaccinations depending on their age. It should not be underestimated how difficult it was to massively expand the booster campaign quickly in the middle of winter with Christmas approaching. I had twice daily meetings on ensuring that the logistics could be met and that any problems or barriers could be cleared. I also used press briefings [SJ/110: INQ000309473] and op-ed pieces [SJ/111: INQ000309493] to further encourage the public to take up the booster vaccine.

113. I would identify that a significant problem during that period was with General Practitioners. I was extremely conscious that there were people in residential care homes, but also those living in their own home and the community who needed the booster quickly, and that it had to be delivered to them at home, as they would either be unable or unlikely to be able to attend a vaccination centre. I therefore asked GPs to prioritise doing this as they would be aware of those most acutely vulnerable in such settings. The British Medical Association (BMA) asked for more money before GPs would be willing to do this. I did not think that this was appropriate. I had made it clear and had spoken publicly about the need to ensure that people did not go to the GP unless it was an emergency to ensure that they could go and undertake vaccinations. I paid GPs the additional money because I could not afford for this not to happen, but I felt that this was holding me to ransom unnecessarily - demanding the rights and resources of public servants, but requiring the incentives of a private businesses [SJ/112:INQ000309474;SJ/113:INQ000309480;SJ/114:INQ000309475; SJ/115:INQ000309478; SJ/116:INQ000309484;SJ/117: INQ000309503; SJ/118: INQ000309514].

114. I also had to ensure that there could be significant expansions of vaccination centres, the use of pharmacists and others, including on Christmas Day, as well as running a media campaign. I do consider that the media campaign worked - as it was astounding how many individuals received a vaccination within a 4 - 6 week period. On 21 December 2021, for example, we had already seen over 20.9 million people in the UK take up their booster

dose since only 30 November 2021 [SJ/119: INQ000309500]. On one day, nearly 550,000 people received their booster vaccine, which was a record number of booster jabs delivered. The media campaign was strong, but the more important thing was boosting capacity to hit the numbers we achieved.

Anti-viral drugs and the Omicron variant

115. Alongside a vaccination task force, there was also an anti-viral task force (headed by Eddie Gray, who had worked for large pharmaceutical companies) which was set up in April 2021 to find and supply effective treatments for those exposed to Covid 19, and to deliver them to be administered at home and in hospital. In the summer and autumn of 2021, it had identified two anti-viral drugs which it wished to procure. One had been approved by the MHRA, and one was going through this process. Both drugs were expensive (one was produced by Pfizer and the other by Merck). The Treasury were not very keen to fund the cost of these drugs because of their expense.

116. When the Omicron variant came along, I spoke with Eddie Grey who indicated that the anti-virals were very effective at preventing the development of severe disease amongst those who were immune-suppressed or who were not able to have a vaccine. There needed to be a stockpile of them [SJ/120: INQ000309476; SJ/121: INQ000309488; SJ/122: INQ000309506; SJ/123: INQ000309499]. I was told by the taskforce that if an order was not made for the drugs, they would almost certainly be sold to other rich countries. The Treasury was vacillating and did not want to fund the stockpile or only offered a small amount of the cost of the medicines. I spoke to the Chief Secretary of the Treasury, the Chancellor and No.10 (via Dan Rosenfield, who was the Prime Minister's Chief of Staff at that time) about this. I would describe myself as both pushy and vocal with the "centre" on this subject. As an experienced minister, I was willing to take that risk, but had I been a less experienced minister I am not sure I would have had the confidence to "push".

117. This meant that during the Omicron wave, the NHS had identified those who were most vulnerable in England. They were given PCR tests and given a specific number to call if they thought they had Covid. Someone would come (by courier) to pick up this test, to test it as a priority and then within 24 hours to deliver anti-virals to that person. This system operated throughout England, but the other four nations also had access to these drugs (this was not something that the UK governments had to provide - I decided, along with officials, that it was necessary for this cost to be covered by the UK government, rather

than each devolved administration and to deliver them pro rata). This was a highly effective system for the 20 - 30,000 people in this country who needed this protection.

Increase in testing

118. The third plank of the response to the Omicron wave was the provision of lateral flow testing everywhere. My instructions to the Department were to procure as many of these tests as possible as quickly as possible. It became very difficult to procure tests, because the manufacturers were running out of stock and prices were rocketing as countries around the world sought to buy tests. The UK needed 40 - 50 million tests per day to be able to ensure that testing could happen frequently and easily to avoid spread. The Treasury said that the cost was too expensive and were refusing to pay for it. I ignored them and told the procurement teams and UKHSA to procure the tests and that I would sort the position out with the Treasury later. As I said above, I was a very experienced minister by this time and was aware of the workings of the Treasury: I therefore felt I had the confidence to make this decision. I suspect a less experienced minister would not have made this decision as it was highly risky.

