Monday, 25 November 2024

(12.00 pm)

MS CAREY: My Lady, may I check that you can see and hear me all right?

LADY HALLETT: I can, Ms Carey, thank you very much indeed. I'm truly sorry that I can't be with you today but, as you can probably hear, I've been advised to rest, and if I can't rest, to work from home, so that's where I am. But thanks to the Inquiry team, who leapt into action, I'm confident we can proceed without any delays and in the normal fashion apart from the fact I'm not there.

So thank you very much.

MS CAREY: Thank you, my Lady.

My Lady, the first witness, indeed the only witness today is Sir Sajid Javid, who is in the room. Can I ask, please, that he is sworn.

SIR SAJID JAVID (affirmed)

Questions from LEAD COUNSEL TO THE INQUIRY for MODULE 3

MS CAREY: Sir Sajid, good afternoon.

A. Good afternoon.

Q. You became Secretary of State for Health and Social Care on 26 June 2021 until your resignation on 5 July 2022; is that correct?

A. That's correct.

Q. By way of background, I think you became an MP first of

all in May 2010. Before that you had had a background in investment banking. And do I take it from that, you did not have clinical experience as at the time you were appointed Secretary of State?

A. That's correct.

Q. We are familiar with the role and indeed the responsibilities of the secretary, so I don't need to take you through that, but can I ask you this at the outset. By the time you took up the job in June 2021, what was your assessment of the state of the NHS as at the time you were appointed Secretary of State?

A. Well, clearly, obviously, the pandemic had started and the country had gone through a very, very difficult time and the NHS had gone through a significant amount of challenges and stress. I think I would say by the time I came in June 2021, certainly from the people that I first started talking to, my office, in the NHS itself and others, I think from listening to them at the time that they felt it was sort of -- things were calmer, there was a, sort of -- better structures in place, the sort of -- you know, certainly at that point it was felt that the high point of the crisis, when there was so little known about the virus itself and how to protect ourselves against it, was -- you know, things weren't -- there were more knowns at that time.

But, as well as the country still being in partial lockdown, a lot of discussion was going on about when we should lift those restrictions, but also a huge amount of stress on the NHS because of not just obviously people from Covid, many -- you know, still thousands of infections at that time, but also the pressures of getting the vaccine out as quickly as possible and the many people we knew that had stayed away from the NHS and wanted them to come forward but knowing that that would present even more challenges with demand.

Q. When you were sort of gaining an assessment of what everyone had been through and the state of it in June, who were you talking to or taking briefings from?

A. A number of people. So I had a -- as I say in my evidence statement, I, sort of, refer to -- first there was, like, a rhythm of regular, sort of, meetings to both stay updated but also to help me make decisions. And they would be meetings with No. 10 team, for example, with the Prime Minister himself, quite regularly, almost every morning initially, in a morning meeting, with my -- with the team at the department itself. Especially certain individuals such as the CMO, the deputy CMOs, the department of secretary, the NHS leadership, especially the CEO, the Chief Medical Officer and others, and also Jenny Harries and her team

in UKHSA. And there -- I mean, there were many other people involved but what I've stated there, probably some of the people that I would meet, you know, almost, you know, every -- some of them every day and some of them more than -- you know, many times in the same day but at least every week there would be very regular meetings.

Q. You said a moment ago that perhaps the height of the uncertainty had passed. Were you able to gain any assessment of how the workforce were feeling, what their morale was like, what their resilience levels were like when you started in June?

A. Yes, but in the early days, in the first, sort of, couple of weeks it was more through -- rather than any sort of direct contact with the workforce in the NHS, if you're referring to the NHS workforce specifically, it was through people that were having direct contact, so the leadership of the NHS.

Very early on I also wanted to start meetings with some of the CEOs of the NHS, the various -- some of the trusts. I started having discussions again early on with some of the representatives of the workforce, the royal colleges, the BMA --

Q. I'm going to ask you --

A. -- the Royal College of Nursing and others.

Q. All right. Before I do ask you about those --
A. Yes.
Q. -- can I just ask you about a number of things you say in your statement. And if it helps you, Sir Sajid, I'm at paragraph 41, but you say your overall priorities during your tenure were around three key themes: Covid, recovery and reform.
A. Yeah.
Q. And I think you go on to say you sought to advocate for greater investment in pandemic resilience both domestically and internationally.

Can I ask, are you able to give us some practical examples of how you advocated for greater investment and, indeed, what fruit was borne from that advocacy?
A. Yeah, so, you know, when I talk about investment, it's about -- particularly I think I'm referring to here, it's always financial resources.

Already I was aware there had been a significant increase in financial resources both for the NHS to deal with Covid but also the, sort of, wider system with other interventions to deal with the pandemic. But more specifically, when I came in, I think one of my -- you know, as I said here, the -- my -- I sort of framed my role as dealing with three things, not, sort of, one after the other, but they were all at the same time,

which is, as it says -- first and foremost, right there then, is obviously the Covid pandemic is still going on. There's the recovery from that pandemic. I mean, I wasn't thinking "It's over", and obviously later we learned -- the Omicron variant, for example, comes along. But then also thinking about longer-term reforms. And also some of the issues that I think that the pandemic has sort of shined a light on about, you know, health inequalities and other important issues like that within the health system.

But to give you a specific example with the sort of Covid emergency and recovery at the time, I was keen to secure extra resources, especially for what I'd call, sort of, elective recovery -- you know, for the elective -- both in terms of diagnostics and also ops. And I think at the time that eventually, you know, through the process, when it was worked through, I think I secured around an additional £8 billion in that financial year. Some 5.9 billion of that went into what's called the Elective Recovery Fund to fund more operations and diagnostics, and also £700 million into something called the Targeted Investment Fund.
Q. Clearly your efforts bore fruit financially. You say though in your statement that you advocated for greater resilience, domestically and internationally. Tell us

about the international element to your statement there?
A. Well, it was -- so I think when I'm writing that here in this paragraph, I was thinking about international cooperation around Covid specifically at that time, and there were a number of things on my mind and one of them certainly was the -- prior to me becoming the health secretary the government had already, rightly, made a commitment to share vaccines with countries that basically couldn't afford them and I was very keen to make sure we were following through or on our commitment and at pace within other countries.

The second thing was about information sharing. The UK had, I think compared to many other countries, had invested a lot of time and effort in creating databases, including international databases, and I was keen that that information was being shared.

And then thirdly, I remember soon after I came in that I was briefed on some international initiatives specifically that the UK had been involved in, one was with the -- well, a number were with the World Health Organisation, especially around discussions that had already started about a pandemic treaty which was sort of looking forward to, you know, how can we be better prepared as a world for the next pandemic, learning lessons, and I think the sooner we -- if there was

an agreement on that globally the better.

So that was something I was engaged in.

And then, lastly, also there's an organisation called GAVI which the global -- it's the global organisation of vaccinations -- global association of vaccinations and immunisations, which the UK was, I think, probably the second- or third-largest donor, being a very generous donor, and I was keen to see how we could work with GAVI and other similar organisations in vaccinations and not just the delivery of vaccinations but also actually getting them into people's arms globally.
Q. Well, that gives us a sense of what you were trying to convey in that paragraph. You do say, though, at your paragraph 43 that you imposed formal parameters around what decisions you wanted to take personally --
A. Yeah.
Q. -- and other areas of decision-making which were delegated to junior ministers, and you set them out. You say, I think, you wanted to take personal responsibility for the NHS care bill -- I'm not going to ask you about that --
A. Yes.
Q. -- but you do say:

"... how the NHS was handling Covid in hospital

wards; hospital waiting lists ... and prioritisation of surgeries ..."

To name just a few of your areas of personal responsibility.

And why those particular areas, Sir Sajid?

A. First of all, it's -- in any government department it's not unusual for the Secretary of State to set out early on who is going to focus on what, including the Secretary of State. It's worth, sort of, highlighting this was the sixth government department that I'd ran and so I'd had a bit of experience in running departments generally but also how to, sort of, try and get things done.

So, first, this should be happening in any case. But then in terms of deciding who does what. Some of it was already set out when I came into the department and I felt that where ministers were in place, for example the health minister at the time, Ed Argar, and I felt that if it generally seemed that the individual was doing a very good job, I thought that there shouldn't be much change in their mandate in particular, but the areas that I've highlighted here that I picked, and as you say, this is not an all-inclusive list, there are many others, these are just examples.

These are the ones that I decided were very

important for the Secretary of State personally to deal with, because --

Q. Can I interrupt you.

A. Yes.

Q. Sorry. Can you give us a sense of when you say you want to take personal -- what do you actually do? How does it manifest itself in the workings of the department?

A. Yeah, so what it would mean is that, you know, if you just take one of these diagnostic centres, prioritisation of surgeries, what that would mean is that -- I'm referring there specifically to an initiative that we'd had which was early days at the time, which were around community diagnostic centres. We basically wanted to open up many more diagnostic centres to work through the backlog of people and they weren't just in hospitals, they could be in other settings, so it was quite a new, different initiative, and I was really keen that stayed at pace, but because it's new, though, issues might come up and I thought it would be much quicker in terms of delivery of those diagnostic centres if I was dealing with them directly.

So what that means is that every time an issue came up, if it was either a policy paper, a meeting to make decisions, it would be me leading that meeting rather than one of my junior ministers.

Q. I see. Thank you.

You mentioned a moment ago work that you'd done perhaps with unions, CEOs, the front line, and I'd like to ask you about that.

A. Yes.

Q. In your statement you say you had a number of meetings with nurses in particular in February 2022, as that coincided, I think, with a recess in Parliament.

A. Yes.

Q. Two things: did you speak to anyone on the front line though prior to that, given that you were appointed in June of 2021? What were you doing for the eight months or so prior to the meetings in February '22?

A. Yeah, no, lots. In fact when I -- soon after I got appointed I was very keen to get out there, if you will, out of my office and into hospitals and other clinical settings to speak to both staff and patients, but to, sort of, get a sense myself and hear directly from people on the front line.

And I think that probably started I think in the first, sort of, week I was in the job and I would try my best to actually every week to get out somewhere and make a visit and -- it wasn't always the case, but that would be my aim every single week, sometimes more than one such visit in a week. And so I made many, many

visits before February '22 -- you know, I don't know how many, but it would have been, if it's every week, would have been tens and, you know, 20, and -- but also sometimes I would make visits that would -- if I'm going to a particular area like Birmingham, or something, I might see two or three different settings in The Midlands area at the same time to try and make the most of my time, but one I think wanted to do was to make sure that when I made such visits I wasn't just meeting or speaking to the leadership, which is important, it's hugely important, so I'd go to a health trust, for example, I remember, for example, Milton Keynes, one of the Milton Keynes health trusts I visited where I had actually a very good meeting with the CEO and his top team, and I think in the past maybe meetings would have stopped around having those types of top-level meetings, but I had said before I went, and I continued this throughout, that whenever I make such visits we must try to have meetings for me with the frontline staff, nurses and porters, and others, but without any of their senior management present, so I only wanted myself, one of my private secretaries, and then the frontline workers without any of their senior managers, so I could hear from them directly and I would start often by saying to them, "Feel free to say anything you want, we're not

taking notes, just be very open and honest because I want to know what's working well and what's not working well."

Q. Pausing you there. Can I ask you then, for example, in relation to the nurses that you met, what kind of things were they telling you and, more importantly, how did that impact your response or directions you gave to the Department of Health? How did what they were telling you translate to actual action for something you could do practically for them?

A. Yeah, so when I -- I mean, I met with many, sort of, nurses normally as groups in hospital -- typically hospital settings. And I would hear for example things -- some things about things that have gone right and gone really well and nurses understood the country, there was a crisis and it was going to be difficult for everyone but they were on the front line and I felt that overall nurses were doing a great job and they needed to be heard.

I heard about morale generally. Staff morale was tough, given the extra burdens and the pressures that Covid had brought. And it would lead me then to, sort of, enquire when I would, then, sort of, get back to the office, so to speak, and then maybe sit down with the NHS leadership and stuff is to bring those issues up and

ask what's being not just in that trust I've heard it from, but in other trusts.

I would hear, for example -- I remember one group, I can't remember which hospital it was but nurses explaining to me -- it was in an A&E ward -- that they felt that their local hospital was very well integrated with the sort of -- with the ambulance service and they had some newer technology that allowed them to communicate more efficiently with ambulances where they were and who was about to come in, and they hadn't had that before and how it had made a big difference to their workday, to the pressures they had, so then I would take that back to when I had my weekly meetings with the UEC team, the urgent and emergency care team, I would then be able to bring that up because I had heard it directly.

So the point: many examples of things that I heard, I found it hugely valuable to have that kind of engagement.

Q. What about in your meetings with porters?

A. Yes.

Q. What kind of things were they telling you about how the pandemic had affected them? And again, what did you do about it, what did you take away from your meeting with them?

A. Well, I think I do remember porters, certainly a group of porters telling me about -- and they weren't complaining, it was more sort of to -- explaining that because of the job they had, the very important job that they had throughout the pandemic, and they couldn't stay at home, they couldn't sort of work from home, and they felt much more exposed to the virus. And certainly in the early days when a lot less was known about the virus and certainly when there wasn't the vaccine and in some cases possibly not enough PPE or the right type of PPE to go into hospitals, they were really concerned, but how they still kept coming into work which -- so -- and it just -- and that was before my time, what they were referring to was before my time as health secretary but I completely understood it and it just made me, you know, think that obviously I can't change what had happened, especially when they're talking about PPE and the lack of vaccines, but it just again made me think about the next time this happens, when we are having the next pandemic is that -- you know, this is exactly the kind of things we need to be better prepared for but also thinking about people just like that on the front line.

Q. In your statement you make reference to other meetings that you had, including meetings in relation to cancer,

and we may look at that. But there was also meetings with those who were involved with patients that had dementia. Can I ask you about that, please. Do you remember now what was sort of discussed in the meetings where you were speaking to people who were involved in dementia and what kind of issues were they raising with you? I presume you met with family --

A. Do you mean in relation to Covid or do you mean in general?

Q. I think it was -- well your statement doesn't make it entirely clear. It's at paragraph 76, Sir Sajid, if it helps you. You had meetings in relation to Monkeypox -- I don't need to ask you about that. Regular meetings on cancer with the NHS lead and then you say:

"... similar meetings on mental health and dementia."

A. Yeah, yeah.

Q. And it's really if there's a link between what you were hearing in the dementia-related meetings and how the pandemic had affected those with or caring for people with dementia?

A. I think what I'm referring to here were -- on dementia specifically, since you asked about that, is not specifically linked to the pandemic and Covid. My reference here is that -- if you go back to where we

started a moment ago by -- my priorities, Covid, recovery and reform, and in terms of my, sort of, recovery, but especially my reform work, was that, as I mentioned a moment ago, I think for me simply coming into running the health service, the department at that time, Covid had revealed, I thought, a sort of -- a lot of inefficiencies in the system broadly, a lot of inequalities in health outcomes, and I felt also a lack of joined-up government in many serious illnesses. And three of those that I identified as a priority were dementia, cancer and mental health, and actually a fourth one was suicide prevention.

But the first three I'd spent a lot of time on and I asked for ten-year plans to be developed, long-term reform plans, but what I was specifically trying to get at is that it's not just a job for the health department, it's a job across government. So, for example, dementia there's a role for DWP department, there's a role for the education department, for local government, and I felt that government wasn't, sort of, working together to address these serious ill health issues.

Q. Acknowledging the wider picture as you've just alluded to, can I descend now to perhaps some detail about the NHS itself and in particular the issue in relation to

admission ... the highest recorded since the collection began."

Now, Sir Sajid, clearly A&E waiting times, ambulance waiting times, and the like, are nothing new, but would you agree they were exacerbated by the impact of the pandemic?

A. Yeah, absolutely. The primary cause of these very poor numbers is the pandemic.

Q. Yes. Now, seeing that bleak picture as you did, I think, on a regular basis, can you help with what steps you took, for example, upon receipt of this information, to try to improve A&E waiting times, insofar as you were able. And we appreciate that there's not a magic wand here, but tell us what kind of things would you say, would you do, would you direct the department to do about this?

A. Yeah, I mean, so, you know, first of all, the -- it's -- I thought it was important in terms why is -- why is this happening. And obviously it's -- I think it's obvious it's the pandemic, but then we need to break that down: what is it? What aspects of the pandemic are driving this?

