Witness Name: Sir Sajid Javid

Statement No: 2

Exhibits: SJ/01-SJ/83

Dated:17/06/2024

UK COVID-19 INQUIRY

DEPARTMENT OF HEALTH AND SOCIAL CARE

Module 3: Witness Statement of the Right Honourable Sir Sajid Javid MP

I, Sir Sajid Javid, MP for Bromsgrove will say as follows: -

INTRODUCTION

1. I make this statement in response to a request from the UK COVID-19 Public Inquiry (the Inquiry) dated 25 March 2024 made under Rule 9 of the Inquiry Rules 2006 (the Request) asking for a personal statement detailing my specific involvement in decisions relating to the impact of the pandemic on the UK's healthcare system between 1 March 2020 and 28 June 2022.

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

3. I have already made a witness statement in Module 2 of this Inquiry about various matters relating to the pandemic and have also filed a witness statement in respect of vaccines and therapeutics. I exhibit those to this witness statement for assistance.

Recollection / Recall

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

5. Given time constraints, the Department has not been able to conduct a full search of all potentially relevant documents. It has, however, sought to find relevant documents which highlight the essential issues which this witness statement raises. I have also been unable to go through all the documents that my private office would have received during this period given the number of documents and the length of time that would take. The private office of the Secretary of State operates a "triage" system deciding what information I need to see and how and when I see it. The Secretary of State gets sent, and is also copied into, multiple submissions, advice notes and other sources of information daily. I was not necessarily able to read all of it. I did read all submissions directed at me where I had to make a decision.

6. I will explain the acronyms used in this witness statement where appropriate but note that the corporate witness statement has explained many of them, which I will adopt.

PERSONAL BACKGROUND

7. I have set out my personal and professional background in detail at paras 7-12 of my Module 2 witness statement previously submitted to the Inquiry. Please see here:
"7. I first became an MP in May 2010. Prior to this I had a career in investment banking over 18 years working in various roles in Chase Manhattan Bank and Deutsche Bank, including working in New York from 1992-1996 and Singapore from 2007 - 2009.

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

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

10. I then became a backbencher until 26 June 2021. During that time, I did not participate in any Select Committees; I did not join any MP groups, some of whom had formed various groupings to promote like-minded causes (for example, the Covid Recovery Group of MPs) and largely kept my counsel. I did not want to be seen as interfering from the back benches and was also aware of the complexity of decision making in crises, not all of which could be explained fully in public (because, for example, of national security considerations). I did my job as a constituency MP, and broadly supported the government on its programme in respect of Covid. I also led a

project at Harvard looking at lessons from international governments for how to prevent and better manage future pandemics. I did not recall seeing the Prime Minister in person while I was a backbencher, except for one occasion in 11 July 2020 when I had lunch with him, and his wife in the garden at Chequers. This was not a work event but of course work was discussed. I checked beforehand if this meeting complied with the rules in place at the time (which at that time permitted outdoor meetings of more than six people) before attending the event. I also saw the PM in his office in No. 10 on 1 December 2020.

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

12. I have agreed to be a Commissioner for the Institute for Government on its project called the "Commission on the Centre of Government" to examine how to improve the ways that No. 10, the Cabinet Office, and the Treasury work. As part of that I spoke at an event held on 3 July 20231 about the strengths and weaknesses of the centre of government. I consider that whilst this has not been entirely influenced by my experiences of the response to Covid 19, but by my entire ministerial career, that the Inquiry may find my recommendations to improve decision making to be helpful to their consideration of the issues raised by this Module of the Inquiry. I have therefore set out some of my observations during the course of this statement."

8. Prior to becoming an MP in May 2010, I had an 18-year career in investment banking working in various roles in Chase Manhattan Bank and Deutsche Bank, including working in New York from 1992-1996 and Singapore from 2007-2009. This involved working in intense and high-pressure environments, although of course these are different to the public facing pressure one experiences as an MP and government minister. A lot of my work was focussed on financing for businesses and government, which required taking on large amounts of information and specialist advice very quickly and then making decisions on lending and financial risk with potentially significant consequences. I found that background very helpful when I moved into politics.

9. My parliamentary career prior to the pandemic is as follows:

    a. Parliamentary Private Secretary (PPS) to the Minister of State for Further Education in the Business, Innovation and Skills, appointed in November 2010.

    b. PPS to George Osborne, who was then Chancellor of the Exchequer, appointed in October 2011.

    c. Economic Secretary to the Treasury, appointed in September 2012.

    d. Financial Secretary to the Treasury, appointed in October 2013.

    e. Secretary of State for Culture Media and Sport, along with being Minister for Equalities, from 9 April 2014.

    f. Privy counsellor, April 2014.

    g. Secretary of State for Business, Innovation and Skills, appointed in May 2015.

    h. Secretary of State for Communities and Local Government, appointed in 2018.

    i. Home Secretary, appointed on 30 April 2018.

    j. Chancellor of the Exchequer, appointed on 24 July 2019 **(SJ/01-INQ000479876**).

10. As I have explained to the Inquiry previously, I was Chancellor of the Exchequer until 13 February 2020, when I resigned after the Prime Minister, Boris Johnson, asked me to dismiss all of my special advisers at the Treasury and replace them with No10 appointees. I made a personal statement in Parliament on 26 February 2020, setting out my reasons for resigning.

11. I then became a backbencher until 26 June 2021. During that time, I did not participate in any Select Committees; I did not join any MP groups, some of whom had formed various groupings to promote like-minded causes (for example, the Covid Recovery Group of MPs) and largely kept my counsel. I did my job as a constituency MP, and broadly supported the government on its programme in respect of Covid.