Long Covid

119. Long Covid was the subject of medical research and identification during my time in office. By 2021, long Covid was being investigated and clinics were being set up to try and examine the issue and the wide range of symptoms which were caused in some people after a Covid infection. When examining any NPI, one has to examine the likelihood of this preventing transmission of the virus and weighing this against other factors. That would include the risk of some people having long covid.

The DHSC budget and the Omicron variant

120. As discussed above at paragraphs 50 and 51, during the summer of 2021 I had to agree a "downward" trajectory of funding for the Department given the difficult fiscal situation. I had, however, agreed with the Treasury that if there were to be a significant deterioration in the Covid position then the Treasury would allow the Department to use a contingency budget to procure the relevant antivirals, vaccine delivery during this period. This came into effect from November 2021 onwards.

121. I have identified above the difficulties I had with the Treasury approving spending for anti-virals and testing during the Omicron variant. By this stage in the pandemic, the Treasury was seemingly no longer adopting a view of paying whatever was needed to

solve the problem before examining its efficacy with more scrutiny and time. I recognise that the Treasury does have a role in assessing value for money and effectiveness, but I felt that by the time we had satisfied the various tests required by the Treasury we would not be able to order the goods.

122. I have been asked questions about the resourcing of the NHS during winter 2021. I would identify that there were sufficient resources to deal with the treatment of those with Covid 19, but that such treatments did come at the expense of the treatment of other conditions as there was not sufficient monies to pay for all the programmes. In particular, the Omicron variant had a material impact upon the waiting lists for surgery, which kept getting larger.

Living with Covid - January and February 2022

123. In the new year I made a formal recommendation to the Prime Minister by letter on or about 18 January 2022 [SJ/214: INQ000309513] regarding how to approach the phasing down of measures brought in to mitigate Omicron. In this letter, I said that the:

> *"DHSC, NHS and UKHSA consensus view is that a sustained plateau of COVID hospitalisations is the biggest risk faced by the NHS",* and that for this reason *"we need to continue to encourage public caution even if Plan B measures are not renewed".*

In respect of NPIs, I specifically recommended:

> *"... Whether Plan B measures are extended or removed, the government will need to maintain a cautious tone in public messaging, encouraging people to avoid risky behaviours, to test regularly and to get boosted. The critical role of boosters in minimising the severity of the Omicron must cut through in our messaging, so as not to undermine support for any future push on vaccination and to ensure maximum possible uptake among health and care workers given the forthcoming deadline for vaccination as a condition of deployment. It will be important to stress that relaxing Plan B measures will not be 'freedom day' and significant pressures on the NHS remain.*
>
> *If Plan B measures were relaxed, we should do so on a gradual basis, for example by strongly advising the continued use of the NHS COVID Pass to access settings and by recommending a return to workplace on a gradual basis with COVID secure*

measures in place. Face coverings are a low cost measure which reduce transmission through source control, and act as a visible reminder of the ongoing COVID risk. Analysis shows a marked return in face coverings wear since they were made mandatory on 10th December. In the Plan B decision process, ministers should particularly consider whether to continue to require face coverings in indoor settings, for another three or six weeks. If mandatory face coverings in indoor settings cease the government should continue to strongly advise the public to wear face coverings in crowded indoor settings where people come into contact with those they don't normally meet."

124. On 21 February 2022, the Government published "Living with Covid 19" [SJ/125: INQ000309523]. This was a Cabinet Office document, but one which the Department contributed to. I agreed that it was necessary to publish a "road map", but where the Treasury, the Prime Minister and the Cabinet Office and I disagreed was how much of the apparatus, which was constructed during the pandemic, particularly in respect of the infrastructure around testing, scientific research and funding should be maintained. I considered that there should be capacity kept into the system from February 2022 by way of sufficient stocks of lateral flow tests (and capacity to have them produced in large numbers quickly), to have relevant laboratories continue to work on new variants, to maintain the increased number of scientists who had been recruited into the UKHSA to deal with the Covid response, to maintain the tests undertaken on the water and sewage supply, to have random testing on flights and that would all continue to require funding. The Treasury did not agree to fund this and so DHSC funded this by making cuts to other parts of its budget (cuts which the Department could ill afford) [SJ/38: INQ000309516; SJ/126:INQ000309522;SJ/127:INQ000309524;SJ/128:INQ000309505;SJ/129: INQ000309501;SJ/130: INQ000309452]. I felt that it would be irresponsible to "disarm" ourselves (particularly when most of continental Europe was still undertaking significant Covid precautions) and we needed to keep "weaponry" for a surge if needed.

125. I did not consider that the Treasury were acting unfairly in not permitting me additional funds, as having been the Chancellor I was aware that it is only the Treasury that must carefully consider how much money is raised and can be borrowed and I was aware that our borrowing was extremely large during the Covid pandemic, by necessity.