And you had this combination of people coming to A&E that might be -- it might be related directly to Covid, and so they might be in really bad health, need

waiting times. I think you were briefed regularly in relation to different aspects of waiting times.

Can we have on screen, please, INQ000372786.

And if we go to page 2, just to situate ourselves. This is a ten-page document which covers a number of different waiting times, A&E, 111 calls, referrals to treatment and the like. I'm not going to go through them all with you, Sir Sajid.

A. Yes.

Q. Here is an example from September 2021, so you'd been in post three months or so by that stage.

A. Yes.

Q. And we can see that in relation to A&E there were 14 trusts undertaking field testing of new standards as part of a clinical review that were not required to submit 4-hour breaches, therefore not everyone's performance had adjusted, but if you look at the second bullet point:

"95% A&E standard not met, 112 out of 112 Trusts with Type 1 departments ... missed the standard (for all types)."

And if we just go down to the bottom bullet point:

"In September 2021, the number of patients waiting over four hours [104,000-odd] and over twelve hours [5,000 people] from decision to admit to

emergency care, because they've got the virus and it's been particularly bad for them. But also, and this was going to be a huge amount of it, is that this is, as you say, September 2021. By then, I think I'm right in saying that the lock -- the sort of lockdown restrictions had all been lifted. There might be other restrictions in place but the country was feeling like it's sort of getting slowly back to normal, people out and about again and things and feeling, I think, more comfortable to access healthcare and weren't, sort of, keeping themselves away like they had during the height of the pandemic. So a lot of people returning to healthcare. And a lot of the problems they would have had that had there not been a pandemic they might have gone through their usual process in the NHS, without A&E, that it may be the issue had become more acute. So I think there was a lot of like what I would say is sort of delayed demand even for A&E.

Also I think a part of the aspect here -- part of the reason here was accessing non-emergency care and people getting frustrated that they maybe tried to get a hold of their GP or other forms of non-emergency care but they tried so many times and feeling that they're not getting through and the system is not responding well enough and then turning up at A&E, whether that's

through ambulance or at the door.

And so the answer to your question about what we were trying to do is that I had a number of meetings with NHS, with the department, ambulance trusts and others about this particular issue, and then I think it was in September that same month we published a 10-point plan on UEC, on emergency -- urgent and emergency care. And that included a number of initiatives.

So, for example, one of those that sort of stood out, I was told because it's one of the biggest issues, was the more people -- if there were enough call handlers, qualified call handlers, more people could be handled through the NHS 111 service.

Q. I'll come on to that.

A. And so that was one thing that we invested in, in terms of resources and trying to train up more people.

Another was through, you know, what, sort of, more support could we give to primary care, to GP services, and that -- then this fed into, I think, later, the sort of winter care package, I forget the exact name we called it, the extra 250 million -- the winter fund that we offered GP services.

And then also we -- we were -- in fact on this issue I also felt I also needed more data, I needed more granular data, which I started getting what I sort of

called a UEC, sort of, dashboard, and -- and then I started asking for it at least a day before the meeting, so I could study it before I'd have my meetings, and then I started having almost twice weekly meetings on this particular issue, to see and make sure that we were doing everything we possibly could be doing.

Q. Can I pick up on one of the things you just said there, which was NHS 111.

A. Yes.

Q. In fact if we go to page 4 of this document, we can see that some of the other aspects of waiting times that you were given were the number of calls going into NHS 111, and indeed some of the data, if we look in the middle of table 5, was the proportion of calls that were abandoned. By September 2021 it was 25.6% of calls abandoned.

A. Yes.

Q. Just to help you, Sir Sajid, in March 2020 we heard there were, I think, 1.1 million calls out of 2.5 million calls that were unanswered. So 40% went unanswered 18 months before. It's now down to 25.6% but still a large proportion of calls were abandoned. That's not to say people might not have rung back, we appreciate that. But do I understand it correctly even

as at the time you became Secretary of State, there was still concern that NHS 111 didn't have the capacity to answer the calls that they were receiving?

A. Yes, absolutely.

Q. And do I take from what you've just said that you tried do something about that --

A. Yeah.

Q. -- in -- by increasing the number of call handlers?

A. Well, yes, call -- and also there was -- increase the number of call handlers and I believe there was also something where -- some kind of initiative with British Telecom as well, about how the calls were handled and distributed around the country.

Q. Final page on this. If we go through, please, to page 8 of this document. You were receiving information about the "Post Covid Assessment Service (Long Covid)".

A. Yes.

Q. And we can see that as at September 2021, in August there had been 5,488 referrals. That was a slight drop than in the previous four weeks. A proportion of those that were accepted.

One looks at -- they were telling you the access, the types of people that had been assessed. Clearly there was mainly white people. Most of the people were women. And then the age groups indeed. And you can see

there that, in fact, 1,000 of those, 31%, were under the age of 45. And then the majority of people there were aged between 45 and 64, and a smaller percentage aged 65 plus.

And if you look at the waiting times, of those who had had their initial assessment during the reported period, 40% were seen within six weeks, 55% within eight weeks and 19% were waiting longer than 15 weeks.

And then there was regional variation. So it looks like they were doing better in the North West at being seen within six weeks compared with what was going on in the South East. So clearly a lot of data there about Long Covid.

When you saw regional variation like that, what do you actually do as Secretary of State to try to address what, on any view, is a wide disparity, isn't there, between how the North West was performing and how the South East was performing?

A. Do you mean with reference to Long Covid only?

Q. Yes, long Covid.

A. So I would -- you know, I would want to know as to -- what are the reasons for such a disparity. So, for example, could it be the provision of services, could it be the communication of the -- could the service exist but is there poor communication? You know, and

obviously there could be other issues as well. And then what we are doing -- you know, "we" is sort of more broadly, but specifically NHS -- to address them.

I noticed this was in -- I think these numbers -- yes, as you say, it's from August.

Q. Yes.

A. I believe that in -- you know, throughout the pandemic but I think particularly in June of that year there was a big, sort of -- I think an announcement by my predecessor, it would have been around Long Covid, but in particular about more provision and more resources. And I think, if I remember, it's something like £19 million was allocated for more clinics specifically for this and something like 145 hubs were stood up across the country.

So, I knew that -- so, looking at this, I would have known then, but I would have wanted to, sort of, be updated that -- you know, what's now happening, is that money actually going into creating the hubs. Because we had no time to waste. You know, you didn't want an announcement back in June, only a couple of months before this, that people sort of -- perhaps sort of, you know, haven't understood the urgency of that. And I think I would want to be updated on making sure that those hubs are indeed opening, they're operating, are

there any issues, and so it's not just an announcement that, you know, maybe -- you know, it's the right announcement but is it actually being delivered.

Q. Can I stick with Long Covid, and I think by the time you had become Secretary of State there had been various pieces of guidance and calls for research and indeed funding for research, as you've just referred to. You're right that in June Mr Hancock had launched the Long Covid plan for 2021 and 2022, including the 19 million Long Covid clinics and various amounts of funding. And I think in July 2021 you announced 15 new studies and just shy of 20 million to help improve the understanding of Long Covid and identify effective treatments.

Can we just look at some of the projects that were being envisaged.

And can I have on screen INQ000283460_4.

This is just a summary of some of the projects, but you can see that there was one being done by University College involving more than 4,500 people with Long Covid to test the effectiveness of existing drugs to treat Long Covid.

A. Yes.

Q. And then there were various other studies, including,

for example, the LOCOMOTION study at Leeds focusing on identifying and promoting the most effective care, and indeed one being done, at the bottom bullet point, EXPLAIN, at the University of Oxford, looking at diagnosing ongoing breathlessness.

Can I just ask you this, were you involved in actually identifying what projects should get the funding or just securing the funding itself?

A. More in securing the funding. And I think, you know -- certain what would have happened here is that once the officials working with the NHS have identified which projects are to get funding, I would have seen a list, but it wouldn't have -- I would not have changed it or made any other recommendation, on the basis that the officials would know better because they would have the expert advice and they'd understand each of those. I would have been keen for the -- for them to get on with it.

I do remember -- because the funding for all this was -- so it was announced, as you say, by my predecessor in June. This -- these studies you're referring to -- this announcement on these 15 studies was made soon after I got in, like a couple of weeks after I got in. I think -- I'm pretty sure that within my first few days I asked about -- certainly I had

a briefing on Long Covid but I asked what was happening to the funding, and I wanted the team to, sort of, accelerate this investment because, again, I didn't want there to be an announcement with no follow-through. And I'm sure, because this happened quite quickly, I would have been pleased that they'd identified the projects and started getting them funding very quickly soon after the announcement.

Q. Now, we've heard that there were Long Covid roundtables that were already in existence by the time you became Secretary of State, and I think you attended one yourself on 23 September 2021. We have a minute of that.

Can I have on screen, please, INQ000067409.

I think they were normally chaired by Lord Bethell. You attended this one. And in the ONS update we can see there that it was reported that prevalence of Long Covid at 12 weeks was highest among women, middle age people and people with existing illness.

Then if we go down to the NHS England update and the bullet -- sorry, the note that starts:

"CH said that based on data from September, there were 6,000 referrals to the assessment services over a 4-week period. 88% ... were accepted. The

rate of referrals is only around 30% of what was anticipated which may mean many people are not coming forward."

Now, once this was been discussed in the roundtable, Sir Sajid, what did you ask to be done about this and why, on the face of it, it looks like there are quite a large number of people not coming forward for assessment?

A. I think actually one thing I'd point out here, there were -- as you say, there were regular roundtable -- this -- the -- a task force was set up. In fact, I think the NHS had set up their task force back in 2020 and the -- but the -- from ministers there were regular roundtables.

Also at this meeting, I think I'm also right in that Maria Caulfield was there as well and she was a minister in my department that was responsible for -- broadly for patient care and patient safety. And one of the jobs I'd given her when she had come in as minister was to also be the minister for Long Covid, because I thought it needed a very specific focus from a minister, and I believe she was at this meeting, she regularly attend these meetings.

But on your question, I couldn't tell you today, like, specifically in relation to what's just

highlighted here what I would have asked but I can tell you with a high degree of confidence what I probably would have said is: how do we -- there are clearly people out there that should be coming forward that are not so how -- what are we doing, what is the NHS doing, what is the department doing to try to encourage them?

And this was -- actually it was a broader problem. It wasn't just an issue with Long Covid, and that's important enough. We had a very big issue of people not coming forward --

Q. Yes.

A. -- and that was important to me. Because, first of all, obviously people -- if people have some illness that needs to be addressed, the sooner they get it addressed, it's good for them. Obviously it's better overall also for the NHS as well. But I just felt not enough people were thinking that the NHS is, sort of, open, so to speak, and they can start coming back now with the issues they might have stayed away from at the height of Covid. And in fact I made many, many public appeals on TV, radio, media, elsewhere, again and again, just asking people to come forward, and that would have included people clearly that might have symptoms of Long Covid.

Q. Can I just ask you to stand back away slightly out of

Long Covid for a moment. We've heard -- we've asked a number of people, indeed we've heard a lot of evidence about the Stay at Home messaging and whether the balance was right. And you were, I think, Chancellor of the Exchequer at the very beginning of the pandemic --

A. Yes.

Q. -- and then on the back benches for a while before resuming your role as Secretary of State now for health.

What do you think, Sir Sajid, about whether the balance of the Stay at Home messaging was right and would you do anything different if you were -- or advise a future minister to do anything different?

A. Look, I think it was the -- overall in principle it was the right messaging. I think what's very difficult is to the balance, getting that right. Because, you know, it demands -- it needs some kind of clarity, and I think that most of the time that was there but I think later on during the pandemic there were moments before -- this is -- the moments -- I'm referring to before I was health secretary, and I speak now not as -- therefore as health secretary, but I was a backbencher, as you say then, but I felt that some of the messaging could be a lot clearer. But I do -- having said that, I just think it is very difficult to get the right balance.

Q. I think everyone acknowledges the difficulty but

a solution is perhaps harder to find.

Can I go back to Long Covid, please. And in that roundtable in September 2021, if we could go to page 3 of that document, I think you actually then spoke to and were addressed by a number of Long Covid sufferers who spoke about their experiences. It's just coming up now.

And we can see there in that top box that a sufferer explained that she was from Manchester, one of the -- six most deprived areas, had caught Covid early on in the pandemic, was disbelieved by her GP, who dismissed her, and months later was still suffering. She says she's now been referred to the Long Covid services. Often not been able to travel to multiple different hospitals for appointments.

"[The] model of service is not accessible for many people who live on a low income or are disabled."

And indeed reference there to online support groups being set up and then regularly hearing from people who are saying they were disbelieved by their GPs.

Once you heard it from the sufferers themselves, can you recall now what you did to, firstly, address concerns that people were being disbelieved by their GPs?

A. Yeah, I was actually -- yeah, well, I remember actually

now, hearing that. And I was very concerned about that.

But I'll tell you one of the reasons I was -- it sort of particularly caught my interest is that, you know, I know people that suffer or live with ME and CFS. And I know that's not Long Covid, but it is a serious illness that affects at least 200,00 maybe 250,000 people in this country. It's a very serious illness. Actually has some symptoms that are not dissimilar from Long Covid.

And just from my own, sort of, personal experience, I've heard from so many people -- and also as a constituency MP, that people that have -- who are living with ME and CFS felt that GPs -- in some cases they'd say: GPs are not listening, they don't recognise it, they think I'm just lazier, should just get out there, do a bit of exercise. And this comment that this individual obviously is making about Long Covid really reminded me of that and I saw some sort of similarities in that.

And I thought -- one of the issues with ME and CFS is that it hasn't received enough research and -- because it hasn't been -- by the -- overall by the system been taken seriously enough, by everyone, and that's -- made -- what was -- something that made me want to act even more than otherwise on this, because

I really recognise what this individual was saying, and I'd heard it before as well with reference to Long Covid as a constituency MP.

And so as a result of that, I certainly would have -- one thing we already talked about was the research around how can we, sort of, make sure this research is happening, but also I think I enquired then about what is the NHS or the health system doing about this, making sure, for example, GPs do know about this, that they do take it seriously. And I was told the -- for example, that NICE was setting out new guidelines, it had -- already had guidelines on Long Covid -- new guidelines, and also how it would be communicated.

I'm sure I would have asked it to come out even sooner than what they planned, and I believe that in November that year that NICE did publish its guidelines, and the point being that it gets out to every clinician and practitioner out there so there's better awareness.

I also -- by the way, I also started a separate review of government's handling of ME and CFS as well, and I asked them to work closely with the same team that was looking at Long Covid.

Q. Can I just jump forward a few months and look at the waiting times in relation to Long Covid again.

And can we have up on screen, please, INQ000479860_9.

Sir Sajid, this is now January 2022. We just looked at September 2021 data.

If possible, could I have up the September 2021 data. It was INQ000372786, I believe.

So on the left of the page, if you're looking at it, it's waiting times from September 2021, as we just looked at. On the right side of the page, here we are now in January 2022, and if one just looks at the -- thank you -- both at the bottom, the waiting time boxes, in fact it looks like the position's got slightly worse in some respects, better in other respects.

But we can see there during the reporting period, 39% now waiting six weeks. I think it had been 40%, so it's got better by a percentage. 55% down now to 47%. And 35% though were waiting longer than 15 -- so looks like a rise there in the amount of time people were waiting.

And there is still the regional variation. Length of waits were 81% in North East were being seen within six weeks compared with 4% in the South East. 64% of patients in the South East were waiting over 15.

So may I put it like this: a mixed picture of some progress in some of the waiting times coming down,

assessment times coming down, but not in other respects.

When you got a sort of jump like that three months on, where it's not improved across the board, what did you do as Secretary of State to try to ensure that those great disparities we're seeing there in regional variations were addressed. It looks like something hasn't quite worked from September 2021 to January 2022.

A. Yeah, I would have -- so I would have seen these updates on activity regularly.

Q. Yes.

A. I think part of it probably also reflects the number of people because one is obviously a few months after the other, and so the number of people, sadly, with Long Covid is probably increasing as well because -- just the way the virus is -- because I think the second set of numbers is during the Omicron -- yeah, it's 22 November to 19 December, so that's during the Omicron wave. And so infections have been rising as well.

I would -- so I think I would have -- again, I can't tell you specifically in relation to this what I did, but I can tell you what I, sort of, would have done is to ask about -- again about the resources and are we putting enough resources into this, are all the hubs being stood up, is there enough awareness amongst GPs to recommend people to the right services.