12. During this time out of government I also led a project as a senior fellow at Harvard looking at lessons from international governments for how to prevent and better manage future pandemics. I was also involved in projects with an artificial intelligence company. Although the focus of this work was more general artificial intelligence rather than healthcare specifically, I have an understanding of the immense potential of these technologies which I believe will be relevant for a future pandemic. I explain these matters later on in this statement.

13. On 26 June 2021, I was appointed as Secretary of State for Health and Social Care following the resignation of Matt Hancock. I resigned from this role on 5 July 2022. I am now a backbench MP, and I am standing down at the next election.

MINISTERIAL ROLE AND WORKING RELATIONSHIPS

Role and responsibilities

14. My role as Secretary of State was primarily to oversee the strategy for the delivery of the health system in England. This means overseeing NHS and social care, the latter being only part funded by central or local government monies and largely delivered by the private or charitable sector. The structure of the Department is set out in detail in the corporate statements and will not be repeated here.

15. Broadly, in terms of the NHS, my role was to set its overall strategy, ensure it was accountable to that strategy, and manage any crisis situations or unexpected matters that might arise. As Secretary of State, I set the overall budget for the NHS alongside the Treasury and No.10. Thereafter, I would try and keep the NHS accountable for how it was spending that money, so that it was going to the places that I considered were to be a priority, and that the monies were being spent appropriately. I was also responsible for appointing its leaders, including the Chief Executive and Chairperson of NHS England. Sir Simon Stevens had decided to step down, and I appointed – a

new CEO, Amanda Pritchard. My view was that a new leader of the Board was also required, someone external with a business background who could help make the NHS more efficient. I, therefore, started the search for a new Chairperson, which culminated in Richard Meddings being appointed in March 2022.

16. Shortly after I joined the Department, I also decided to change the name of Public Health England to the Office for Health Improvement and Disparities (OHID) in around October 2021 as I wanted it to reflect my focus on reducing preventable illnesses and disease, and of health inequalities in the healthcare system. One of my priorities was to work on health inequalities and health prevention, both in the NHS, but also in wider public health work and interventions.

17. My predecessor had introduced what became the Health and Care Act 2020 into Parliament, and I spent quite a lot of time during my period in office helping to navigate the legislation through Parliament. This was designed to assist in dealing with some of the issues and challenges in the healthcare system, by setting up and replacing the Clinical Commissioning Groups (CCG's) with the Integrated Care Boards which would provide more integrated working and more accountability within the system.

Issues and challenges in the healthcare system

18. There were several key and pressing challenges facing the healthcare system in June 2021 when I became Secretary of State. Top of the list was, of course, the huge strain on the healthcare system caused by the pandemic. Overall, I cannot think of any aspect of the healthcare service that was not impacted by the pandemic.

19. The NHS was struggling with the number of NHS patients with the virus, and there was the need for those without Covid to be separated to avoid infection and further spread (often called nosocomial infection). Alongside this, I also recognised that many people were staying away from the NHS altogether, which would only build up the waiting list and create challenges further down the line. Compounding this was higher absentee rates than in normal times due to staff testing positive for Covid. Covid centres around hospitals were tasked with dealing with the most vulnerable – for example administering intravenous antivirals for those with cancer – so the health service had to treat these patients in a way which required more resources and time.

It was not just hospitals which were stretched, primary care services and mental health services were also strained. During the pandemic GPs were doing a lot of work online, which created further challenges for the NHS. We were also asking GPs to go out into care homes and private homes, which took further resources away from primary care services in the community.

20. I spent a lot of time as Secretary of State with my team thinking about the short-, medium- and long-term impacts of Covid. The short-term impact was of course the immediate impact on the population and the ability of the healthcare system to cope with a rise in infections. In the medium-term, we had to consider what would happen once hopefully things stabilised, particularly the massive backlogs that would have developed. We published an NHS document in 2022 which addressed how the NHS would deal with waiting lists **(SJ/02-INQ000087534**). This was an NHS England plan, and not one produced by the Department of Health and Social Care but I endorsed the steps to be taken within it by the NHS. The most important thing I could do to support this was to obtain the relevant monies from the Treasury to enable greater capacity in the system. The DHSC worked to secure the provision of £8 billion bound worth of money to aid elective recovery from 2022/2023 - 2024/2025, supported by £5.9 billion Elective Recovery Fund and £700 million Targeted Investment Fund to drive up elective activity by expanding words, installing modular operating theatres, upgrading outpatient spaces, expanding mobile diagnostics and upgrading screen technology. It also included increased bed capacity and equipment, modernising digital technology and creating better use of data by the NHS and 2.3 billion for the backlog of diagnostic tests. There were four ways in which capacity could be increased, which were **(SJ/02 INQ000087354, page 15**):

    a. Increasing the workforce and supporting them.

    b. Using digital technology and advanced data systems to free up capacity.

    c. Working with the UKHSCA on infection prevention and control.

    d. Making effective use of independent sector capacity.