126. Again, the then Prime Minister did not want to recognise or accept that maintaining this level of Covid response would therefore mean that other cuts would be needed to the health budget, and I did not want those health cuts to take place. In this situation, the Prime

Minister is the adjudicator or arbitrator between different spending departments when deciding how any spending reductions should be allocated. Each department and its Secretary of State seeks to protect its budget as far as possible. I went to the Prime Minister to say that if he wanted to maintain the health budget and not have cuts to continue with the necessary infrastructure for the possibility of a future surge in Covid then it was his responsibility to go to other spending departments and to "move" the money from that department to the Health budget, as the envelope of spending could not be any larger. This is how budgetary allocations work in Government. The Prime Minister however wanted to have his cake and eat it - to reduce the overall budget whilst not cutting any programmes or spending. That was not feasible but was the position which was adopted.

127. I considered that it was necessary to have an agreement with the Prime Minister that everyone would acknowledge that this difficult financial position had to be maintained to avoid any backtracking to this. I remember that the Prime Minister had still not agreed to this position the night before the Living with Covid Plan was due to be presented to Parliament and published, and so I indicated that I would not agree to make the spending cuts without his assurance that he would support them - a Cabinet meeting was then cancelled because of the disagreement between us. We reached a compromise later that day, but the Covid Plan had to be put back until that had been the case.

128. It was necessary to learn to live with Covid at this point - a phrase I used in my earliest days as Health Secretary. It was not possible to continue with NPIs or significant restrictions for a longer period because of the long-term impact that such would have upon the society and our economy. That involved considering the impact that NPIs had upon those whose lives were restricted - both the direct effects of isolation but also the indirect effect of loss of schooling, loss of social life, worsening of mental health, worsening of other physical health conditions, and the risks to those in abusive relationships.

129. The UK did learn to live with Covid effectively, and was able to enjoy months of more freedoms in the first half of 2021 than almost any other comparable country - the benefits of which are difficult to quantify, but very real. I regard this as a significant achievement for our country that I am proud of, having learned lessons from earlier parts of the pandemic. The public were somewhat aware of how far ahead we were of most European countries and elsewhere when they travelled, but while in normal times this might have been a major government 'reset moment', it was largely absent from the media narrative in this period due to the dominance of the Covid-related 'partygate' stories. I was very concerned about these emerging reports, and repeatedly said so publicly. The manner in which they were

dealt with was a contributing factor to my decision to resign my position later in July of the same year.

130. While as a society we have successfully been able to move forwards since Omicron, my concern about our funding for living for Covid - which remains - was the degree to which we remained sufficiently alert to dangerous new variants or entirely new viruses through the early warning capabilities and other capacities that were developed in response to Covid. I made the case for maintaining significantly more investment in preparedness to No.10 at the time, and the relevant budgets will have since reduced further in real terms due to higher than anticipated levels of inflation. It is clear that better preparedness before Covid would have saved a huge amount of reactive resources, not to mention lives - unfortunately it is not clear to me that we have fully learned our lessons from this pandemic in that regard.

Public health messaging

131. As identified above, I considered that the UK's public health communications during the time that I was Secretary of State for Health were adequate, and in respect of communications around vaccinations and boosters they were clear and consistent.

Enforcement of fixed penalty notices

132. I was not involved at all in the design or enforcement of such fixed penalty notices and the Department was not involved in these, or in any discussions about the enforcement of any such penalties.

Lessons learned

133. I am asked whether an economic equivalent of SAGE should have been set up. As I was not in office, I am not entirely sure what expert advice was examined. I know that the Treasury has access to both internal advisers but also external advisers. I am not sure, at the beginning of the pandemic, it would have been possible to have effectively modelled the economic impacts with any clarity as no-one was clear how long the pandemic would last, how many people it would seriously impact and the indirect impacts on the economy, save that they would be huge and global. By the time I became the Secretary of State for Health and Social Care, it was clearer what the impacts were on the economy, and the factors were weighed up in discussions.

Reflections on the NHS

134. One thing that became self-evident to me from the pandemic was that other Western European countries (such as Germany, France, Spain) all had more capacity in healthcare during the Covid pandemic in respect of doctors, ventilators, nurses, beds, etc. than we had. That helped these countries both in the Covid response and also in being able to maintain their care and treatment running in parallel with this, which we were less able to do.

135. My view is that the reason for this is that whilst all these countries do have universal healthcare systems which are provided to the whole population based upon need, the way that this is funded is different in the UK to other countries. Their systems are funded by general taxation in part, but not in full. They also have funding by way of compulsory insurance, co-payments etc. Our system is funded almost entirely by way of general taxation. That means that in every spending round process, the health department has to compete with the other priorities of the day, which inevitability leads to the shaving of budgets, day to day and capital budgets.