And I must also say though I think that during that time, this period, November 22 -- sorry, 22 November to 19 December, I think a lot of my bandwidth, so to speak, would have been on Omicron.

Q. Yes.

A. And perhaps I would have had less time to spend on other issues, no matter how important they are, because Omicron was a serious threat to the country and the NHS.

Q. We're going to look at Omicron in just one moment.

A. Yes.

Q. Can I just finish on Long Covid, and can I ask, please, about some comments that the Inquiry's Every Story Matters record has heard.

A. Yes.

Q. Can we have up on screen, please, INQ000474233_0180. And the section beginning "Other pandemic changes to healthcare often made it harder to access care for Long Covid, adding further frustration":

"... some experiences highlight the difficulties faced in using a telephone or online consultation to communicate their symptoms and the impact this had on them. Contributors were frustrated that telephone or online appointments did not provide care to the same standard as seeing a healthcare professional ..."

And you will see there, Sir Sajid, two quotations

from people that spoke to Every Story Matters. The first person said:

"It's so hard to see a GP now. I have to send photographs to my doctor's WhatsApp telephone number where you send your name, date of birth and the photographs ... it's just not the same."

And a second contributor said:

"I managed to see healthcare professionals through virtual consultations. They instructed me to monitor my own vital signs like pulse and blood pressure and even guided me through examining my own throat. But I found this mode of consultation inadequate; there's no substitute for a physical examination by a professional. I was diagnosed with Long Covid. While this diagnosis was a relief, it also taught me a crucial lesson: virtual consultations have their limitations."

Were you made aware, firstly in the context of Long Covid, that perhaps in some respects virtual consultations were having an effect on those who were seeking diagnosis and/or treatment for Long Covid?

A. I don't remember specifically with reference to Long Covid but I was made aware more generally, and that would have included Long Covid, that virtual consultations have their limitations.

Q. It brings me on to that topic, if I may. Because I think you've certainly seen evidence provided by the Royal College of GPs and, indeed, we heard from Dr Mulholland.

Can I have a look on screen, please, at INQ000097867.

And we are now in, I think, September of 2021, so just before Omicron really hits. And if we go down in the letter to you from Richard Vautrey, the chair of the BMA's GPs committee. Clearly there's reference there to:

"GPs, Practice Managers, and other primary care professionals share patients' frustrations when they face long delays for an appointment or waiting times ..."

A BMA survey revealed that two-third of GPs experienced abuse, including threatening behaviour or violence, and that had got worse in the last year.

And indeed there was another survey done by the Institute of General Practice Management that found that there was GP staff experiencing abuse, not only that, threatening behaviour, racist abuse, sexist abuse.

When you received this letter, if we go over the page, there is a request for you -- thank you -- the paragraph beginning "This situation is not acceptable":

"We call on you to publicly support and defend dedicated GPs and primary care staff against this onslaught of misinformation and abuse promoted by the media. It is essential that patient care is protected ... We believe that there must be accurate, timely and regular communications from the government to the public, which reflect the realities of the situation ..."

Now, no one is obviously doing anything other than condemning abuse of staff and GP practices, but there was a call on you to publicly support and defend dedicated GPs. Did you do anything in response to this issue being raised with you and, if so, what?

A. Yes, and, sadly, this wasn't the only time this issue was raised with me and this was an important letter and I totally understood why it had been raised with me again and, actually, having these numbers were -- I mean, they were shocking. In a sense it was good to have some numbers around it and get more information but there were shocking numbers because, as you say, abuse of, whether it's doctors or any health professional, or anyone, is completely unacceptable but in a situation where, you know, in this case it was talking about GPs, GPs in particular were facing so much pressure and challenges and clearly they couldn't operate in the same

way they had done pre-pandemic and I think it's fair to say the vast, vast majority of the public completely understood that and worked with GPs but there were, sadly, cases of abuse.

I remember one case in particular in -- I mean, there were many, but the one I remember in particular was a very horrific case in a doctor's surgery in Manchester and when -- when I heard of that particular case I happened to be going to Manchester, in any, case that same day or the day after, and I made a visit to the surgery and met staff and met others and it's an issue that I and the department and the NHS took very seriously. We talked with representatives of GPs about what more we could do to try and give security and comfort to GPs, but also publicly, whether it's in Parliament, or elsewhere, I would have said this kind of behaviour is completely unacceptable and that people must recognise that GPs are under a lot of pressure.

Q. I think you are also aware that RCGP were concerned in September 2021 where you said in Parliament that, "More GPs should be offering face-to-face access and we intend to do more about it." You said that it was not intended to create a league table but it appears certainly that was how it was potentially reported in the press and that many members of RCGP felt demoralised

by what they perceived as a constant media attack and a lack of support from the department and, indeed, from ministers.

Can you help us, what were you trying to achieve when you said, "More GPs should be offering face-to-face access and we intend do a lot more about it"?

A. What I was trying to achieve is -- I think, during -- in 2020 when we all first learned about the pandemic and the Stay at Home sort of requirements came out, there was no vaccine or it was very early days for the vaccine. I think that at that time everyone, including the general public, GPs and stuff, understood why it's not really going to be possible for almost anyone to see their GP face to face, unless there is some kind of emergency situation, or something. I think that people expected most consultations to be virtual or trying to avoid face-to-face contact. By September, the period that you asked me about when I made that comment, in September 2021, we were, as a country, thankfully, we were in a lot better place vis-à-vis the pandemic in terms of vaccination, other treatments, and also the Stay at Home requirements, other sort of limits on social interactions had -- almost all of them had gone, and I think there was a reasonable expectation of the public that it shouldn't be as hard as it was to get

a GP appointment as it was in the previous year, a face-to-face appointment.

Now, that said, I felt that in a vast majority of cases, especially for those patients that believed that they were adequate -- that virtual appointment is perfectly okay and it works but in some cases it might not be the right type of appointment and it might not be adequate. We've just seen an example that you've shared with me from someone who had Long Covid who felt that had it been face to face maybe there would have been a better outcome. And that's what I was reflecting in that statement.

And also, at that time in Parliament amongst Members of Parliament of all political backgrounds, it was one of the number one issues that MPs would bring up with me either formally or in the lobbies or in the tea rooms, and stuff: what is the government doing about bringing back more face-to-face appointments? And that is MPs reflecting what their constituents are bringing to them, particularly elderly constituents who, whether it's the technology, or otherwise, found virtual appointments incredibly hard. It doesn't mean to say they cannot work and for many elderly it was on the phone, so it wasn't like a video conversation that you might have, say, for a younger person who has access to

that kind of technology and is comfortable with it, it would be a phone call from a GP and clearly for someone that has -- well, a number of ailments, having a GP call on the phone may not be adequate.

Q. Given that you were hearing from a number of different quarters about the concerns that it wasn't working, do you think enough was done to try and convey to those who would prefer face-to-face appointments that that was still an option available? We've heard there was a perception, certainly, that people couldn't get a face-to-face appointment. Could more have been done to dispel that perception, do you think?

A. I think it mattered where your -- on your GP surgery. I mean, there were some surgeries even at the time I made that statement that were doing virtually no face-to-face appointments, and in other parts of the country it was a realistic option. I think what we -- what I wanted to see, what the NHS wanted to see, because it pays for those GP services, was, where possible -- obviously, ultimately, the GP has to be the judge of that, rightly so, but where possible, where a patient was requesting a face-to-face appointment, the GP should do that, if it was safe and right to do so.

So there was really almost like some kind of postcode lottery depending on where you were, what kind

of GP surgery that you were registered with, whether you were going to get a face-to-face appointment even if you had requested it.

Q. May I move to Omicron and the planning for winter 2021, into 2022. And in Module 2 you gave evidence that in relation to the planning and preparation for, indeed, Omicron and that winter, the NHS was a huge factor in this, we wouldn't want to see our hospitals overwhelmed.

That's what you said to Module 2.

A. Yes.

Q. What did you understand "NHS overwhelm" to mean or to look like?

A. It would have been the NHS unable to cope with emergency cases, A&E effectively becoming closed because it was -- had too many patients, ambulances not able to arrive and drop people off in any kind of reasonable time, you know -- just to explain that a bit more. Even in pre-pandemic times, so just before the pandemic, the NHS is traditionally run on a very tight sort of capacity constraint. I think about roughly 95% in terms of beds, if you measure it like that. And that's a lot tighter than comparable countries. And so there's not much, sort of -- there's not much give in that and obviously the pandemic came along and that meant the NHS didn't just have much capacity, whether you measure it in terms

of beds, doctors, nurses, and I felt that, you know, a year on, which -- just over a year on when I was Secretary of State, and Omicron had started, and when I learnt that it was -- that the key difference between Omicron -- the first thing we learned about it, before we knew it was less severe, which obviously was welcome news, before we knew that, we just knew that it was a lot, lot more contagious, and that's what really worried me, and that's why I was concerned that at the rate it was spreading, if it turned out that it was severe or not enough people had vaccines or the vaccines weren't going to work properly, that the NHS may become overwhelmed.

Q. We have heard a lot of about the "NHS overwhelm" and it may be thought to be a rather subjective word. What is "overwhelm" to you may not be to the nurse on the front line or some, indeed, of the witnesses that we have called. Do you think now, looking back, that it was the right word or the right way of describing the aim to protect the NHS?

A. I mean, I don't -- if you didn't have that word, I think you'd probably come up with something similar and you'd probably ask me the same question about that word.

Q. It's just that it might be thought that if you're cancelling all non-urgent elective care, that is

an example of the system being overwhelmed.

A. Yeah -- yes.

Q. It might be thought that if you are making difficult triage decisions about who should go to hospital, who should go into intensive care, that is an example of overwhelm. And I just really wanted your reflections now, some years on, as to whether you thought it was a helpful way of looking at and conveying the real state of the NHS during the pandemic?

A. I don't think it's unhelpful.

Q. In your statement you set out a number of the contingency measures that were put into place to prepare the healthcare system for that winter of '21 into 2022, and I'm not going to go through them all, but you say at your paragraph 100, Sir Sajid:

"... some, but not all, of the contingency measures that were formulated for the Autumn ... Winter plan 2021 were helpful in preparing the healthcare system to respond to the pressures of Omicron."

Can I ask you, what measures do you consider were not helpful in preparation for Omicron?

A. I think that's probably a reference by me to -- I think some were -- I mean, I don't have them all in front of me now, but some were more important than others. It's not they were -- it's not that they were completely

unimportant, I think there were some measures there that we'd set out in the winter plan, that there were other ones that should be focused on.

Q. One of the factors that was taken into account was workforce absences. It was clearly higher during Covid than it had been pre-Covid. And you say this in your statement, that there was a reserves programme launched in November 2021, and you considered that having a reserve scheme on a standing basis is helpful in the times of crisis. By and large it was kept in place and still exists now, with the head of the NHS announcing an extension until March 2022 --

A. Yes.

Q. -- you leaving I think later, your role as secretary, a little bit later that year.

What for you was the main benefit of having that reserve programme, and do you think it would be useful in the event of a future pandemic?

A. Yeah, I think the main benefit was just -- so to take its name, that if you have experienced clinicians on reserve, so to speak, and then you know who they are, what their skills are, where they are in the country and other factors, then it's something that in an emergency, health emergency situation such as a pandemic, it's much easier for the NHS, for the health system more broadly,

to ask those people if they're able to serve and if they're able to help, if it's been well thought of in advance.

So the second part of your question, is it helpful to think about something like this sort of going forward? Yes, it is.

Q. We heard from Amanda Pritchard from NHS England that planning for the winter started in June 2021, but by December, when Omicron had really started to take hold, there were concerns about the response because there were in fact far fewer beds available now because there'd been an attempt to resume non-urgent elective care.

Clearly there was some availability of some Nightingale units, Sir Sajid, and you say in your statement, at your paragraph 102(e) you were:

"... informed that the way in which Nightingale hospitals were set up during the first wave ... had not been effective as a primary reason was we simply did not have enough sufficient doctors and nurses to operate them."

And then you discuss that with Amanda Pritchard.

Just pausing there, who informed you of the fact there weren't enough doctors and nurses to operate the Nightingales?

A. Oh, I think it would have been more than one person. I'm sure Amanda told me that. I'm sure the Chief Medical Officer told me that. The national clinical director. I mean, it was well known that there weren't enough staff to -- you know, doctors, nurses, or other clinical staff for the so-called -- for the Nightingale hospitals. At the time of Omicron and what we -- learning from that experience what I heard -- the suggestion from Amanda and her team which I thought was sensible was that what could be done to help the NHS with capacity was to, sort of, extend existing wards rather than have completely new wards or so-called Nightingale hospitals and to focus them on, sort of, I think what they refer to as step down care, so still care, medical care but maybe less demanding than otherwise and therefore staff could be proportioned adequately.

I think we -- the NHS started calling them surge wards, I think the name Nightingale was tagged onto that. It didn't really mean anything other than they were just sort of surge wards, but that's how we handled it during Omicron.

Q. And were you satisfied that surge wards, Nightingale units, call them what you will, that there would be sufficient staff to help ensure that decent levels of

care were being provided in those surge wards?

A. Well, it turned out that way but really I didn't know at the time when we decided that because I didn't know what was going to be the path of Omicron and we quickly decided -- I quickly decided within a couple of weeks of learning about Omicron that the way out of it was through pharmaceutical defences, especially through boosting but we had to boost record numbers of people and also we had to get record numbers of tests out there and also make sure we had the antivirals, which we all did successfully in the end, but, I think, had it not been for that, then perhaps the staff numbers wouldn't have been enough.

I also just want to add, you asked me about winter preparation, but even before we knew about Omicron, just knowing that winters historically can be tough, and also we had information about the flu, and the seasonal flu, and what we tended to do was to look at how flu had performed in the southern hemisphere and that would give an indication of what happened in the northern hemisphere in our winter, and I was concerned that it could be quite a difficult winter -- obviously not knowing about Omicron at the time. But we put together a winter, sort of, package, access package for GPs, and there were £250 million of funding available for GPs and

a whole programme of support and I was very disappointed that when we took that to GPs -- GPs generally as individuals really welcomed it in my interactions with GPs, but the BMA's General Practitioner Committee was very much against it and didn't recommend it, and that was very disappointing because I felt that they weren't putting the interests of patients first, which is what I would have expected in a time of national crisis.

Q. The final document before we perhaps break for lunch.

If I may, can we just have up on screen, please, INQ000270035_4.

Sir Sajid, this is an Omicron NHS planning meeting or, I should say, a note of that meeting on 7 December 2021. I won't take you through all of it but you can see there that you're present. There's a number of names that are familiar to us now present.

A. Yes.

Q. Clearly there was concern about the transmissibility of Omicron and AP, Amanda Pritchard, setting out a number of actions underway to try and ensure there was sufficient capacity.

Could we go to page 4 of that document. There we are, thank you very much:

"[Secretary of State] queried NHS's capacity to respond to a [25,000] scenario ..."

Was that envisaging 25,000 extra patients?
A. 25,000 total.
Q. Total, all right.
"... triggering escalation to level 4 [at the NHS]".
A. Yep.
Q. "[Amanda Pritchard] noted this could be done, but stressed difficult decisions would need to be made with significant implications, including on electives."
Did you understand that to mean that potentially a suspension or certainly a slowing down --
A. Yes.
Q. -- of elective care?
A. Yes. Yes.
Q. Then you say -- you:
"... queried what more could be done on staff leave and absence.
"[Amanda Pritchard] suggested maintaining flexibility, while staff should be taking leave in some areas, while others will rely on goodwill and staff rolling over leave to next year."
A. Yes.
Q. No one is underestimating the difficult decisions that need to be made but was it really being suggested that you might cancel some staff leave?

A. Yes.
Q. Even notwithstanding the fact that staff had been through wave 1, wave 2, and no doubt needed a good period of absence or leave? Why were you pondering taking that step?
A. Well, because it's a national emergency and at times of national emergency people sometimes have to cancel their holidays and their leave, even over Christmas, and whilst you're absolutely right, the staff, particularly in the NHS more than probably anywhere else in the country, had felt more stress and challenges, and had been through an incredibly difficult time, I think that had -- as I say, with Omicron because of the booster campaign, and other interventions we took it didn't turn out to be as bad as some of the scenarios had suggested but I think it was responsible to prepare for different scenarios including worse than those that actually transpired. And I think it would have been wrong not to consider this issue of -- this particular issue of staffing and leave.
Q. And we can see there that:
"[Jenny Harries] stressed high transmissibility will mean greater levels of nosocomial infection ..."
And I'd like to turn to that topic after the lunch break.