21. I set out at various places in this witness statement the work that the DHSC did to support this, but to summarise them here this included:

    a. Merging Health Education England and the NHS England under the Health and Care Bill to provide a co-ordinated approach to service, financial and workforce planning. This was a central part of working on elective care, as it was not just about training new staff but also retaining staff and providing them with greater skills.

    b. Helping the NHS financially to use artificial intelligence software to free up time.

    c. Having more people to do the work. This included producing an NHS workforce plan (which I worked upon during my time in office but was announced by Jeremey Hunt when he became Chancellor in 2022), including seeking to fulfil the exiting commitment of 50,000 additional nurses, and recruitment of 5,000 healthcare support workers. The NHS also had a reservist's scheme which was rolled out nationally in 2022. This was all work undertaken by the NHS.

    d. Supporting the NHS creation of the "virtual ward" to free up capacity.

    e. Creation of NHSX to supply and enable IT and AI based development to improve health such as automatic patient registration and discharge.

    f. Working with the UKHSA to ask them to create best practice guidance for infection prevention and control.

    g. Working on and signing contracts with the independent sector so that capacity could be used, and to encourage the development of partnerships with the independent sector.

    h. Supporting the NHS to expand community diagnostic centres. The NHS announced 40 of these centres on 1 October 2021 with at least 100 by 2025. This came from Professor Mike Richards review of diagnostics.

i. Developing the My planned care platform by the NHS X.

22. The role of the DHSC in respect of NHS England is to provide oversight and accountability of the work that they are undertaking and develop broad health strategy alongside NHS England and other partners. It is not my role to micromanage or make decisions on behalf of the NHS. It is for the NHS to decide how best to deliver the backlog, and for me to use whatever powers and support I could give to support that.

23. As Secretary of State, I also spent a lot of time discussing the DHSC budget with the Treasury. The spending review of 2021 left non-NHS budgets in the department in a challenging position, and as I identified in my module 2 witness statement and my witness statement for Module 4, I often had to enter into significant debates with the Treasury on additional spending for both covid and non-covid related health issues which emerged (such as the procurement of anti-viral medication). I had to spend less money on discretionary areas, such as broader public health messaging or the provision of sports programmes to children to tackle obesity. At the end of this witness statement, I give some reflections on the changes I consider are necessary to ensure NHS funding can be sustainable in the future.

24. For the long-term, it was clear we needed to learn the lessons of the pandemic, both domestically and internationally. Domestically, the pandemic shone a light on the poor health of much of the nation. Health disparities were compounded by a poor approach to preventative healthcare. Alongside this, I felt key areas of health policy required a reset after the pandemic, particularly because of new and emerging technologies. I wanted to develop 10-year plans in major areas which I thought needed addressing. These included cancer, mental health, dementia and a suicide prevention plan alongside a specific strategy to address health disparities**.** Many of these areas were areas of concern regardless of Covid, but the pandemic made it more vital there was a strategic long-term plan. I asked OHID to begin working on a White Paper looking at health disparities, as I felt addressing these differences was not only a moral responsibility, but an economic imperative for the health and wealth of the country **(SJ/03-INQ000468609).** I also initiated an independent smoking review, led by Dr Javad Khan OBE **(SJ/04-INQ000479873),** and an independent review of "equity in Medical Devices" lead by Dame Margaret Whitehead **(SJ/05-INQ000339294)**. Unfortunately, and to my deep frustration, most of these

initiatives, including the 10-year plans, were scrapped once I left the Department, despite considerable work having been done.

25. I also felt strongly that the NHS needed a long-term plan for its workforce. I considered there were two main obstacles here. First, the Department had a separate unit, Health Education England (HEE), that was not part of NHS England, but which was responsible for its workforce plan. I was surprised that this was an entirely separate unit and could not understand why the NHS was not responsible for its own workforce plan, and instead subcontracted this out to another body with its own chairperson. I felt it was obvious that the NHS should have a firm understanding on what its own workforce needed. When I queried why this was the case internally, no one could give me a good reason for this separation. I therefore decided that HEE should be merged with the NHS to make workforce planning clearer and help ensure the workforce strategy needed to meet future demand could actually be achieved. This took place on 22 November 2021**(SJ/06-INQ000479841)** and merger completed on 3 April 2023 **(SJ/07-INQ000479874).**

26. The second obstacle was that the Treasury did not want me to publish a 15-year long term plan for the workforce, which had been ready for some time, because it was worried this would lead to increased spending pressures in the long term. The Chairman of the Health Select Committee at the time, Rt Hon Jeremy Hunt MP, agreed with me and subsequently approved the publication of the plan when he became Chancellor. A plan has since been published and I exhibit it here as **(SJ/08-INQ000292664**).

27. Another key area I focussed on was improving digital services and the use of data in the healthcare system. As with workforce, I was surprised to find when I joined the Department that there were different and disparate units working on digital issues, for example NHS England, NHS England Digital (NHS-D), and NHSX ("user experience") I consolidated all of these under NHS England. I also commissioned and published another review on the NHS' data strategy, 'Data Saves Lives' (published 13 June 2022) **(SJ/09- INQ000479871)** which set out a series of commitments including:

    a. investing in secure data environments to power life-saving research and treatments;

b. using technology to allow staff to spend more quality time with patients;

c. giving people better access to their own data through shared care records fort the NHS App. These commitments were in addition to the very large £200m investment already made in the Data for Research and Development programme.

28. This strategy took forward recommendations from the final report of the Goldacre Review 'Better, broader, safer, using health data for research and analysis' (published on 7 April 2022) which explained how data could drive innovation and improve healthcare **(SJ/10- INQ000458892).** I was particularly keen for the June 2022 strategy to be put into action as quickly as possible as I felt many of the plans were crucial, particularly in the area of drug discovery. In the final few weeks before I left the Department in July 2022, I delivered a speech setting out the plan for digital health and social care **(SJ/11-INQ000479872)**. I have set out in this witness statement those parts of the speech which may be helpful for the inquiry.