136. To obtain the capacity to meet the health needs of the 21st century, we need to fund the NHS adequately which involves looking at funding from sources other than just general taxation. I would suggest that we need to seriously consider having a charge (for those who can afford it) for the general practitioner and to use other sources of payment or investment into the system which recognises that general taxation is not the only, or sole way of funding this. I also consider that the current way of funding is not efficient - we are the 6th highest spender on health according to the OECD, but we do not have health outcomes commensurate with this. We spend more - our spending on the NHS has gone from 27% day to day of public spending in 2000 to 44% now without commensurately greater health outcomes. I consider that there needs to be a fundamental reconsideration of how we fund the NHS and its model. We need to consider different versions of a contributory principle, to complement, but not replace general taxation. I would wish this country to look at the Republic of Ireland, where hospital care is free, but one pays for GP care and there are circumstances where payment is required for attendance at an injury unit unless a GP has identified that it is necessary. In Norway and Sweden, countries which have strong principles of social welfare, a visit to the GP comes with a cost of around £20 (depending on means). Germany has a social health insurance model enabling a greater choice of providers (including not for profit providers). We pay for prescriptions, for

optical and for dental care (with major qualifications for young people and others on low incomes).

137. My view is that unless the NHS is radically reformed, the principles upon which it was founded will not survive much longer. I made a comprehensive case for major reform in the 'Dorchester Address' speech as Health Secretary on 8 March 2022, although there was less appetite for reform in No10 at the time. The case for this was informed by having seen the strain in the NHS during the pandemic. Our demographics are not those of 1948, and the results of a population which has much larger numbers of those over the age of 80 (now at around 3 million and growing very fast) requires a response to chronic long-term conditions which are expensive. Furthermore, whilst Covid reminds us that the risk of serious infectious disease has not disappeared, it is recognised that most of our health problems today relate to obesity, cancer, cardiovascular issues, and degenerative disease, rather than the infectious illnesses which killed so many before the arrival of mass vaccination programmes. The resources required for all those diseases are intensive and expensive.

138. I know that the very strong feeling in the public is that they recognise the NHS' dysfunction - but can be very sceptical of attempts to change it . But having the NHS as a totemic shibboleth prevents proper debate about necessary changes, and a shying away from politicians from all parties of some hard truths. I would say that the same could be said about social care: everyone recognises that the current system does not work and has said so, but the will to ask radical questions and make change is stymied.

139. But we must face this. In 2022/2023, one in six adults has been unable to access a medical appointment.[13] The waits for treatment are much longer than in most other European countries. The only answer that the NHS must demand is to make people wait. This is not the norm elsewhere and should not continue to be the case.

Long term preventative illness

140. I also consider that we need to focus money and services on preventing illness. I understand that up to 40% of all NHS spending goes upon preventable conditions. When I was the Health Secretary, I tried to implement various long term plans - for example about

[13] This is all taken from an article written by Sajid in January 2023 available at www.sajidjavid.com

mental health[14] and other diseases. It is necessary to think ahead, to work upon prevention and to spend on public health in a manner which is commensurate to the costs incurred if such support is not put into place.

Workforce plan

141. I began the process of the workforce plan which was published in July 2023[15]. It is essential to having resilience and capacity both in pandemic and non-pandemic times for there to be stable numbers of nurses, doctors and the many other health staff who work in the NHS. The current level of vacancies in the NHS is unacceptably high and must be reduced.

Digital innovation

142. I firmly believe that digital innovation is required, which is why I published a digital health and social care plan whilst I was Health Secretary.[16] This involves innovation such as being able to have digital access to records between hospitals and primary care sites and the use of robotics in operations. There needs to be adequate funding for these systems to be put in place which over the long term will be cost saving.

Concluding remarks

143. All political parties need to come together with those in the profession to recast the 1948 settlement for the 21st century. This does not mean dismantling or privatising the NHS but recognising that there needs to be different ways of providing services, and of paying for such services. My preference would be a Royal Commission on such matters which could operate as a truly expert body and be able to make recommendations which may be unpalatable to those facing short term electoral concerns. We cannot keep avoiding the problem by burying our heads in the sand, as otherwise we will not have an NHS in fifty years' time.

[14] https://www.longtermplan.nhs.uk/wp-content/uploads/2019/07/nhs-mental-health-implementation-plan-2019-20-2023-24.pdf
[15] https://www.england.nhs.uk/wp-content/uploads/2023/06/nhs-long-term-workforce-plan-v1.2.pdf
[16] https://www.gov.uk/government/publications/a-plan-for-digital-health-and-social-care/a-plan-for-digital-health-and-social-care

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 make, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Rt Hon Sajid Javid MP

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NAME

Personal Data

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Signature

18/10/2023

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Dated