MS CAREY: Would that be a convenient moment, my Lady?
LADY HALLETT: It is, Ms Carey. Thank you very much.
Sir Sajid, I'm sorry we have to take a break for lunch, but I promise we will finish your evidence this afternoon.
THE WITNESS: Thank you.
LADY HALLETT: Thank you very much. I shall return at 2.10.
(1.10 pm)
(The short adjournment)
(2.10 pm)
MS CAREY: My Lady, good afternoon, I hope you can see and hear me all right.
LADY HALLETT: I can, thank you very much, Ms Carey.
MS CAREY: Sir Sajid, may I pick up with where I left off before lunch --
A. Yes.
Q. -- and nosocomial infections. We've heard a lot of about them, including the rates in wave 1 and wave 2, and it's not that, but clearly as Omicron emerged, high-community prevalence led to high infection rates in health and social care settings.
And in your statement you say that in particular you were provided with information that during the Omicron wave there were much higher levels of nosocomial transmission in mental health and learning disabilities

healthcare placements and community NHS trusts. And the Inquiry has been looking at the impact of the pandemic on child and mental health settings. Were they a feature of high nosocomial rates, as far as you can remember?
A. So were "they", you mean mental health settings?
Q. Yes.
A. I think through Omicron, yes, yeah.
Q. And when you became aware of the higher levels of nosocomial transmission in mental health and learning disabilities placements, and community NHS trusts, what steps, if any, did you take to try address that problem?
A. Well, I think in all settings, including those, you know, trying to stop, you know, the spread of the virus in such settings, nosocomial infections was a priority, but in terms of the steps actually taken, in all cases that I can recall, I took the advice and accepted the advice of infection protection control which was run by UKHSA but also with the input of the NHS and others, including the CMO.
And I don't remember ever once, sort of, you know, questioning or wanting to do something different to that because I thought it was very, very important to, on such an important issue, to listen to the experts.
Q. And you make it clear in your statement at paragraph 115

that you were not involved in the decisions of the UK IPC cell --

A. Yes.

Q. -- so I'm not going to ask you about that. But more generally, you say in your statement that you weren't aware of concerns around the quality and suitability of PPE. Was there any, by the time you became Secretary of State, concerns that there wasn't enough, it wasn't the right type, or it wasn't in the right location? Can you help with whether there were those kind of issues raised with you?

A. No, I don't -- in terms of, you know, is there enough, is there enough for the right type, that wasn't really an issue that came up -- for me.

Q. Absolutely. And can I -- can you help me to this extent. Were you aware of potentially a distinction between the protective nature of the blue masks as proposed to the protective nature of the FFP3 respirator masks?

A. I knew that there were different types of masks, FFP3, FFP2 and obviously the sort of -- what you refer to as the blue masks. I knew that in certain settings the -- in terms of what I'd been told by the IPC, by UKHSA, was that FFP3 was more appropriate. But in terms of the -- if you asked me about the technical differences between

the different masks, I wouldn't know the detail of that.

Q. Okay. You do give an example in your statement at paragraph 121 about issues concern inequalities around PPE.

A. Yeah.

Q. And, Sir Sajid, we've heard a lot of evidence about PPE, in particular FFP3 masks, not always being appropriate for either women, for people from black, Asian and minority ethnic communities, for different facial, types, sizes, and you speak of an occasion at Conservative Association dinner where a Sikh doctor told you about being asked to cut his beard in certain clinical situations, and you say you took the doctor's details as you thought it was a reasonable issue to look into.

What was being raised with you by the Sikh doctor and what steps did you take to look into the concerns that he was raising?

A. Yeah, what -- so as it says here, that his concern was that for him to comply with -- as he understood it, to comply with the rules at the time, that he would have to cut his beard. And him being Sikh in this case, as part of his religion, that would not be something that he could do or wanted to do.

What he was suggesting -- it wasn't that he should

be allowed to, sort of, have rules that apply to him, that don't apply to others, it wasn't that at all, and that would be wrong because, you know, just from a scientific, medical point of view, if having a beard exposed was a risk, then that shouldn't be allowed, and he wasn't arguing that at all, but what he said was that there was a clinical workaround, that there was a different type of mask, or PPE, in effect, that could be used to cover beards and that he felt it was effective and that it wasn't being taken seriously enough and being considered by the NHS because there was such a small minority of people that would benefit from that.

I thought in response that what he raised was reasonable issue, because he wasn't asking for any kind of special treatment, he was -- thought the same rules and the high quality of those rules should apply to everyone regardless of, you know, what their faith may or may not be, but if there was a sensible workaround that, from an IPC perspective, would work, it should be considered.

So in that particular case I took his details, which was a business card he gave me, and when I went back to my office a couple of days later I gave it to my office and said, "Can you -- can someone please follow

up on this."

Q. Right. Were you aware more generally, that example aside, of whether, by the time you were in office, the PPE available was more diverse, in the sense that it fitted a broader range of people? Do you know whether there was sufficient supplies of wider types of PPE?

A. I don't know.

Q. Okay.

A. I wasn't aware of that.

Q. All right. I think you say in your statement, just finally on IPC, no issues in relation to ventilation in particular were raised?

A. No.

Q. Do I take from that that there wasn't any requests through you or via you to improve the use of portable ventilation in perhaps the older hospital estate?

A. Not that I recall. The only time -- one time I can recall ventilation being discussed was in school settings.

Q. Right.

A. When we were looking at can we remove some of the restrictions on children attending school or having to go home if someone is infected by -- could ventilation be improved. But that was primarily being led by the Department for Education.

Q. Yes, understood. All right, can I turn, then, to vaccination as a condition of deployment.
A. Yes.
Q. We heard from Mr Hancock last week that VCOD, if I can use its acronym, was discussed at Covid-O, the policy was introduced in social care settings in regulations that came into force in November 2021, and I think you say in your statement, if it helps you, paragraph 119, Sir Sajid, that the Prime Minister asked you to consider now making VCOD mandatory for NHS staff.
A. Yeah.
Q. And I think there was a consultation that ran from about November over the course of winter 2021.
A. Yeah.
Q. We have a letter from the RCN that I'd like to ask you about.

Can I have on screen, please, INQ000417535.

It's a letter from Pat Cullen the director at the RCN. It's dated 22 December 2021, and can we see in the -- scroll down a little bit, please. Keep going. Page 2. There we are. The paragraph beginning "The other current policy", which the RCN asked for delayed implementation of is VCOD:

"The RCN recognises vaccination as a key pillar in infection control and disease prevention in healthcare

settings and believes that all health and care staff ..."

But they were concerned about it being brought in, if you read down, that it might further marginalise those who remain unvaccinated and put further pressure on service capacity, ie the number of staff available to look after the patients, and they were effectively asking that implementation was delayed.

When you received a letter like this, what was your position in relation to whether there should be any delay in relation to the rollout of VCOD. I know it didn't come into force but I just want to look at what was being said to you in the consultation phase.
A. Yes, so as you say, during this time, this is, what, December 22?
Q. 22 December '21, yeah.
A. The consultation was still going on. The regulations, as it were, for this had been set out, so the government had set out what the policy would be, when it would become effective from, the rationale for that, I think I'd stood up in Parliament and explained it. It was supported very widely throughout Parliament, including by Her Majesty's opposition, and we made it very clear that the only way this policy works is if we stick to the date that we had set out, unless there was some

overriding reason not to.

And whilst this letter is important, and the RCN is important, I was pleased to have regular contact with them, including Pat Cullen herself a number of times, it wasn't going to change our mind in government because the policy was introduced for infection protection control reasons to protect vulnerable people in hospitals and this letter wasn't going to change that.
Q. All right. They're not objecting per se, it was merely a request for a delay.
A. Yes, but -- I understand that but a delay today, then a delay again tomorrow, and so forth, so I didn't really see it in the context of "Let's delay it by a few weeks" I saw it more in the context of, "Can you stop the policy".
Q. All right. Did you receive, in fact, objections from other areas of the healthcare system objecting per se to the implementation of VCOD within the NHS?
A. Yes, I'm sure I did. I can't remember specifically from which organisations but I'm sure I did, yes.
Q. All right. So can I summarise it, perhaps, I hope fairly. There was some support, including from the opposition?
A. Yeah.
Q. Some, perhaps, taking a middle road of bring it in but

perhaps not bring it in now, and then some people who were wholly opposed to it; would that be a fair summary of where you got --
A. You mean in Parliament or you mean in general?
Q. Generally. As at the consultation phase.
A. Yes.
Q. When you sought to bring it in -- I won't go through all of the guidance, but it was proposed to bring it in for frontline workers as well as non-clinical workers not directly involved in patient care but who may have face-to-face contact with patients such as porters, cleaners, or receptionists. So slightly broader than the doctors and nurses and healthcare professionals.
A. Yeah.
Q. Why was it thought important to widen the pool of people that might be required to vaccinate?
A. Because the whole purpose of the policy was to reduce the possibility of infection in a clinical, hospital setting. And just step back here. Why was that, you know, very important, is that because the patients, by definition if they're in hospital they're ill, they're more clinically vulnerable than the regular population. And if it could be -- you know, if the risk of them catching Covid could be reduced in that setting, then that's what we should do.

Now, every decision to try to do that, this is a form of infection and protection -- control, obviously this is a balanced decision and it comes with, you know, benefits, of course, but also costs. The benefits I think are self-evident: if you can reduce -- if people aren't infected because they've been vaccinated, or less likely to be infected because they're vaccinated, they're not going to infect someone else. And so I think that benefit was clear. The potential cost of the policy would be if ultimately there were people, including the groups of workers that you just mentioned and referred to, that refused to get vaccinated, then they would eventually leave the health service if they could not be persuaded.

And that was a balanced decision. I think we absolutely made the right decision both at the time and in retrospect we made the right decision, but the purpose of it was to reduce infection for patients, which meant that anyone that was in a patient-facing role, including porters and cleaners that might come into contact with patients, was, you know, subject to the policy.

Q. Can I ask you, please, about some examples that the Inquiry has provided you with from our spotlight hospitals, where the Inquiry sought evidence from on the

ground, as it were, if I can put it like that.

A. Yes.

Q. Can I just show on screen, please, INQ000474214_13.

I just want to look with you, Sir Sajid, at the impact it had on the hospitals and the kind of work they had to do in preparation for the rollout of VCOD.

And this is an example taken from Lewisham, the Queen Elizabeth Hospital in Lewisham. They had about 3,000 staff at that hospital.

And if you look at paragraph 2.37, one can see there that in January 2022 the trust board confirmed that 973 permanent and 282 bank staff who were in scope for mandated vaccine had yet to demonstrate they'd received both vaccinations. By the end of the month the numbers had changed slightly.

And then they actually did some work breaking down the group, and if you look in the middle of that paragraph:

"The analysis undertaken by the Trust at this time demonstrated the lowest uptake ... was amongst the most junior roles within the organisation, ie, all clinical support roles the vast majority of which are healthcare assistants. This was particularly worrying as all roles within these professions would be categorised as 'frontline' and then fall within [VCOD] ... In addition,

uptake of the vaccine was poor amongst the Trust's Black and Bangladeshi communities. Black staff (who account for 29% of the Trust workforce) ... [are] nearly 54% of those who were in scope ..."

And if we could just scroll down to the next paragraph:

"VCOD presented a [difficult decision] for staff who refused to have the vaccine due to the limited ability for the Trust to redeploy them."

You can see there it added to the workload, stress and anger amongst all members of staff, and clearly had a significant adverse impact on workforce morale.

So that's an example from Lewisham. May I give you a slightly different example, and could we go, please, to INQ000472879_7. This is from Warwick Hospital. And paragraph 34.

"130 [of their] staff were in patient-facing roles and due to be dismissed ... represented 2.6% of the overall workforce ..."

You can see there set out that in fact there was -- people had had one dose but had not received the second dose.

Then could we just go over to the next page, please, and paragraph 35:

"The impact of VCOD cannot be underestimated,

particularly the damage to the HR teams ..."

It goes on, that statement, to set out significant damage to employee relations, there are managers who refused to have conversations with their staff members as they fundamentally disagreed with the government approach. And due the very late decision to repeal VCOD, which I'm going to come on to, potential applicants for vacancies had already been turned away as they had indicated they were unvaccinated.

So a number of different issues there. Firstly, losing staff and not being able to redeploy them. And secondly, the impact on the morale.

What steps had you taken during the consultation in the run-up to this guidance being given to ensure that we weren't going to lose a vast number of staff at a time when there was already pressures on staffing capacity?

A. So there were a number of discussions that took place both within the department and directly with the NHS. Importantly, the leadership of the NHS, you know, the Chief Executive Officer, the Chief Medical Officer at the NHS, that they supported this decision and its implementation and the fact that it could be successfully implemented within the NHS. And that meant a lot to me because, at the end of the day, you know,

they would understand the NHS and staffing morale and these issues more than I would, because that's their main job. And I took all that into account.

We -- they had set up within the NHS a system of communication of why the policy exists, why vaccination is important, how it protects patients, and then also information and sessions available for staff, either one-on-one or in groups, about the efficacy and safety of the vaccine and again emphasising why it was important.

So, looking at the examples you've just shared with me, I can still totally understand why it's not in all cases an easy decision to implement and why it can lead for some employees to anxiety and anger, even. But that doesn't mean it's not a valuable policy. This was an important tool, a very important tool in the pandemic in infection prevention and control. I believe we should absolutely keep a tool like this in the box for future pandemics -- because we might need it again, and where you have a vaccine for a virus that is effective and safe and requiring frontline health workers to take it. As I say, it was right at the time, and it's something that, you know, I think certainly for me, when we reflect back to it, I think it was absolutely the right policy to follow. We'll get into why, eventually,

it was dropped but in both cases when we implemented the policy, then dropped the policy eventually, it was led by science and medical fact and that's the most important thing here and then we had to think about the practicalities. There were tradeoffs, as I said, and you've pointed to some of them but it was a balance that we thought was the right balance which was to implement the policy.

Q. I'll come to the reversal of the policy in a moment, but can I ask you this perhaps on behalf of some others that are in this room: given that we've looked at potentially a disproportionate impact on black, Asian and minority ethnic workers who, for whatever reason, didn't want to have double vaccination, were you aware it was likely to have a disproportionate impact on that cohort of staff?

A. Yes.

Q. Given that you were aware of that, do you think perhaps that in fact the policy shouldn't have been brought in and it wasn't justifiable to pursue it given that it would have that impact on them?

A. No, not at all. I think all workers in the NHS should be treated equally regardless of their race.

Q. Can we turn, then, to the reasons why the policy was not pursued. It may help you to have a look at the Covid-O minutes, Sir Sajid.

Can I have on screen, please, INQ000091577, pages 4 and 5.

These are the Covid-O minutes from 31 January 2022, and over the course of two or three pages, it sets out the reasons, in short, for why VCOD was not in fact brought in. I can take you to particular parts if you wish, but since you were there, can you help us, why was it that come the end of January 2022, VCOD was not brought in for the NHS and, in fact, was no longer pursued, I think, within the care settings?

A. So when the regulations for VCOD were laid out which I think was early November 2021, what we were -- in terms of Covid, what the country and the world was dealing with at the time was the delta variant. And I believe at the time some 99% of infections were delta variant infections, and what we knew from the evidence that had been gathered on the efficacy of the vaccines at that point was that in terms of preventing infection they were between 65%, I think, to 80% effective, depending on which vaccine one had taken. And so it was effective in reducing infection rates and therefore making people less infectious including in the NHS setting.

So that was the, sort of, the science logic, if

you will, in introducing it.

Your question was then why did we eventually decide not to do it. That decision was made in January of 2022, and despite the fact there only being like a couple of months between November and December, a lot had changed and that was because of Omicron. So Omicron was discovered after the regulations for VCOD had been laid and the policy had been set out and gradually obviously we learnt more and more about Omicron including two very important things. One was just how infectious it was, much, much more infectious in multiples than the delta variant.

And so that by the time we'd made the decision to I think -- by the time of this Covid-O meeting that you're referring to where this decision was made formally in government, I think some 99% of infections then were Omicron and not delta. In fact, I think in the eight weeks previous to making this decision, one-third of all infections in the UK since the pandemic had begun had happened and that's how, just to give you a demonstration of how infectious it was. Also, because it was so infectious it meant a lot of people had -- if they hadn't had vaccines, they'd developed antibodies through infection. And also we learned about Omicron was that although it was more infectious, thankfully it

was less severe in its impact than the delta variant.