29. As the immediate threat of the pandemic needed, I was also to set out more of my approach to institutional reform. I made a speech at Dorchester House on 8 March 2022, which set out where I wanted to see NHS reform at the time. I argued we needed an era of recovery and reform, with the focus being on prevention, personalisation, performance- and people. I considered reform was necessary across all levels the healthcare system, and the government approach to public health.

Daily work pattern

30. My typical working day would begin at about 8am when I would go through my diary for the day. This would often be followed with a visit to No.10 for an 8.30am meeting. My day would start much earlier when I was responsible for doing morning media duties, which occurred once a week during large parts of the period when I was Secretary of State. The morning meetings with No.10 occurred throughout most of 2021 but were stopped from January 2022 onwards. Following this I would return to my office and meet with my private office and Spads (special advisors) to discuss the plan for the day. The day would then be filled with back-to-back meetings.

31. My private office team and Spads would identify what was working well, what needed to be done, and in particular my Spads would let me know what was happening in Parliament. My Spads were essential to the functioning of my office as they enabled me to be aware of the breadth of policy issues, they could focus on different areas of my brief and spend time on internal meetings, stakeholder engagement and in scrutiny of policy. In doing so, they could reflect that my priorities were reflected by the Department and also had discussions with those working in No 10 and other departments, assisting me in making trade off judgements to reflect the bigger picture.

32. I would usually spend all day in my office in meetings unless I had to go to Parliament to make a statement. This would happen on at least once a week. Once in Parliament I would set aside some time to meet with MPs to discuss constituency issues or any particular issues arising from my Statement. I would then return to the Department and continue with meetings. My office would arrange a couple of meetings a week to health or social care settings.

33. Every evening, I would do "box-work", which involves signing documents and reading reports or other papers which my Spads and the Private Office recommended that I read. My typical routine was to complete my box before leaving the office. I would usually leave around 7:30pm or 8pm and be home by 8:30pm or 9pm. On Mondays I would leave later, around 10.30pm, as Parliament sits late. On weekends I would normally spend around 3 or 4 hours on box-work. There were no meetings unless they were urgent. Often there were urgent internal meetings over the weekend, particularly during Omicron, with civil servants.

34. My witness statement for Module 2 at paras 60-69 describes the general structure of my working day, and in particular meetings with key decision makers in central government. To summarise that evidence, there was a "Gold meeting" every week which involved myself, the CMO, the Permanent Secretary, Clara Swinson who was the Director General for Global Health and members of the UKHSA such as Jenny Harries – Chief Executive, Susan Hopkins who was Chief Medical Adviser, Ed Wynne Evans who was Director of Radiation and Environmental Hazards. I would also meet with the UKHSA on a weekly basis.

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

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

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

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

64. Alongside daily meetings about the NHS, I also had daily meetings with the NHS Vaccine Delivery Team. This was as important as the meetings about whether individuals should be vaccinated or not, as it was essential that we could get

everyone "boosted" and vaccines administered to those who had not had them during the autumn and winter of 2021.

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

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

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

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

69.I would also use WhatsApp to communicate with my Special Advisers and my Parliamentary Private Secretary ("PPS") who is an MP whose job it was to be my eyes and ears in Parliament. I would discuss matters with them, and they would

convey information to me by way of WhatsApp. Due to the constant schedule of meetings, and 24/7 nature of media and political issues, this was often an efficient way to ensure my team and I were up to speed on latest developments."

35. Officials from the Department met with me on a day-to-day basis, providing me with advice and assistance – which would include the Permanent Secretary, the CMO and Deputy CMOs, the Head of NHS England and the Directors Generals, as well as individual from the UKHSA. I considered that these individuals worked hard, were very professional and provided me with good advice. Susan Hopkins, the Chief Medical Adviser to the UKHSA would lead meetings during Omicron wave and during that time I would have daily meetings with her and others.

36. Daily meetings would also take place to discuss the Covid "dashboard" where relevant statistics were presented, or where discussions were held about what decisions needed to be made on issues related to Covid.

37. Alongside daily meetings concerning various aspects of the NHS, I would have daily meetings with the NHS Vaccine delivery team to discuss barriers to vaccination uptake, manage any difficulties with the roll out of the vaccine and to discuss issues relating to extending vaccinations or communications around vaccinations. I explain this in more detail in my witness statement for Module 4.

38. When the Omicron variant became known about in November 2021, I would have numerous daily meetings to manage the risks of this, including making decisions about restrictions, the introduction of non-pharmaceutical interventions, booster vaccinations, workforce absence and its impact upon the health and social care sector, hospital capacity, adult social care capacity and travel restrictions. All of these issues required decisions to be made by way of these formal meetings where civil servants would take notes. Meetings involved myself, the Permanent Secretary, the CMO or other officials always had someone taking notes, and I did not use my personal email to conduct government business.

39. As part of the rhythm of decision making, WhatsApp and other informal messaging services, alongside phone calls and discussions would be used as a way to communicate decisions, or to discuss aspects of them, but not to make them. So, for example, if I was attending a press event, I would be sent the "key lines" by

WhatsApp to remember, or when a decision was made, a WhatsApp group would be set up to circulate the information quickly – for example about new guidance. If I was already in a meeting, I may well then use WhatsApp to ask for data to be prepared for a further meeting, but I would not make policy decisions using WhatsApp, and they would be recorded and minuted by officials.

40. I would also use WhatsApp to communicate with my special advisers and my Parliamentary Private Secretary – who is an MP whose job it is to be my eyes and ears in Parliament. We would discuss matters through WhatsApp. Using this sort of instant messaging was helpful because the constant schedule of meetings and the 24/7 nature of media and political issues meant that this was often an efficient way to ensure that my team and I were up to date on various issues.

Decision-making

41. I am asked about my responsibility for operational decision-making in relation to the NHS. I was not responsible for operational decisions but did have an important role in priority setting and holding official to account when failures occurred. As Secretary of State, my role was strategic – ensuring that the NHS had a coherent overall strategy and budget, and then providing oversight through regular meetings with NHS leadership to ensure that strategy was being carried out. My overall priorities during my tenure were around three key themes: Covid; recovery and reform. When I was appointed in June 2021, we were still in the midst of the pandemic. The emergence of the Omicron variant demonstrated how important a focus on battling Covid and driving the vaccination campaign still was. In the medium to long-term, I also sought to advocate for greater investment in pandemic resilience, domestically and internationally. Alongside this, recovery was also essential, with an estimated 10 million people staying away from the NHS during the pandemic. This was inevitably going to create huge pressures down the line, and managing those would be one of the biggest challenge the NHS has ever faced **(SJ/02- INQ000087534**). The third priority was about learning the lessons of the pandemic and implementing an ambitious programme of reform. I knew how crucial making this argument was with the pandemic still fresh in people's minds. Inevitably, focus and interest would drift, so I was determined to make the case publicly and privately to reform to strengthen areas of weakness in our healthcare system and build on areas of success in the pandemic, such as vaccines and digitisation.

42. NHS decisions taken by government ministers typically take one of two forms. Decisions could go to junior ministers. My private office and SPADs would be copied into these decisions, but I would not make the decision formally myself. There were times where I would be told about the decision in a weekly file as a matter of routine; however, this was not always the case with some decisions taken by junior ministers. Where civil servants in the Department and NHS colleagues decided that a decision had to be taken by me personally (as was often the case) then a submission would be prepared by the relevant policy team and then sent to my private office. I would be provided with the submission containing the recommendation from civil servants in the Department, as well as the views from relevant members of my private office and my special advisers. I would read the submission, the recommendation, and the views of my private office before going on to make the relevant decision.

43. I imposed some formal parameters around what decisions I wanted to take personally, and other areas of decision-making which were delegated to junior ministers in the Department. I set out these parameters almost immediately upon joining the Department and sent individual letters to each junior minister detailing their key areas of responsibility. There were particular areas related to the NHS which I wanted personal responsibility for – these included: the NHS Care Bill which was passing through Parliament at the time; how the NHS was handling Covid in hospital wards; hospital waiting lists, diagnostic centres and prioritisation of surgeries; delayed discharge policies; and gender dysphoria.

44. I consider that I had a good working relationship with the Department and its civil servants. Overall, I felt that civil servant colleagues were professional, positive, and incredibly hard working. I cannot think of any notable examples of thinking otherwise. The Department was already going through structural changes before I joined, with the replacement of PHE with UKHSA and the Office for Health Improvement and Disparities, which were changes I supported and pushed for.

45. Where I wanted to liaise with other government colleagues, advisers or organisations, then I would normally ask my private office to make those arrangements. There were, however, also existing mechanisms in place – for example I could raise matters formally in Cabinet or in the sidelines of Cabinet. I also had the daily morning meetings with the Prime Minister to discuss the response to

the pandemic. There were specific meeting such as Covid-S and Covid-O for Covid issues which I or other members of the Department could attend. I had regular formal meetings with UKHSA (weekly); NHSE (weekly with the CEO and leadership; and informally on a daily basis); the CMO and Deputy CMO (weekly; and informally 3 or 4 times a week); the Permanent Secretary (weekly); the NHS England Board Leadership. The Department also had well-established formal relationships and communication channels with external organisations such as the Royal Colleges, the NHS Confederation and the British Medical Association, all of whom I had regular meetings with.

46. As detailed at para. 77-78 of my witness statement for Module 2, I set up a weekly meeting with my counterparts in the Devolved Administrations to ensure that decision-making was as consensual as possible and also to seek their views. I do not consider that there were any significant differences between us in relation to the response to the pandemic. We generally had a good working relationship and a good level of trust between us. Our main areas of discussion were around vaccines and authorisation policy – on which we all took our lead from the JCVI. Other than the one issue I have discussed previously around the vaccination of those aged 5-11, we were all agreed that our vaccination response should be unified, and we endeavoured to share best practices between each other.

"*77.1 set up a weekly meeting with my counterparts in the Devolved Administrations. I understood that this was not something my predecessor did on a regular basis. [SJ/43: INQ000279851; 5J/44: INQ000279853; 5J/45: INQ000309495; SJ/46: IN0000309515]. Every Thursday or Friday we would speak together, to ensure that decision making was as consensual as possible and also to seek their views. We also had informal conversations and had a good level of trust [SJ/47: INQ000309526; SJ/48: INQ000309504]. I also know that officials from all the Devolved nations met regularly and seemed to get on well (including the CMO group). As identified earlier, on vaccination the four nations acted in concert. There were some differences in our approach to NPIs. I suspect, although I am not certain, that had we reimposed NPIs during the winter of 2021 then the other nations would also have done so.*

78.I recall one time when I had concern with the behaviour of the Devolved Administration was about the vaccination of those aged 5-11. It was particularly important to have a common and consistent message about vaccination of this age

group and steps had been taken to have central communications. I heard (via backchannels) that Nicola Sturgeon wanted to announce this policy prior to it being fully ready for a four nation rollout, with relevant scientists, information sheets and communications all being in place. I phoned up Humza Yousaf (who is now the First Minister of Scotland: but at the time was the Health Minister) to indicate that this was not acceptable, and that if this happened, the trust would be lost with his office and that therefore in the future I would have to deal with Ms. Sturgeon's office. Mr Yousaf acted swiftly and resolved the issue, and the matter was announced in concert."