So taking all of that into account, the infection rates, the fact that it's less severe, the fact that so many people had already been infected, and the fact that, actually, the announcement of the VCOD -- this VCOD policy for hospital settings had led to more and more people taking the vaccine in any case, even before Omicron, and we had the boosting drive because of Omicron and there was a good take-up of that generally in the country including amongst healthcare workers, it meant the facts had changed, the scientific facts had changed, and it made sense now to drop the policy because, as I said, if the scientific facts changed, then we should change our minds as well and be open to that and that's what happened.

Q. Understood.

Can I ask you, then, just about one aspect of the Covid-O minutes.

Can we scroll to page 4 and then look over into the top of page 5. And you can see there, Sir Sajid, this picks up on what you were just explaining. The bottom line of page 4:

"Due to the reduced severity of Omicron, the relative number of hospitalisations had halved the cost of the policy now outweighed the potential

benefit."

A. Yes.

Q. Right. Go down to the next paragraph, please, you continue:

"... the professional bodies were clear that vaccination was still the professional duty of those working in health and social care but that it was right to question whether a statutory requirement to force people to get vaccinated in order to keep their job was still the right policy or whether it should be dropped. He said that it did not make sense to retain the policy as it would be challenged in the courts and, given that it would no longer be in line with science, there was a high chance of losing."

To what extent did concerns about a loss of a legal challenge impact the decision, if at all, to abandon the policy?

A. It wasn't unimportant but it wasn't the reason. The reason was the change in the science and the effect of having this policy.

Q. And then I think in due course both the policies were abandoned. Can I ask you this: in the event of a future pandemic would you recommend or advocate for an implementation of VCOD, assuming that there was a vaccine, for any new pandemic?

A. I think it should definitely be a tool in the box. I think it's hard to say today for anyone whether you should definitely do it in the future or not. But I think that one thing we learnt through the pandemic is thankfully there was globally a vaccine was developed, with the UK playing a big role, quite quickly; quicker than I think a fair set of people had expected. And the vaccine, as with the Covid vaccine, if in the future a vaccine is, by independent authorities and respected authorities, deemed to be safe, then if we are asking the general public to take it and it will help reduce infections within hospital settings and make patients safer than otherwise, I think it should definitely be a tool in the box.

It's just worth also knowing that even before the pandemic, the NHS, they have guidelines on vaccines. Their guidelines are contained in something they call The Green Book, so when one looks at chapter 12, I think it is, of The Green Book, it talks about vaccinations of staff in health settings, and whilst some of those are recommended, it also makes clear there are certain vaccines that all health workers, even today, under the Health and Safety at Work Act of 1974 are expected to have -- it's not they might have, they are expected to have, and that includes the MMR vaccine, for example.

So my point is, it's not unusual to expect health workers to have a higher bar in terms of vaccinations, and I think if I were a health worker today, especially one that is -- perhaps someone who is thinking of joining the health service, so post-pandemic, I would certainly take into account that a future government, and bear in mind that this decision, when it was made in Parliament was supported by all the major political parties, so it had almost universal support in Parliament -- obviously, I can't speak for future Parliaments but that's an indication of what governments might do in the future. So if I was a health worker today, I would go in with the assumption that this might be asked of me in the future and if someone doesn't like that, then they can take that into account before they make their decision on what future jobs they would like to do.

Q. In short, are you advocating for there to be an expectation that VCOD might be brought in?

A. Yes, it might be brought in. Yes. It's a tool in the box that future governments might use.

Q. May I ask you, please, about some of the inequalities and vulnerabilities that Covid, to use your phrase, shone a light on.

And it may help just to have in our minds -- can

I have up on screen, please, INQ000309453_8.

This is some data, Sir Sajid, that came from the PHE review, conducted before your time, but if you can see there in the middle of the page the rates of death from Covid by ethnicity that have been adjusted, as best one is able to, to take into account location, disadvantage and the like. But one can see there a clear impact on males, male Bangladeshis, black African men, Pakistani men, Indian men, before we get down to rates of death for "White other". And I think you were aware, weren't you, when you came into post, that there was this disproportionate impact on men, and indeed women, from BAME backgrounds.

So with that in mind, what steps, if any, did you take to try to address the disproportionate impact of the pandemic?

Sir Sajid, may I say this, we are aware of the White Paper that you published in due course, and I will turn to that, but --

A. Well, I never published it. My successors decided not to publish it.

Q. Yes, quite. That you asked to be published --

A. Yes.

Q. -- and had done considerable work in getting ready to be published. But before we get to that, did you take any

particular steps to try to address this disproportionate impact?

A. Yes. I mean, I was -- as you alluded to, you know, I was aware of the -- this disproportionality before, you know, I became health secretary, just from what I'd read and heard, and I was concerned about it then, even before I became health secretary, and -- but now I was health secretary, I was in a position to learn more and, more importantly, do something about it.

First, I wanted to understand it, you know, what were the causes of this. And in particular one thing that stuck in my head, I remember being told, was something like a third of people that presented to ICU with Covid were from ethnic minority backgrounds and that's almost double -- more than double, I think -- than the proportion in the general population. So that -- I was very concerned about that.

And I think some of the factors are understandable. That doesn't excuse them in any way but it's understandable in the sense that, for lots of reasons that I wouldn't get into, that people from ethnic minorities are more likely to be in jobs that were more front facing, that you couldn't do from home, therefore more likely to get infected, more likely though live in deprived neighbourhoods and households --

in multi-occupation households and all of that, and these sort of social factors I think were important.

Also though I was very concerned and wanted to know about whether the -- you know, in -- sort of, even knowing that, that was the health service overall responding effectively, doing everything it could to identify causes that might be in the health system and address them.

So, for example, one of those that I came across and took a particular interest in was the -- some of the medical equipment that was being used during Covid, and that was in particular pulse oximeters, and I had read and then I asked -- before I became health secretary, and then I asked specifically, I think in one of my early meetings, the CMO and others to look into this, get back to me. He was concerned as well, the CMO, in particular, and they pointed to some work that had been done by the NHS but also the Race and Health Observatory within the NHS, and -- and I wasn't satisfied with the answers that I was getting, and that's why I commissioned more work. Eventually that led to me asking for the conduct of a full independent review by -- in the end it was by Dame Margaret Whitehead. Not just in into medical instruments, not just the pulse oximeter, because then I became concerned that maybe

this is much more widespread than just pulse oximeters, because maybe these instruments are not being tested on people of all backgrounds and races, maybe they only used one control group that is, sort of, white middle-class people and so there are other groups of people that are being left behind in making sure these types of things work for them.

I mean, there are many other things that I did but that was one of them in particular. And then that review took place and eventually reported I think in 2024.

Q. Yes, I'm going to come on to the review, if I may, in a minute. Even though I know the review post-dates your time as Secretary of State.

Can I just ask you about the White Paper though. Clearly that was prepared in draft, not then pursued by your successor?

A. Yes.

Q. In it though you make -- or it makes the observation that Covid-19 hit hardest in many of the same communities that have experienced poor health outcomes for generations, mortality rates -- and perhaps as we've looked at -- from Covid-19 in the most deprived areas have been considerably higher than in the least deprived areas. This contributed to a widening of existing

disparities in life expectancy between the most and the least deprived areas in 2020, and a further widening in 2021.

A. Yes.

Q. Do I take it from everything that's set out in the White Paper, and indeed what you've just said, that you accept, sadly, that Covid exacerbated pre-existing health inequalities, social deprivation inequalities and the like?

A. Yes.

Q. And the White Paper touches on a number of different areas, including, for example, the need to address obesity, the need to address people with drug problems, the need to try to address people who smoke, and thereby reduce the strain on the NHS.

Why did you think it was so important when you came into post to try to address these underlying health inequalities?

A. Well, first of all, I've always thought, you know, health -- I've always, in my government jobs that I've had, tried to sort of look at the issues of inequalities from many different angles. Health was going to be no different. But as you -- as I've alluded to and you've mentioned again, is that Covid really, sort of, exacerbated or shone a light on this and you

could see that certain communities we've just talked about, one, it can be based on jobs or social background or regions, were just hit a lot harder.

And in trying to understand that, it became clear to me that, you know, this is obviously a problem -- an issue that is much bigger than Covid, it's been long-standing, and therefore much more needs to be done about it, and it needs to be done obviously within my department, specifically with the NHS, but also, you know, other parts of my department.

So, for example, I had inherited -- Public Health England had been broken up by the time I got there but one part of it which was focused on prevention I changed the name to Office for Health Improvement, and the Office for Health Improvement -- and, sorry, OHID, the Office for Health Improvement -- and the reason for that was specifically not just a name change but it was to get it completely focused on health inequalities, and -- and the first one -- one of the first jobs I gave to it was this White Paper, which I wanted to be a cross-government White Paper and to focus on -- a central mission was: how can we lift healthy life expectancy, you know, across the country, but especially reduce the gap between the best areas, in terms of healthy life expectancy, and those that were performing

the worst?

And as you alluded to, a lot of that came down to -- whether it was smoking, it was obesity, it was alcohol or drug addiction, and -- and that's why I wanted this cross government work done. And it also fitted in with my longer-term plans on cancer and dementia and mental health that I alluded to earlier.

I mean, sadly, when I left the department, a lot of work had been done -- the White Paper was almost complete, I think it's fair to say probably, like, 95% of it was done, the work on the long-term plans had been done, but my successors decided not to go ahead and publish any of that and act on it.

Q. Can I turn then to pulse oximetry, and just take it in stages. I think, Sir Sajid, you went on the Andrew Marr Show in November of 2021 and you were asked about it by Andrew Marr. And he was alluding to a story in the papers that morning which meant -- which basically said that there was a concern that pulse oximeters might not be measuring blood oxygen levels as successfully on people with darker skin. So that was the context. And then he asked you this, he said:

"It's very serious. Do you think that people have died of Covid as a result of the inaccurate readings?"

And you said:

"I think possibly, yes, yes, I don't have the full facts and that's, that would be [a problem], these oximeters are being used in every country and they have the same problem and the reason is is that a lot of these medical devices there or even some of the drugs and the procedures some of the textbooks ..."

And you said essentially you thought it was systemic. All right?

Now, just acknowledging, as you've said there, you didn't have the full facts, COVID Oximetry@home was rolled out across the NHS to try to tackle the number of people going into hospital that might not need to be there, and effectively monitor them at home. If their oxygen levels plus other readings suggested that they needed to go in then they would be brought into hospital.

I wonder there do you think upon reflection that saying that some people might have died as a result of this might have put people off from using and taking up the use of pulse oximetry at home?

A. Sorry, can you ask me the question again.

Q. Yes. To Andrew Marr you said that you had thought possibly some people had died as a result of the

inaccurate readings.
A. Yes.
Q. At the same time as the NHS are trying to encourage the use of it to prevent people going into hospital that don't need to be there. And I wondered if perhaps, although you had said you don't have the full facts, even saying that there might have been people that died might have actually put off some of the very people that we wanted to keep at home and protect?
A. No, I don't -- I mean, that's certainly not the intention of saying it. The intention of saying it is to set out what I thought was a very serious problem with pulse oximeters. And, you know, I've got no reason to think that put people off in terms of using it. But I did think it made the NHS and the wider health system take the issue much more seriously than otherwise. Not just as a result of that interview, of course, but it's -- obviously the reason I answered the question in the way that I did at the interview is it's an issue that I had been spending quite a bit of time on and looking at, and beyond pulse oximeters on to other medical equipment that might suffer in the same way from bias, whether that's race or gender or something else.

Just a -- on the NHS. I mean, the NHS had noted this issue with pulse oximeters and people with darker

skins early on in the pandemic. They had tried to do something about it but I wasn't convinced it was enough. You know, so, for example, the guidelines -- I think I'm right in saying that the guidelines that the NHS issued, and this was before I became health secretary, to GPs and other clinical workers to make sure they were aware of this issue, even in the guidelines they said that the pulse oximeters when used in people from ethnic minorities might underestimate the level of oxygen in the blood when actually they should have said overestimate.

So I just didn't -- and when I learnt that as well, I just wasn't convinced the issue was being taken seriously enough, and also I could not understand why someone hadn't made the next step, which was: if this is an issue with pulse oximeters, where else could this be an issue?

And the NHS just sort of stopped at pulse oximeters and didn't, sort of, think: well, are there other pieces of equipment that we're using -- not necessarily for Covid, but for people's health -- that could have a similar problem? And that is why I then ordered the independent inquiry.
Q. Now that inquiry reported I think in March, 11 March 2024 --

A. Yes.
Q. -- and it did conclude that for people with darker skin tones, pulse oximeters did overestimate the true oxygen levels, as you have just pointed out, and it was potentially -- pulse oximetry overestimation gets worse in patients with low or more dangerous levels of oxygen saturation. And if anyone wants to look at it, perhaps we could call up on screen INQ000438237_51, the review, which I assume you've read, Sir Sajid?
A. Yes.
Q. And I'll just wait --
A. Well, it came out when I was on the back benches, but yes.
Q. All right. If one looks there at figure 5, the review very succinctly set out the number of ways in which the low blood oxygen levels, and not detecting them, could affect, sort of, every stage of someone's journey into and indeed out of hospital.

So, look, if you can see there at the beginning if you're having COVID Oximetry@home or on a virtual ward, it means your deterioration goes unnoticed. Again, it might affect you at emergency department, ward level, ICU level. And then in the review it says, "What more should be done?":

"The search for equitable solutions is now taxing

the minds of many organisations nationally and internationally."

And in your statement you said that you spoke about this publicly and discussed it with your US counterpart.

What was the reason why you were discussing it with your counterpart in the States?
A. There were two reasons. First of all, because he was my counterpart from such an important, sort of, partner country -- but there were a number of things that we would discuss obviously with the pandemic on, and I met him for the first time, it was at a G7 meeting of health ministers. But I specifically wanted to raise this issue with him because I had read somewhere that his boss, the President, President Biden had raised this -- had raised the issue of racial, sort of, taking account of racial inequalities in healthcare in the context of the United States as an issue in the United States, not specifically about pulse oximetry but just more generally, so I thought it would be an issue that he would be concerned about, my counterpart, which he was, but I had a specific suggestion for him which was that I thought that if there was a way to get the UK and the US to jointly require all medical equipment makers in the world that they procure from to make sure that all

their equipment that they produce has been tested on people of all races, then obviously that would be a great outcome but I thought if the UK and the US did it, the US is the world's largest health market and the UK as the world's -- the NHS specifically as the world's single largest buyer of such equipment, then it would set a new global standard and I thought that would be good not just for the UK and the US but it would be globally the right outcome, because so much of this equipment is designed by companies run by white people, tested on white people, and I felt something had to change.

Q. Finally this on this topic. The review was commissioned, I think, in April 2022 and it was nearly two years on before it was published. In your view, do you think that a two-year intervening period, I won't call it a delay, meant that sufficient action wasn't being taken on what is clearly an important issue?

A. I hope not. I don't know, because I was not there in the department any more. But one thing I would like to say is I would just take this opportunity to thank Dame Margaret Whitehead and her team for what I think is excellent work that they did and I think the work that she did was completed a lot earlier than it was actually published.

Q. Different topic, please. End of shielding and the decision to end shielding. Sir Sajid, you deal with that starting at paragraphs 124 onwards in your witness statement. And you say this, that there was no perfect time to stand down the shielding programme; however, your view was that shielding could not go on forever.

Can I ask you, please, why in your mind was it right to take the decision in, I think it was September 2021 when it formally ended, that that was the right time to end the shielding programme and what steps did you put in place to support those that had been on it and were now going to be off the shielded patient list?

A. Yeah, so by the time I had become health secretary, the shielding programme or certainly the guidance on it had been paused and I think it was described to me as it was still kept there as a contingency option, that was the language used at the time.

Then the decision then to be made was, do we keep it as a contingency option or do we end it? And the reason I decided to end it was essentially just based on clinical advice. Again, it's a clinical, sort of, decision based on science and the right medical advice. The advice I received was from a number of people but specifically from Jenny Harries who is the head of UKHSA

and also the deputy CMO, Jonathan Van-Tam, and they were clear that shielding is not without costs. You can think of benefits but it also has costs including medical costs for -- and there were a number of reports and research that had been done that some people who had been shielding, I think it was over -- it was 3.8 million people. And so, obviously, a huge number of people but many of them had complained of mental health problems, other mental health challenges, isolation, loneliness, and other issues, and so all of that was taken into account but especially the fact that now we had vaccines and so much of the population, but especially the shielded population where they could take vaccines, were vaccinated, the general population, I think that a high level of vaccination had been introduced, but I think amongst the shielded population it was something like 91% had received one dose, 88% had received two doses and that meant that we were in a very different position to when shielding was first introduced.

So it was a balanced decision but then the decision based on the advice that I received was to end the programme.

And then just if I may add to that. We then had a discussion about how should we inform people, because

it's very important to get the communication right. I decided there should be direct communication and I was -- it was suggested to me that maybe the Secretary of State should write to people to let people know it was a decision made at the top, so to speak, and after a lot of consideration, and so I decided that was the best way, it wasn't the only way, but it was part of the communication.

And I think you then asked me what plans we made after we ended shielding.

Q. Yes, I did.

A. The decision was that -- not that you just said "end shielding" and that's it, you just move on, of course not. It was to make sure that what we moved to was a policy similar to -- that existed for your clinically vulnerable people and immunosuppressed people, for example before the pandemic, which was a policy of what we, sort of, generally referred to as individual risk assessment. So each individual, obviously their medical needs and their situation will be different to others, and that they would get advice from their GPs and other clinicians about what's right for them rather than a blanket fits all policy of which was just Stay at Home.

Q. I think one of the policies that was put in place was

what is called the Enhanced Protection Programme?
A. Yeah.
Q. What did you understand that to practically provide to those who had been shielding but were now no longer, once shielding was stopped, on the shielded patient list?
A. Well, that actually became particularly important because soon after we made this shielding decision, a few weeks later, we had the Omicron crisis and that was for certain people. Again, the list was drawn up by the NHS, and input from CMO and others, that we thought were particularly vulnerable or remained vulnerable but obviously weren't shielding any more that we had to put in some kind of enhanced protection especially in light of Omicron, and that was -- especially because by then we also had more treatments including antibody treatment -- no, sorry, antivirals.

And so those antivirals could be -- so especially where people either vaccine wasn't effective enough or for some reason they couldn't take the vaccine, but where the antivirals could be something that could help and it could be used post infection as well, which meant that it would be very important to make sure those individuals could access the PCR tests quickly and also they could be given -- those results would be applied

quickly and they would also be sent the antivirals. And so we put in a process of identifying these people, informing them, in most cases sending them a PCR test in advance that they could basically keep at home in case needed, and then if they did need it because they didn't feel well, they wanted to check it wasn't Covid, because for them it was particularly important, given their situation, there was a special number they could call where a courier would come and pick up the PCR test and then, if they needed antivirals, either someone could go and pick them up from a local clinician or a hospital or they would be delivered to them by a courier, and so the whole purpose of that was to have a, as it was called, have an enhanced process for a certain group of people, over 1 million, that we thought were particularly vulnerable and needed something more than what existed before shielding.
Q. Can I ask you, please, about an email on the topic of the Enhanced Protection Programme.

INQ000333292_ 3, firstly, and then we'll come back to your involvement in it. But we are at the very beginning of February 2022, Sir Sajid, and there is an email about the Enhanced Protection Programme:

"As discussed, please see attached submission ... a programme being established to ensure that

people at higher risk of serious illness from COVID-19 (due to a weakened immune system or specific other medical condition) are identified and receive appropriate interventions, support and communication. Feedback by the end of the week ..."

And then can we jump forward to page 1, and bottom there:

"Hi Phil, Secretary of State has agreed to the points in your submission.

"We wanted to highlight the importance of communication/explaining this clearly to those previously in the CV/CEV groups. We need to reassure this group as there has been strong messaging to them previously throughout the pandemic about their vulnerability, and we receive lots of communications from these groups about how they feel forgotten about."

Firstly this, were you aware of communications from the CEV or CV groups saying they felt forgotten about?
A. Yes.
Q. Over what period of time were you receiving those concerns?
A. I'd say throughout my time as health secretary but especially in the, sort of, the first six months.

Q. Correct me if I'm wrong, I think you said earlier that when the shielding programme ended the letter ending it was to come from you; is that correct?
A. Yes.
Q. Just help me with the comms, then; do you think the communications were right if there was still by February 2022 people saying that they felt, effectively, abandoned and forgotten about?
A. Yes, I think both can be right in that I think it's possible that had I not sent the letter and we did the comms around the shielding decision, had not done what we actually did, this feeling could be even worse. So the objective -- there were definitely -- there were people in this important group that clearly felt that they weren't getting enough communication and that was something that was well understood and important to me. But I'm not sure that we would ever get to a point where everyone in this group would feel they've had perfect communication. It was a diverse group. Although they had something clearly in common, when you have 3.8 million people, it's -- some of their priorities within that group can be a bit different to some of the fellow, sort of, members of their cohort.

So, I'm not sure whether we were ever going to get to a position where everyone was going to feel happy

with the communications. But I think what we did in stepping up those communications was important.

One of the reasons I was aware of this, by the way, is that it came up in Parliament -- I'd be in Parliament almost every week making one statement or other to do with Covid, and quite often, quite rightly, MPs would raise this issue or something related to it, and that was something that was increasingly getting me concerned to make sure that we're reaching out to this group and that we're doing all that we can.

Q. Finally this, please, on the Enhanced Protection Programme. Is it right that the Enhanced Protection Programme did not extend the passporting protections such as Statutory Sick Pay and the like. It was there to deal with more sort of either pastoral or more supportive concerns. Have we understood that correctly?

A. I think it's right that it didn't extend on to other --

Q. Sick pay --

A. Sick pay, and -- I can't remember exactly when it was but some of the special provisions around sick pay and other measures were removed and not part of the enhanced programme.

Q. A more discrete topic. Data, please. Whilst you were Secretary of State are you aware whether there were any efforts made by the department to monitor the prevalence

of Long Covid in healthcare workers and obtain data on those sufferers?

A. On healthcare workers specifically?

Q. Yes, specifically.

A. No, I'm not aware.

Q. And was there any department or organisation that you were aware of that was monitoring the deaths of healthcare workers from Covid-19 whilst you were Secretary of State?

A. I'm not aware of a specific department -- or I think you referred -- or organisation, other than it's something the NHS, amongst the information it was collecting, I'd be surprised if it wasn't amongst their data.

Q. Final topic, please, from me and this comes to your lessons learned section in your statement, Sir Sajid. Can you help us, please, with any key recommendations that you would urge the chair to consider in the event of a future pandemic that are specifically focused on improving the response of the healthcare system?

A. Yeah, I think it's fair that even before the pandemic the NHS was massively stretched and that's important because the state of the NHS before the pandemic, especially around capacity and how much, sort of, you know, flexibility and capacity it has is hugely important in being able to deal with a pandemic.

So prior to the pandemic, the NHS has been run by successive governments at almost full capacity. If you look at it in terms of beds, I think the measure is something like they try to aim to run it at 95% of beds are taken. But even if you look at it, broaden that out, if you just look at the number of doctors, number of nurses, number of ventilators, number of IC units, whatever measure you wish to take of the scale of the NHS, it is per capita a lot less than comparable countries with universal healthcare systems. And by that I'm excluding countries that don't have universal healthcare, like the United States, but if you compare to France, to Germany, to Italy, to Japan, to Canada, to Australia, we have a lot less capacity and I think -- first of all, that came through in Covid, all things that we've been discussing today because the capacity just wasn't there and that's why it required a lot of the kind of measures and things that we needed.

Which then leads me on to, very quickly, what can be done about that. I think there is a fundamental design flaw in the NHS, especially with increasing demand for healthcare, and obviously the pandemic exacerbated that but even before that, and it continues of course because of new medicines, because of demographics, because of the change in the burden of the

disease, demand is soaring and supply cannot keep up, and I think one of the fundamental reasons supply cannot keep up is because the NHS is funded almost entirely by general taxation and that has to compete with other government priorities and that's true of any government. When I was chancellor I saw that firsthand as well. And we're already at a stage as a country where the NHS is -- I think today it's something like 44% of day-to-day government spending. 25 years ago it was 27%. It's soon going to be over 50%. Soon the entire government will become, in effect, a subsidiary of the NHS and, clearly, that is not sustainable.

So I think the model is fundamentally flawed and one can measure that in terms of outcomes not just in outcomes in terms of Covid but if you look at whether it's cancer outcomes, it's cardiovascular outcomes, it's diagnostics, whatever measure you care to take, the UK, despite the hard work of everyone who works in the NHS, the system is flawed, and we are generally worse than every other country and that is a fundamental problem with the NHS.

The reason I say this is because I think for this Inquiry to do what I think it is trying to do, which is to learn the lessons from the pandemic and make sure we're better prepared for the next one, if it doesn't

try -- not necessarily address, but raise this issue of the model of the NHS is completely flawed and not sustainable, then I think it's ducking a very important issue, and I know that my Lady doesn't want to duck any issue in this Inquiry and she won't leave it alone and the top recommendation I would make, because politicians in all political parties are too scared to say what I say, and they duck this issue because they're worried about having their head shot off if they say these things, is we should have a royal commission of the great and the good to look at this most vital issue because unless it's addressed then the next pandemic, no matter what lessons you learned from it, we won't be able to deal with it as efficiently if we had an NHS which, pre-pandemic, was actually fit for purpose.

Q. Clearly you advocate, from what you've just said, for a fairly fundamental or radical reform, call it what you will.

A. Yes.

Q. Can I ask, that aside, is there any specific, perhaps more detailed or granular recommendation that you would urge upon her Ladyship that you've observed over your time as Secretary of State that could be perhaps more easily implemented than wholesale reform?

A. Yes, there are potentially many. I mean, and I'll give

you a -- I can share a couple with you now but fundamentally I have to, I think, unless this -- the elephant in the room is addressed, everything else is just slightly better than window-dressing because it won't deal with the fundamental issue. We will still have massive, massive undercapacity when we get to the next pandemic.

Other things that could be done in the meantime are: you could take parts of the NHS and review those independently of the whole system. The primary care system is not fit for purpose. It was a compromise from when the NHS was created. It doesn't work. It's the worst parts of the private sector, the worst parts of the public sector all combined into one, and it doesn't work, and that needs an independent review. It's something I wanted to do when I was in the department but it was blocked by the then Prime Minister.

And there are other reforms especially around -- on prevention, there's a lot more around prevention that can be done, and especially through better use of vaccinations, better healthcare messaging and also a lot more work that can be done across government. That was the purpose of my ten-year plans because, as I alluded to earlier, but I think it's so important, is that there is a lot in terms of better healthcare, especially

prevention, that can be done through help from other government departments, but the way the government is structured, the way priorities are set, understandably for other government departments, health isn't always a priority for them but I think that if all of government came together and worked much better together there are certain areas such as obesity, such as smoking, such as alcohol and drug addiction that can be better addressed.

MS CAREY: Sir Sajid, they are all the questions I have for you.

Let me turn to her Ladyship and see if there is any other matter that your Ladyship would like to raise before we turn to CP questions.

LADY HALLETT: No, just to tell Sir Sajid that I have noted the challenge, not that there was a very great challenge there, just one of the major issues facing us, but I have noted it.

A. Thank you.

LADY HALLETT: It's time to go to Mr Jacobs, please.

MS CAREY: Thank you, my Lady.

Sir Sajid, Mr Jacobs is behind you but if you, when you answer him, could you speak back into the microphone, please.

A. Yes.

MS CAREY: Thank you very much.

Questions from MR JACOBS

MR JACOBS: Sir Sajid, just a couple of questions on behalf of the Trades Union Congress.

A. Yes.

Q. In describing in your statement the draft White Paper, you refer to the recognition that disparities in health outcomes are driven by a number of factors including the nature of employment. In a similar vein, Chris Whitty has described, in this Inquiry, the importance, in his view, of reducing precariousness in work in a pandemic in order to reduce health inequalities.

Do you have a view on the importance in a pandemic of reducing precarious work particularly in those healthcare roles where there is a lower paid and vulnerable workforce such as caterers, porters and cleaners?

A. Can I just ask, when you say reducing precariousness, do you mean -- what do you mean by that specifically? Not doing the work or?

Q. Well, precariousness clearly may manifest in a number of forms but if we focus it on something narrower, if that assists, something like access to sick pay. So workers having sufficient security in their work that they are not driven to presentee-ism, for example.

A. I agree in general with what you refer to as the CMO's view, and I think it would be important to look at such measures. All I would just add to that, though, is that everything is a tradeoff, and every decision a minister makes is a tradeoff. Take the point around, let's say if it was -- I can see how having some kind of enhanced, let's say, sick pay system for certain roles in a future pandemic would make a difference. But it would have a cost. It would have a financial cost, obviously, and in government you'll have to think about what are you not doing to be able to afford that, and so I just, sort of, would caveat you have to balance this out but in principle I agree with your reference to what the CMO said.

Q. And if on one side, there's a pecuniary cost, as you identify --

A. Yes.

Q. -- if on the other side, there's a cost in terms of increased loss of life, an exacerbation of health outcomes for particularly vulnerable groups, do you accept that that's a very powerful factor in favour of taking some action to address it?

A. Yes, I do, but it's worth remembering the NHS makes this type of tradeoff all the time. As you know, the number of drugs that if the NHS could afford them, a lot more

people would live or they'd live longer but it didn't buy those drugs because it can't afford them and so the NHS or the wider, sort of, government system in terms of public expenditure would have to take the cost of any measure into account.

Q. Sir Sajid, there might be an impression from your answers that you acknowledge in principle the point being made but your heart is not really in it when it comes to addressing it as a problem for poor healthcare workers in vulnerable roles.

A. That would be the wrong impression. I just point out fact, which is that decisions that ministers make have tradeoffs, and only a bad minister would ignore those tradeoffs because normally in those situations both sides lose and no one gains anything. So I think that any -- you know, what's more valuable in this is trying to set out what those tradeoffs are and then how you can work around them.

So for example, if this is an issue which I understand and I agree with in principle that is particularly important to -- you represent the TUC, right? -- so it's particularly important to the TUC, it would be more valuable if they said, you know, if you can give this kind of support to workers in a pandemic, maybe you can pay for it by not giving this kind of

support over here that you would do outside a pandemic.

MR JACOBS: I think I've probably used up my time, but thank you very much, Sir Sajid.

A. Thank you.

LADY HALLETT: And I did note, Mr Jacobs, the question for which I did not give you permission, but I'll take it up with you when I next see you in person.

MR JACOBS: So I did mine, my Lady.

LADY HALLETT: Right, Mr Jory, please.

He's probably behind you, to the right.

Questions from MR JORY KC

MR JORY: The same direction, Sir Sajid. I ask questions on behalf of the Independent Ambulance Association.

A. Yes.

Q. In your statement you identify four ways in which capacity could be increased during the pandemic and one of these ways was making use of independent sector capacity which resulted in agreements being signed between NHS bodies and the independent sector.

Now, independent ambulance providers already provide about 50% of all non-emergency patient transport services in the UK but despite the very high level of investment in this area, over £500 million I believe, there's no permanent national team providing oversight. So, looking to the future, and what might perhaps be

done better in the future, do you think it would be helpful to consider creating a national team to include representatives from both the NHS and the independent sector to address the challenges of providing consistent non-emergency patient transport services?

A. Thank you. I think, first of all, I'd say the independent sector played an -- overall played an important role in helping to deal with the pandemic and that of course was welcome. Turning to your question specifically around transport services, I think you said non-emergency transport services, I think it would make sense to have more co-ordination between the public sector and the independent sector broadly, much more broadly, but including on non-emergency transport services.

Q. Thank you. Just one other question, please. Again, looking to the future, given the independent -- sorry, the interdependence between the NHS and the independent ambulance sector, especially in times of surge and demand, do you consider it would be helpful to have an agreed national working protocol between them, including perhaps a register of approved providers and established terms of engagement to ensure that services can be rapidly scaled up when required, for example in the next pandemic?