47. Although there were some differences between us on specific isolation policies, these were not significant – each nation was responsible for its own social distancing and isolation policies, and each of us accepted responsibility for our own parts. The one area where it was crucial to have a UK-wide policy was in respect of exit and entry into the UK, and isolation and vaccination requirements on entry. This issue was dealt with primarily by the Cabinet Office, with input from the Department through Covid-S meetings.

48. I had a good working relationship with the CMO, who I saw roughly 3 or 4 times a week. We worked very closely together on issues of prevention. I also saw the CMO at almost all of the Covid meetings. The CMO also provided advice on the health disparities White Paper, which he was a big supporter of, as well as my plans for reviews on smoking, cancer, obesity and medical devices.

49. I did not have a particularly close relationship with the Chief Nursing Officer for England (CNO). I believe we had around 2 or 3 meetings together in total, usually to get her views on staff morale, pay demands from the Royal College of Nursing and other issues. The CNO sits within NHS England, so it had primary responsibility for overseeing this role and liaising with the CNO.

50. I met with Jenny Harries, Chief Executive of PHE/UKHSA, roughly 3 or 4 times a week, primarily to discuss Covid issues. We also had discussions on the monkey pox outbreak, and I sought UKHSA's input during my negotiations over a financial settlement with the Treasury. I met with the CEO of NHS England 3 or 4 times a week as well; we also had one formal meeting per week. I had a very solid, professional working relationship with Amanda Pritchard. She was my pick for the role from the shortlisted candidates, and I always believed she was the best person

for the job. I believe we made a good partnership and respected each other's shared motivations and areas of mutual specialism. I do not have any views on Simon Stevens, who preceded Amanda Pritchard, as he was in the role for only a few weeks when I joined the Department and was in the process of handing things over to her.

51. I had a roster of regular meetings with the various professional bodies. I met the British Medical Association (BMA) and the Royal College of Nursing (RCN) most regularly. A lot of our discussions with the BMA were based around the issues of pay and pensions. I found the General Secretary of the BMA, Chand Nagpaul, to be professional and good to deal with. However, I had a less constructive relationship with some junior members of the BMA leadership. In particular, Irrelevant & Sensitive

Irrelevant & Sensitive

Irrelevant & Sensitive My and the Department's relationship with the BMA's General Practitioner's Committee broke down as a result of this incident. Conversely, I tried – and believed that I managed to – develop a good working relationship with the RCN. I considered that the BMA sought to take commercial advantage of the position that the government and country were in with the Omicron variant to demand more money to administer vaccinations – despite the fact that their workload in other areas was being reduced so that they could undertake this task. I felt their rigid approach was unethical, and not in the public interest. The vaccination programme could not have been administered as speedily as it was without General Practitioners, so I agreed to their terms but I found it most unsatisfactory.

Impact of decisions on those with protected characteristic or vulnerabilities and OHID

52. Considering the impact on vulnerable or minority groups was a formal part of the decision-making process. Every submission which I was presented with, which

required a decision, would have a specific section on equality impacts and the potential effect on vulnerable groups. I would describe this as "baked in" to the decision-making process. As I have said in my previous witness statements, I am the son of Pakistani immigrants. Both before and after my time in office, health inequalities, access to treatments, diagnosis and managing illness was a central concern of mine.

53. I had meetings with the CMO and others on why a disproportionate number of people from minority ethnic communities had died from Covid 19 and to understand the work that was being undertaken to improve health outcomes **(SJ/12-INQ000309457), (SJ/13-INQ000309454), (SJ/14-INQ000309453), (SJ/15-INQ000485243), (SJ/16-INQ000485242)**. I was aware of the PHE study which was undertaken in June 2020, and which showed the disproportionate impact, and I knew that OHID was set up to address some of the health inequalities which led to this disproportionate impact **(SJ/17-INQ000399820).** The CMO and I had several informal conversations about health inequalities given my interest in the subject, and I think he was pleased that I was looking to take practical action on these issues.

54. President Biden and the Prime Minister reached an agreement at the G7 in June 2021 to establish a twinning arrangements between the NHS Race and Health Observatory (RHO) and the US CDC office for Minority Health and Health Equity to explore inequalities together in both medical devices and technologies, and I discussed this issue with US Health Secretary Becerra (and we authored a joint op –ed in November 2021 on this issue) **(SJ/18-INQ000309465).** The MHRA had also acted with the FDA (the US body which regulated medicines) and Health Canada in jointly publishing the Ten Guiding Principles for Good Machine Learning Practice which included at principle 3 the need for diverse study populations, and to prevent algorithmic bias in AI and software based medical programmes.

55. I took decisive steps to lessen disparities by commissioning a White Paper on Health disparities **(SJ/03-INQ000468609)**. A White Paper is a policy document which set out proposals for future legislation. I would have wanted this to be published and was disappointed that it was not. I did this shortly after coming into office (in September 2021) identifying to the Prime Minister that I felt that this would be a good way to focus and take forward the work of OHID **(SJ/19-INQ000421424), (SJ/XX12-**

INQ000309457), (SJ/13-INQ000309454), (SJ/20-INQ000309494), (SJ/14-INQ000309453), (SJ/21- INQ000309441).