A. Yes.
MR JORY: Thank you very much.
Thank you, my Lady, that's all I ask.
LADY HALLETT: Thank you. Good short answer.
I think probably we'll break now, because Mr Weatherby, you have slightly longer than the time it would take us up to the break, so we'll break now for ten minutes if that suits everybody and return at just about half past.
MS CAREY: Thank you, my Lady.
(3.22 pm)
(A short break)
(3.32 pm)
MS CAREY: My Lady, good afternoon. I think the next counsel to ask questions is Mr Weatherby King's Counsel.
LADY HALLETT: It is. Yes, please, Mr Weatherby.
Questions from MR WEATHERBY KC
MR WEATHERBY: Good afternoon. I ask you questions on behalf of the Covid-19 Bereaved Families for Justice UK group. Just a few points from me. In your statement you explain that you had twice weekly meetings with the national director for UEC, urgent and emergency care. For reference it's paragraph 112, but we don't need to go there.
A. Yes.

Q. And primarily you discussed ambulances and accident and emergency in view of long waiting times, noting in the statement that ambulance waiting times went up considerably during the pandemic and you explain that there were particular concerns about ambulance stacking during the emergence of Omicron in 2021.
So, first point. The data you had that was coming through to you as Secretary of State, indicated that ambulance response and A&E waiting times were unacceptably high; that's right, isn't it?
A. Yeah.
Q. Now, again, the last piece of evidence you gave when Ms Carey was asking you questions may have answered this point but let me put it to you anyway.
A. Yes.
Q. Do you agree that response and waiting times and ambulance queueing were long-standing issues which had pre-dated the pandemic and should have been addressed, frankly, before the pandemic?
A. I do, but my Lady has just disappeared from the screen. Do you want me to answer it or shall I just --
LADY HALLETT: I think I pressed the wrong button. Very sorry.
A. Could you ask me that again, please. Not the whole question, just the last bit.

MR WEATHERBY: Right. Well, I was putting to you that you'd agreed that the data that you received indicated that response times and waiting times in A&E were unacceptably high, and I was putting to you, do you agree that the response and waiting times and ambulance queueing were long-standing issues that were known prior to the pandemic?
A. Yes, they were clearly exacerbated by the pandemic but they were long-standing issues.
Q. Indeed, and therefore, frankly, should have been addressed before the pandemic as general points not just related to an emergency?
A. Is that a question?
Q. Yes.
A. I think -- obviously, I was not there before the pandemic but I think that there were initiatives and measures to try and address it but that doesn't mean to say, going back to your first question, it still wasn't a problem when the pandemic started.
Q. So it was a problem. And do you agree that the problem was exacerbated during the winter with its associated risk of high levels of Covid, and was foreseeable, and that once the pandemic had struck but before you came into office, that further measures should have been taken to alleviate the problem before you came into

office so that the winter 2021-22, the position would have been that you'd have gone into that better prepared?
A. I'm not sure what further measures could be taken or could have been taken that weren't being taken before I got into office because, as you mentioned too, and I've said in my evidence, I started having regular meetings with the national director for UEC and in some cases I would have them more than once a week and I think I alluded to earlier I'd ask for the data in advance, I'd ask for more data and things.
Q. Yes.
A. I even brought in people from outside the health system to try and give a different perspective and to give advice, and I think although I brought in a lot of measures myself, that's not to say that there wasn't much -- there was still a lot being done. I think the problem was before I was in that role the real sort of -- a lot of bandwidth, so to speak, was taken on Covid itself, the vaccines, the delivery of those vaccines.
Q. Indeed.
A. Recruitment, retention, and also there was a high rate of absenteeism because of Covid, including in the UEC service, and I'm just not sure what more you could have

done.
Q. I see. Okay. So it's an intractable long-term problem which needed earlier attention, and in the course of the pandemic it was very difficult to do anything about it; is that right?
A. Things were being done but, because of the pandemic, the problem -- it didn't lessen in any way.
Q. Okay. Next point, I think back to 111, and Ms Carey took you some statistics, and you were provided periodically with data and you agreed this morning, from the document that Ms Carey showed you, that even by September of 2021 something like 25% of 111 calls were being abandoned.
The next set of data -- I'm not going to take you to it but a similar document, you've seen it in your evidence pack, it's actually at your tab 10, and for the transcript it's INQ000479860 -- a similar document but slightly later.
A. Yes.
Q. We know from that document that the number of abandoned -- proportion of abandoned calls was about 23.3% in December of 2021. So a similar level, slightly lower, and indeed from that document it was suggested that the projection was it was then going to fall in 2022.

But do you agree that these levels of abandoned 111 calls were by the end of -- by the autumn or winter of 2021, were unacceptably high?
A. Yes.
Q. And particularly so given that members of the public had been encouraged since right from the beginning of the pandemic to use 111 as a first point of contact for non-urgent advice?
A. Yeah. Well, 111 and possibly their GPs.
Q. Sure. And was this something that you had been aware of generally through the pandemic, that there were problems with 111 and the performance of it, in terms --
A. You mean before I was health secretary?
Q. Yes.
A. Yes.
Q. And therefore by when you were health secretary, and by certainly the winter of 21/22, the problems were and had been foreseeable, shouldn't there have been better planning in relation particularly to staffing by that point?
A. I'm not sure there could be better planning. I mean, the whole health system -- and obviously UEC is a very important part of it but other parts of the health system, we've talked today about whether it's primary care or acute care, for example, was under stress.

There were staffing problems throughout the health system. There were a lot of vacancies going into the pandemic. It was -- obviously those problems continued during the pandemic. And that, alongside the other infection protection and control measures that had to be -- had taken place, that reduced capacity, and other measures, I'm just not sure there could be -- because it was a pandemic, I'm not sure what else, in practical terms, could have been done.
Q. All right, just as a follow-on to that, in terms of a lesson learned for the future, for example, where something is obviously going to be something which is a first point of contact, shouldn't there have been an emergency surge plan for staffing and for telephone banks and the rest of it in terms of 111?
A. You see, because I came in sort of halfway through the pandemic, I hesitate to comment on what happened in terms of emergency services in the first part of the pandemic, when I wasn't there. So was there a surge plan or not, I don't know --
Q. Ah, okay --
A. -- and so --
Q. -- the Inquiry has heard evidence about that, so I won't ask you about that.
A. Yes.

Q. Let me put it a different way, going forward, having been Secretary of State for Health, would you agree there should be a surge plan for services, particularly like 111, for the future?
A. Yes.
Q. And finally on 111. You, at paragraph 112, again you talk about a "big recruitment drive" for call handlers. What I'm not so clear about is when that actually happened?
A. It started -- I believe it started happening quite early on in -- in terms -- early on as in in my term as health secretary.
Q. Right.
A. And it continued certainly through the second half of -- well, certainly from --
Q. Okay, but it --
A. From when I started as health secretary, certainly through to November.
Q. Okay. So, but this was something that you instituted or was instituted during your time --
A. It was something that was suggested by the national director in the wider NHS and it was something that I fully supported.
Q. Yes, but during your term from June 20 --
A. Yes, but it doesn't mean to say that there wasn't

something already going on before it was suggested to me.

Q. Yes, all right. Finally this, and it's my last topic, shielding, and most of the points I was going to ask you about have already been asked so I don't need to do that, but you've told us about 3.8 million people being subject to shielding and you've talked about the step down or the ending of shielding.

A. Yes.

Q. And one of the things that was needed were individual risk assessments.

A. Yes.

Q. And that's from primary care, from GPs primarily?

A. Primarily, yeah.

Q. Can you help us as to what additional resources were provided to ensure that there would be sufficient capacity for GPs and NHS clinicians to provide individual risk assessments or bespoke risk advice to those who would previously have fallen within the shielding cohort, or who were coming out of the shielding cohort, given the numbers involved?

A. Yes, well, it wasn't -- because it takes time to recruit GPs, you know, clearly it wasn't going to be just, sort of, a situation where you provide extra funding and suddenly you have more GPs. That wasn't -- I felt

generally that was not going to be the answer.

Q. Yes.

A. So what was done was to try to take away from GPs other things that they would have -- ordinarily have done without the pandemic and, sort of, reduced their workload so that they could focus more on not just this issue but increase -- later on, soon after we removed shielding, when we had the Omicron crisis, we did more of that. So it was more about reducing -- sort of, shifting workloads --

Q. Right, so instead of further resources --

A. -- and also making sure, where possible, that some of the resource that you could recruit more easily than GPs, because GPs obviously -- you know, it takes a long time to train a GP, were, sort of, other clinical support that might help GPs, not necessarily with that task -- with doing it as individual plans but maybe take other work off them and release them to do more of those kind of assessments.

Q. Right, so no further resources but freeing up GP time to do it?

A. There were -- was more resources for other things for GPs but the -- I don't want to pretend that we thought that, you know, offering a lot more financial resource was suddenly miraculously going to result in

a lot more GPs. It was to use funding to try to shift workloads, to help with workloads in other ways, so it could free up GPs' valuable time.

MR WEATHERBY: Thank you very much.

LADY HALLETT: Thank you, Mr Weatherby.

Now I think it's Mr Simblet, who is just behind to you to your right.

Questions from MR SIMBLET KC

MR SIMBLET: Thank you, yes.

Good afternoon, Sir Sajid.

A. Hi.

Q. These are questions on behalf of the Covid Airborne Transmission Alliance (CATA), which I think has been in correspondence with you. I'm going to ask you about that in a moment. It's an organisation of healthcare workers and others who came together during the pandemic because they were concerned about the need to protect healthcare workers from Covid's airborne nature, and in particular had concerns about appropriate protective equipment.

So I'm going to ask to be put on the screen, please, a letter that was sent to you in April 2022.

It's INQ000300490.

There it is on screen. That's the first page. I don't need to go through it. You can see there's

a number of constituent organisations in CATA.

What I want to -- if we can turn to the second page of that, please, you can see it's been signed by Dr Barry Jones on behalf of CATA, which was then known as CAPA.

And they had written to you -- I'll highlight the appropriate bit in a moment -- suggesting that the risk of transmission of SARS-CoV-2 could be managed in a simpler and safer way by implementing, in particular, two measures that they had bulled.

So if we can go to the top of the page, the second one we needn't -- is about booster vaccinations, needn't worry about that for the moment, but can we highlight the first of those bullet points, please, and I want to ask you some questions about that.

A. Yes.

Q. So I'll read it out for the record:

"The clear acceptance of the airborne transmission of SARS-CoV-2 and what that means for indoor environments and the provision of respiratory protective equipment (RPE). This includes FFP3 and similar respirators which are effective and approved by the Health and Safety Executive for protection against airborne pathogens whereas the surgical masks currently provided to staff are not."

So that's what they were suggesting.
So my questions are these. What did you understand to be the route of transmission for Covid-19? Did you consider it to be airborne?
A. Yes. To some extent, yes.
Q. And in that context, were you aware of previous concerns raised by healthcare stakeholders about the quality and suitability of their PPE and particularly respiratory protective equipment?
A. Yes, but not to a very sort of high level. What I mean by that is that I think, you know, a lot of issues around -- and they were real issues, of course, around protective equipment and, sort of, PPE as well, were -- preceded me, and by the time I came in as health secretary there were still issues raised, and your letter here you point to, in April 2022, is a good example of that, but it wasn't an issue that was coming up often. And whenever it came up, like with this letter, whilst I don't -- obviously I've seen the letter in the evidence pack, I don't recall it -- necessarily seeing it at the time, but it doesn't mean to say I didn't see it, it just means I don't recall it. What I would have done is, you know, after reading something like this, I would have asked my officials to make sure that the people that were -- the experts that were

setting IPC policy, that's basically NHS and UKHSA, were aware of this and they would then either give me advice or in a meeting it will me what they are doing about it.
So this is saying something specific, which is saying -- you know, basically asking for more FFP3 or making sure that and similar respirators are effective and approved, as it says here. But that would have been -- it's something that I would have been concerned about, but it would have been a job of the NHS, primarily, to make sure that is happening.
Q. Thank you. And, I suppose in a similar vein, at paragraph 120 of your statement -- I don't need that to be shown -- you say you were aware of concerns about the supply of PPE, and you are talking about things like restocking and so on, but not about the quality and suitability of it. Does that mean that you yourself didn't know of specific concerns around, say, the supply of respiratory protective equipment such as FFP3s, and to what extent were you aware of concerns of the sort that are in that letter?
A. It didn't come up much for me. And that doesn't mean to say it wasn't coming up within the wider system, including with junior ministers, but there -- it wasn't an issue that I recall as being brought up with me directly to address.

MR SIMBLET: All right. Well, thank you very much. Those are my questions.
A. Thank you.
LADY HALLETT: Thank you, Mr Simblet.
Ms Hannett next, please.
Usually right at the back behind you, to your right, Sir Sajid.

Questions from MS HANNETT KC

MS HANNETT: Sir Sajid, I ask questions on behalf of the Long Covid Groups.
A. Yes.
Q. I want to start, if I may, by asking you about Long Covid in children and young people.
You were asked this morning about the ministerial roundtable that you attended on 23 September 2021. At that same meeting, Long Covid Kids proposed that a public awareness campaign could help the public understand the effects of Long Covid on children.
Do you agree that not enough had been done to communicate the risk of Long Covid to children and young people by that point?
A. I agree with the importance of communication on this important issue. I mean, I hesitate to say that -- your question was asking me to agree if not enough was done. I don't think I have enough information to say whether

enough was done.
Q. Following that meeting then, what specific steps were taken to communicate the risk of Long Covid in children and young people?
A. I can't tell you what specific steps were taken. Long Covid as an issue was something my predecessor, I believe, and myself -- and my department, we took very seriously. I think we talked earlier about some of the measures, initiatives that we took.
The purpose of me having this roundtable and attending it myself to listen myself to the issues was to reflect that and to act on that. At the end of the meeting, during any roundtable, particularly that roundtable, we would have taken -- my office would have taken note of what was said and what I agreed to. There would normally be a follow-up meeting. I can't remember exactly what was discussed in that follow-up meeting on that specific issue that you raise. But then if my team would have said to me that we will communicate that to the NHS, to the wider health system, and we will make sure that the communications are improved, I mean, generally I would have -- on an issue like that I think I would have asked them to update me in a few weeks' time what's happened. I don't remember what that update was, but -- I believe they would have taken action but

I just can't tell you specifically what form that communication took.
Q. Just moving on to now then, do you agree that there should be a public health campaign now to communicate the risks of Long Covid to children and young people?
A. I don't know. I haven't thought about that enough.
Q. Moving on then to Long Covid services. You were asked earlier about what was done in response to concerns about Long Covid clinics. You approved further dedicated funding for Long Covid services in July 2022. In your experience, do Long Covid services require continued dedicated funding to maintain the level of services required by the commissioning guidelines?
A. Yes, I think so. I think that Long Covid, as I was saying earlier in our discussions, I think it's very real. I think that, helpfully by now, that all, sort of, GPs and clinicians accept it's a very real thing that people are living with and trying to deal with.
I think it does require not just a -- continued dedicated services but also continued research and other levels of support.
But your question was about having a dedicated support and I think, given the number of people that are living with Long Covid, I think that is justified.
Q. You've talked about dedicated support and we talked

about dedicated support and research. Would you also agree that there needs to be specific communication about the existence of those Long Covid services to the general public?
A. Well, I think probably -- the reason I'm saying "probably" is I just don't know what the current communication is, and so it's hard for me to determine whether it's enough or not. But certainly in principle, you know, should those services -- you know, whatever services exist, you know, should they be properly communicated, properly understood? They should, and I hope they are.
Q. Thank you. I'm going to move on now to talk about vaccinations, if I may.
A. Yes.
Q. You said earlier that during the Omicron wave infections were rising and there was an increase in the numbers of people with Long Covid.
A. Yes.
Q. Do you think more could have been done and still needs to be done to inform the general public that vaccinations reduce the incidence and severity of Long Covid?
A. If more still needs to be done now or ...?
Q. Well, at the time -- both -- that is a question that

looks both historically and to present day.
A. So, sorry, was your question -- is it could more have been done at the time of Omicron?
Q. Indeed, yes -- well, let's start there, shall we, start at that point.
A. Yes. To inform people that vaccinations work, was that your question?
Q. Well, that vaccines specifically reduce the incidence and severity of Long Covid?
A. No, I'm not sure more could be done at the time. I think we were doing everything we could to communicate that.
Q. Specifically in respect -- do you recall that vaccination communication specifically referred to the effects of vaccination on Long Covid?
A. No, if you are distinguishing between, you know, vaccination effect on contracting Covid versus Long Covid, I don't think that distinction was made often, but to get Long Covid you've got to have Covid, and so if the message is -- which I believe at the time was very, very clear -- is that if you take -- if you get vaccinated, especially if you get boosted, you'll reduce your chances of contracting Covid, and therefore chances of contracting Long Covid, I think that was clear.