56. That draft White Paper was focussed upon reducing inequality in health outcomes between geographic areas. This White Paper involved significant discussions across government, by, at least in part, the setting up of a Health Promotion Taskforce in 2021 to work on major cross departmental health issues. There was a ministerial group chaired by myself and a group of officials working across Whitehall including the CMO **(SJ/22- INQ000421425), (SJ/23-INQ000421426).** I met with officials from DHLUC and the White Paper was at the stage of "write round" - which is to send it to all government departments for a final chance to raise any concerns with a view to publication on 4 July 2022 **(SJ/24-INQ000421435).** All major policy publications were scheduled via a "grid" system operated by Number Ten which decided which piece of policy should be published on what date.

57. The White Paper is a lengthy document and I would ask that the Inquiry reads it for detail about the proposed policy positions that I wished to take. In summary, however, the proposal was to increase healthy life expectancy by five years by 2035 **(SJ/03- INQ000468609)** and to reduce the gap between areas by 2030. The Paper recognised that progress in healthy life expectancy and life expectancy was stalling and that the pandemic had a significant impact on this[1]. It also recognised the disparity in health outcomes within England, and that the risk factors for ill health are complex and the contexts in which people live, including their education, nature of their employment, housing, income and family and relationships all make a significant contribution to our health outcomes[2]. It identified that over 40 per cent of ill health and early death is due to preventable risk factors, and is related to tobacco, alcohol and obesity[3].

58. A chapter of the White Paper examined how health services could contribute to reducing health inequalities. The White Paper emphasised the need for system wide action to address the wider determinants of health and support health behaviours (for example, introduction of the smoke free generation). But the White Paper recognised that what was also the need to keep people healthy by having equal

[1] Executive Summary draft white paper, paragraph 3.
[2] Paragraph 7, executive summary white paper.
[3] Paragraphs 7 – 9 of the executive summary.

access to and using various health services essential to the building blocks of good health which include (see paragraph 219 of Chapter 9 at (**SJ/03:INQ000468609, page 82**) which includes:

a. Services relating to smoking, diet and alcohol;

b. Vaccination services from infectious disease;

c. Services which detect and manage significant risk factors or health conditions as early as possible;

d. Treatment services for people with mental or physical health conditions.

59. NHS England introduced a "Core20PLUS5 framework" in 2021 to seek to embed and prioritise the reduction in health disparities by 2024, which defines a particular cohort of individual and then focuses upon 5 clinical areas which required "accelerated improvement". The cohort are called from the NHS Core20 which were the most deprived 20 per cent of the national population as identified by the index of Multiple deprivation and those which every integrated care board identified as experiencing poorer health, including those from minority ethnic populations and includes inclusion health groups. This was to undertake work on five clinical areas of focus:

1) Maternity – to ensure continuity of care for women from ethnic minority groups and from the most deprived group;

2) Severe mental illness – to ensure annual health checks;

3) A focus upon Chronic Respiratory disease – driving up intake of relevant vaccinations – such as Covid 19, but also flue and pneumonia, to reduce infective exacerbations;

4) Early cancer diagnosis;

5) Hypertension case finding – to allow for interventions to optimise blood pressure and minimise the risk of myocardial infarction and stroke.

60. It was identified that these were the biggest risk factors driving both death but also disability related to the above conditions, so focussing upon preventative action

would help to reduce disparities. The proposal was to seek to identify those at high risk of development serious illness or in the earlier stages to avoid mortality and long-term ill health, particularly from major preventable killers such as cardiovascular disease and cancer.

61. The White Paper sets out the significant variations in premature mortality and long-term health from certain major conditions (paragraph 240 of the White Paper at (**SJ/03: INQ000468609, page 87 - 96**)), which includes:

    a. Diabetes where there is a 60% difference in prevalence between the most and least deprived areas.

    b. Cardiovascular health, which affects over 6.4 million people and which accounts for around a quarter of the life expectancy gap between the richest and poorest in England. Early detection and management have a major impact in reducing health disparities but there are significant gaps in diagnosis.

    c. Cancer: there is an 6% difference in diagnosis of cancer at the earliest stages between the most and least deprived areas of the UK. It is estimated that around 30,000 of extra cases of cancer are attributable to social economic deprivation. There is lower participation in screening programmes and also geographical disparities in survival rates from cancer.

    d. Mental ill health. People with severe mental illness die around 15 – 20 years earlier than the general population. Those from the most disadvantaged groups have much higher risks of developing mental health conditions, including depression, psychosis, self-harm and suicide. Those from minority ethnic groups are less likely to access primary mental health services, and there is a long-recognised disparity in those from Black British groups detained under the Mental Health Act. The NHS launched an Advancing Mental Health Equalities Strategy to support the NHS Long Term plan.

62. Alongside side this, various other steps were to be taken which include:

a. Building on the work undertaken during Covid 19 on vaccination to maximise vaccine uptake targeted at the needs of local people, as well as designing vaccination service to sit alongside community-based prevention and obtaining better data and digital services to book vaccinations.

b. Continue the work already in place by the UKHSA and NHS England on TB (where an action plan was published in July 2021), the HIV Action plan to reduce new HIV infection by 80% and priority programmes for Hepatitis C and B focussed upon inclusion health groups most affected by infection.

c. Improving the design and delivery of prevention programmes to improve uptake for disproportionately impacted groups in respect of diabetes, cardiovascular disease. This includes commissioning 5 yearly checks for all those age 40 – 74 who do not have a diagnosis of CVD to check for their likelihood of having a heart attack or stroke in the next 10 years. The lowest uptake of such checks is in the most deprived areas.