Q. Would you agree that at the time many people were not aware of the indiscriminate risk of acquiring Long Covid, and therefore wouldn't you agree that explaining that vaccines had the effect both on Covid and on contracting Long Covid that might have increased uptake?
A. No, I'm not sure, because I think it might have confused the message. I think -- you know, I was doing a lot of media at that time myself, so were many others, and I'm -- thinking about it, I think if I went out and said that "Get boosted and reduce your chances of getting Covid and Long Covid", I think it confuses the message. So I'm not sure.
Q. I'm going to turn to talk about inequalities. You've been shown earlier that we only have data on the ethnicity of people referred into the Long Covid clinics but not on the number of people who have Long Covid overall, ie those who have Long Covid but aren't within the NHS clinical system.
A. Yes.
Q. In fact there's little research impact of Long Covid on different ethnic groups or their ability to access Long Covid care. What, if any, work was done while you were in office to better understand how Long Covid impacted people from BAME groups?

A. The -- you know, the data that I had -- yes, I don't -- I think in many cases it didn't distinguish between different ethnic groups and -- but I believe, you know, later -- over time the collection of data on Long Covid improved. I don't know what -- where that eventually got to after I left office but I think having -- given the fact that we already now know that the pandemic affected different groups, including different ethnic groups differently, I think having such data is important. I couldn't tell you though how -- what the quality of that data eventually became.

MS HANNETT: Thank you, Sir Sajid.

Thank you, my Lady.

A. Thank you.

LADY HALLETT: Thank you, Ms Hannett.

I think the next person to ask is Mr Puar, who is usually middle back, as I look at the ...

THE WITNESS: Yes, I've got it, thank you.

Questions from MR PUAR

MR PUAR: Yes, afternoon, Sir Sajid.

I ask questions on behalf of Covid Bereaved Families for Justice Cymru, who are a group of bereaved families in Wales, and my question to you is regarding your relationship with devolved administrations.

A. Yes.

UK Government, or indeed any devolved administration?

A. First of all, those relations were very important to me, as they were very important to my devolved nation counterparts, and basically I think very important in addressing the pandemic for the whole of the UK because, you know, as we all know, the pandemic didn't stop at internal national borders and it was really important to co-operate and work together.

So when it came to working together, I think there was amongst ourselves, that group, there was an understanding and acceptance and recognition of, you know, certain things in health were devolved, and certain things were not. And so there were clearly actions that the UK Government took -- sorry, for England, that didn't apply to Wales or Scotland or Northern Ireland for that matter. You know, we discussed, for example, VCOD earlier as an example.

But there were other areas where we were making joint decisions where we could have deferred if we'd wanted to but we felt that, for lots of reasons, not least having a sort of single message to the wider population and building confidence was important, and that, for example, was on vaccinations and vaccination policy about when the JCVI had given its recommendations about how it would work and how we would communicate it,

Q. Now, at paragraph 46 of your witness statement, you describe meetings that you had with your counterparts in the devolved administrations.

A. Yes.

Q. And you describe working relationships, good working relationships, with a high level of trust. You may be pleased to hear that Baroness Eluned Morgan says something similar in her witness statement. What she says in her statement to the Inquiry is this:

"... I was pleasantly surprised by the amount of contacts I had with my counterparts. During the height of the pandemic, the health ministers from each of the four nations met almost weekly. This was entirely down to the determination and commitment of Matt Hancock and Sajid Javid who, as health ministers, took the relationships with the devolved nations very seriously albeit that I felt that the Welsh Government's influence over any decisions reached by the UK Government was limited. These meetings continued until in or around the summer of 2022."

So my question to you is whether Baroness Morgan is correct about the lack of influence the Welsh Government had in respect of UK Government decisions, or can you think of an example where the Welsh Government did have influence on the decisions taken by the

we could have chosen different ways to communicate it, for example, even if we accepted the decision.

So you asked me about examples where the Welsh Government, for example, may have influenced the decision. I can think of instances where I think it was Eluned Morgan, obviously, as you said, the Welsh health minister, would suggest when -- for example when we should announce a decision, the way we should announce a decision on vaccines, and on one occasion I'm sure she talked about: something was -- else was being announced in Wales and if we say it at the same time it might get ...

So, we -- you know, we took timing into account, and the way it's announced and -- and so there were decisions like that. I'm sure there were others but I think notwithstanding there was a general acceptance that there were devolved competencies, there were instances, whether it's the Welsh Government, the Scottish Government or the Northern Ireland Government, where it would have certainly influenced my decision-making.

MR PUAR: Thank you, Sir Sajid.

Thank you, my Lady, that's my question.

LADY HALLETT: Thank you very much, Mr Puar.

Ms Sen Gupta, please. Usually to the left as

I look at the hearing room behind --
THE WITNESS: Thank you.
Questions from MS SEN GUPTA KC
MS SEN GUPTA: Thank you, my Lady.
Good afternoon, Sir Sajid. I represent the Frontline Migrant Health Workers Group. Our client's members include outsourced non-clinical healthcare workers, largely from ethnic minority and migrant backgrounds, and clinical nursing and healthcare assistant staff, all of whom are from a migrant background.
Our questions relate to your draft White Paper, health disparities, levelling up health, which was not ultimately published, as you've explained.
Ms Carey asked you some questions about the disproportionate impact of Covid-19 on ethnic minorities and our questions are about migrant health workers in particular.
Paragraph 53 of your witness statement refers to the PHE study of June 2020, disparities in risks and outcomes. That study found a particularly high increase in all deaths among those born outside the UK and Ireland and those in a range of caring occupations including social care, and nursing auxiliaries and assistants, and the particular vulnerability of migrants

and their significantly higher mortality rates during the pandemic.
Were you aware of those findings when you commenced your work on your proposed White Paper?
A. First of all, can I say I think migrant workers are a very, very important part of our health and social care system for that matter and had we not had the level of support that we did from such workers, I think things would have been a lot more challenging and difficult than they already were.
Was I aware of those concerns you raise? I think yes, but I can't tell you it was definitely from that same PHE study. I think there was, certainly by the time I became health secretary, there was more of a general awareness but also I had an inquisitiveness personally about this issue and so after asking these questions I became more and more aware.
Q. Thank you. Your draft White Paper made only limited reference to migrants. It did not refer in any detail to addressing the health disparities faced by migrant communities, including migrant healthcare workers. You've referred to OHID the Office for Health Improvement and Disparities. Bearing in mind the significantly higher mortality rates in migrant communities, do you agree that before the next pandemic

OHID should specifically seek to address the health disparities faced by migrant communities, including migrant healthcare workers?
A. Yes.
MS SEN GUPTA: Thank you.
Thank you, my Lady.
LADY HALLETT: Thank you, Ms Sen Gupta, and I think lastly we have Mr Wagner who is usually sitting somewhere near Miss Sen Gupta.
Questions from MR WAGNER
MR WAGNER: Thank you very much.
Good afternoon, Sir Sajid. My name is Adam Wagner and I ask questions on behalf of the Clinically Vulnerable Families. I want to ask you, first, about shielding. I take it from your earlier evidence that you would agree it's important to understand the views and the experiences of those who were asked to shield?
A. Yes.
Q. Did you consider carrying out any consultation, a formal consultation with those who were shielding to understand their views on how the programme, whether it was effective, whether there was still a need for shielding measures, before ending it?
A. I don't specifically recall thinking about doing a consultation, no. I don't think it was suggested

either.
Q. Would you agree shielding was a novel programme in the sense that it hadn't been tried before --
A. Yes.
Q. -- certainly in this context?
A. Yeah.
Q. Wasn't it necessary, given how important getting the views of those individuals was, to do some sort of consultation, to have some sort of objective understanding of the effectiveness of the programme before cutting off the support?
A. No, I don't think so. I'm thinking about it now whilst you ask. I don't think so. I don't think it was necessary because shielding was introduced based on scientific and medical fact. Shielding was removed based on scientific and medical fact. And whilst the people being shielded, all 3.8 million plus of them, are hugely important and it's important to get the whole policy right, they're not medical or scientific experts, and I think that such an important policy should be grounded in fact.
Q. But you referred before to some of the downsides of shielding such as being stuck inside the home, psychological impacts, not being able to go to work, that sort of thing. Those aren't scientific questions,

are they? They are questions of fact.
A. Getting that kind of sort of information from people that are being shielded is important but I do recall when we made the decision there were -- you asked me specifically about consultation and a consultation, to me, has a specific meaning in government.
Q. Yes.
A. I've never known a consultation to take less than eight weeks, for example, and normally they take 12 weeks and it's a big, formal process and that doesn't mean to say that you don't have evidence on making a decision, including from those people that are most affected or likely to be most affected. So I already had information, particularly from the CMO and his office, on the issue of some of the negative impacts, the inadvertent negative impacts of shielding and, clearly, obviously that would point to a decision of removing shielding and those were taken into account. But I didn't think it would -- I don't think it would justify having a week's long consultation when I think the science behind it, ie that what we had learnt already about shielding, about the other sort of health impacts, but also taking into account vaccinations, as well, and where we were then versus when shielding was introduced, I don't think consultation was going to

change any of that.
Q. You sent a letter on 17 September 2021 to the shielding group advising them that the shielding programme was coming to an end, and in it you suggested that people could continue practising social distancing, ask visitors to take lateral flow tests before, wear face coverings, to avoid crowded spaces, et cetera. I want to ask you about healthcare settings specifically.
Now, Dr Catherine Finnis of CVF gave oral evidence to this Inquiry that that advice was, and still is, in the healthcare settings almost impossible to follow because people who have a high risk of Covid-19 when they visit healthcare settings they face a lack of structural protection. So lack of ventilation. Doctors and nurses not wearing masks. Having to crowd into spaces. When you wrote that letter, did you consider the practical implications or difficulties of clinically vulnerable people taking those measures when they went to healthcare settings?
A. Yeah, I think the -- clearly that was a general message to 3.8 million people about some measures that they might be able to take. It's not that they obviously had to take those measures and it's not that in all settings that they would be suitable. But that is why the central message of that same letter was the -- key is

really an individual risk assessment which would mean taking into account what that individual -- what's best for that individual including in certain clinical settings. Because it's worth keeping in mind there were clinically vulnerable people before the pandemic and, sadly, there always will be, one way or another, and those people need extra layers of protection, including in health settings, and just as before Covid, there were a set of precautions that may be able to put in place for when such individuals visit a health setting, it's possible, sort of, post-Covid as well.
So I think it was left to an individual assessment to determine what that -- how that setting should be approached and what's possible and what's not possible, rather than there being a central policy on it.
Q. But my question was, did you consider healthcare settings particularly and the difficulties that clinically vulnerable people would experience there, especially post-Covid when obviously as well as --
(Unclear: multiple speakers)
A. Yes, I would say I considered it to the extent that I felt that it was something that would be dealt with through the individual risk assessments.
Q. Do you accept that those at higher risk from Covid-19 remained at that time, remain now to be particularly

vulnerable to being exposed to the virus when they attend healthcare settings?
A. I don't know about now.
Q. What about then?
A. Yes, because Covid -- there was a lot more Covid around then and also we had the Omicron wave.
Q. And healthcare settings are quite straightforward places to get Covid --
A. Well, they could be. Even though, of course, in healthcare settings there were a lot more stringent controls, and infection protection controls than you have in non-healthcare settings.
Q. Well, your predecessor, Mr Hancock, on Friday, I think, Thursday, said that you -- hospitals were one of the places you were most likely to get Covid at the time; would you agree with that?
A. I think that was certainly more the case when he was health secretary because Covid was just discovered, we didn't know enough about it, we didn't really know how to -- as much as we learnt much later about how to control infection, we didn't have as good ventilation and we certainly didn't have the vaccines and the treatments and some of the other medications that we had. So I just think it was much tougher when he was there, and it's not to say -- I'm not arguing with your

point about healthcare settings, you've got to be much more careful that people may contract it there but I think a lot of the policies that we had in place, by the time I was there, were reducing that risk, not least to mention the VCOD policy because even before VCOD there were very high levels of vaccinations and obviously that increased even though VCOD wasn't implemented in all healthcare settings, but when Mr Hancock was Secretary of State there was no vaccine for most of the time and even when there was, uptake took a while including in healthcare settings.

Q. Finally I want to ask you about access to antivirals which is something you've already referred to a bit in your oral evidence.

A. Yes.

Q. In your statement, and in fact earlier today, you say that one of the rationales for ending the shielding programme was the availability of antibody therapies and antivirals, and you spoke about the various ways in which you tried to give access to people who needed those antivirals who were immunosuppressed. Many of CVF's members who are clinically vulnerable, immunosuppressed, or clinically extremely vulnerable, have reported historic and, indeed, ongoing difficulties accessing antivirals within the required five days from

the start of symptoms, particularly because of difficulties processing the PCR test in time and getting a decision to approve access to the antivirals from the Covid-19 medical decisions unit.

Can you recall what, if any, processes you had in place to make sure that immunosuppressed people who were at the highest risk from Covid-19 infection were in fact able to access antivirals?

A. Yeah, I think, I believe on the CEV list, the clinically extremely vulnerable, 3.8 million, I think roughly about 400,000 were immunosuppressed, and for those people in particular that's where we tried to put in place the -- it's something we discussed earlier, which were the enhanced protections, so alongside the individual risk assessments after we ended shielding, it was a policy of identifying those, and I think it was -- it was a process certainly run by the CMO's office but it's something like, I want to say 1.3 million people, it was just over -- it was around that number that were on this enhanced list and the plan was to make sure they had easy access to PCR tests, many of them were sent PCR tests without asking for them, so they had them available and so they could be tested and antivirals could be delivered to them quickly if they became infected.

That was the policy.

I can't sit here and say that I think that worked perfectly in every case. I know there were many cases that were successful and it did lead to people getting antivirals much sooner than they would have otherwise, but it is possible also that for some people that process didn't work as well as it should have.

MR WAGNER: Thank you.

My Lady, may I have permission to ask the final question on the list? I know I am over time.

LADY HALLETT: You may, Mr Wagner.

MR WAGNER: Thank you.

My final question on the same point. Do you accept that if antivirals were not in fact practicably available or promptly offered to many people at a higher risk of Covid-19, and just accept that -- if you accept that as a proposition, I'm not asking you whether it is necessarily correct, would that have impacted on the decision-making process as to when to end shielding and the justifications for it?

A. The antivirals were an important part of the decision-making process to end shielding. So I can say it certainly was taken into account that we had them, that they were -- it was something that the UK was one of the first, sort of, countries in the world to procure

them and they were going to be made more available and -- but, having said that, I would say that there were also other factors and I think probably it's fair to say that the vaccination rate in the country, obviously not just of those in that cohort but the general vaccination rate in the country, were probably more important than the decision-making -- in the decision-making than the antivirals.

Q. But the vaccinations don't necessarily work well for the immunosuppressed, that's the issue.

A. Oh, no, that's -- of course that is true but what I meant is the vaccination, more broadly in the general population, would also mean there's a higher level of protection in the country from infection than there was before vaccinations.

MR WAGNER: Thank you. Those are my questions.

LADY HALLETT: Thank you very much, Mr Wagner.

I think that completes the questions for you now, Sir Sajid. Thank you very much for your help. I do know what a burden it is to ask you to keep coming back to answer the questions. If you want someone to blame, blame your former colleagues who set the terms of reference extraordinarily wide.

But on that point, can I just manage expectations. You set me a challenge earlier and however tempted I may

be to accept a challenge I am bound by those terms of reference. So I hope you won't be disappointed if you discover that I can't go quite as far as you would like, because I just don't have the powers to do it. But anyway, we'll see how far we can go.

THE WITNESS: Thank you, my Lady.

If I may just say -- I mean, that point I made earlier about the NHS and its general sort of -- the system it operates under, I do believe and I think it became -- I think it's a vital point in dealing with a future pandemic, and so that's why I made the point that -- in the way I did, but I understand what you say and I hope there is something the Inquiry can do about that. That's the first thing.

And the second thing, if I can say, is get well soon.

LADY HALLETT: Thank you very much, Sir Sajid, I'm very grateful to you.

Very well, we'll sit again at 10 o'clock tomorrow. Thank you, everybody.

MS CAREY: Thank you, my Lady.

(The witness withdrew)

(4.20 pm)

(The hearing adjourned until 10.00 am on Tuesday, 26 November 2024)

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