d. Undertaking targeted work on diabetes under the NHS Diabetes prevention programme, and a new Cardiovascular prevention programme to improve detection.

e. IN respect of cancer, using the Cancer Alliances including targeted lung health checks on the most 27 deprived communities. This was alongside the James Brokenshire Cancer Fund (named after the former MP and friend of mine) which provides monies to drive improvement in early screening and detection including novel cancer screening.

f. In respect of mental health, both supporting the NHS Advancing Mental Health Equality Strategy but also – and I was a passionate advocate for this – to develop a cross government 10-year mental health plan to improve the nation's health and wellbeing. I also had a very strong commitment to the development of National Suicide Prevention Strategy and to work on tackling suicide risk amongst high-risk population groups. As I have spoken about, one of my brothers took his own life and that had a profound impact upon myself and my family and made me determined to reduce the numbers who end their lives in this way.

g. To minimise disparities in blood, organ and stem cell donations (fewer than 6% of all blood donors are from ethnic minority communities). This involved NHS Blood and Transplant service to increase the numbers of those from minority communities on the Bone Marrow Registry, having better matching of blood, and recruitment of black blood and minority ethnic stem cell donors.

h. In respect t of rare diseases – which impact 3.5 million people in the UK, the NHS created a 2022 Rare Disease Action land including education and new digital resources. The White Paper in particular looked at sickle cell and thalassaemia, which disproportionately impacts minority ethnic groups and where there is evidence of inequalities int he cares to patients and to improve care and treatment for those with sickle cell and thalassaemia.

63. Alongside this work, and as identified in Chapter 9 of the White Paper, the DHSC and NHS had also provided a Women's Health Strategy, recognising that women spend a greater proportion of their lives in ill health and disability. There was also work and a specific plan to develop a cross government delivery plan on ME/CFS which I announced on 12 May 2022. There are over 250,000 adults age 40 – 69 in ME, but with unknown numbers of children. The White Paper recognised the disparities in awareness of this condition amongst clinicians and ability to access specialist treatment. As part of this intention to develop a delivery plan, I sought to build on two core principles: one that there was not enough knowledge about ME/CFS and that we must listen to those with the condition **(SJ/03 - INQ000468609, page 101).**

64. The draft White Paper (Chapter 9) **(SJ/03- INQ000468609, page 101 – 103)** identified that those who are socially excluded, experience multiple risk factors for poor health – such as poverty, violence and complex trauma and who experience stigma or discrimination are not consistently accounted for in data – which includes those who are homeless, vulnerable migrants, sex workers, the Roma and gypsy and traveller community, those who are depends on drugs and alcohol, prisoners and victims of modern slavery. The White Paper did not ignore theses groups, identifying the work already done in these areas including:

a. Substance misuse treatment and support for those sleeping rough since 2020/21;

b. GP registration campaign for such groups;

c. Integrity care models for those who were homeless to prevent discharge from hospital back to rough sleeping in some areas;

d. New specialist mental health provision for those who are homeless in 23 high need areas by 2024;

e. Work on developing healthcare in the prison estate.

65. I resigned on 5 July 2022 and the paper's publication was cancelled by my successor as it didn't fit with their new priorities. I recognise that some of what I put in place – most notably the creation of a smoke free future has come to fruition for which I am very glad. I have read the witness statement of Jonathan Marron dated 28 March 2024 **(SJ/25-INQ000421760)** which sets out the other policies which are still being pursued by the Government. I am pleased that the work is being continued but consider that it should have a central focus in any future government, of whichever party. As was said in the draft White Paper[4] , I considered that the lessons from the Covid 19 pandemic should be learnt. This included that with clear and shared purpose, action taken in partnership between health service, communities, and the public private and voluntary sectors could help deliver results in particular in addressing disparities in health outcome.

66. Lessening health disparities was not something that can be done by the Health and Social Care Department on its own: it requires a cross government approach that impacts people throughout their lives (from Start for Life which are services provided for parents and children under the age of 2) and involving housing, education, local government, planning and green spaces. A healthier society is more economically productive, and a health system focused on prevention is more cost effective. It will also make the population more resilient to future pandemics. That was why the Health Promotion Task Force was set up on a cross departmental basis, which met for the first time in October 2021.

[4] Executive summary, paragraph 11 – 12

67. I considered that improving public health and reducing health disparities was a priority of mine. I therefore took an interest in and asked for briefings on and advice on improving diet, eliminating smoking and reducing drug and alcohol dependence, all of which contribute considerably to poor health outcomes (see for example **(SJ/26-INQ000479848)** which shows the interest I took in seeking to improve the diet of the nation).

68. Alongside this, I commissioned a review into Equity in Medical Devices by Professor Dame Margaret Whitehead **(SJ/05-INQ000339294)** which was designed to examine disparities in efficacy of certain devices – including pulse oximeters but also other devices, and to make recommendations as to how such disparities could be lessened. The report was published in 11 March 2024 **(SJ/05 - INQ000339294) (SJ/27- INQ000479875)**, following evidence gathering between August 2022 – October 2022. I raised this when I came into office as I had read that pulse oximeters were not reliable for those with darker skin and found out that the testing of such oximeters was primarily on white skin as they were seen as the biggest global market by the manufacturers of the equipment. I spoke about this publicly, and also discussed this with my US counterpart. My idea was that the US and UK should work in concert and identify that they would only procure medical equipment which had been tested on all ethnicities and races, as our share of the market would provide a strong incentive for manufacturers to then undertake this work. I was unable to continue with this idea because I resigned, but I consider that any of my successors should seriously consider this.

69. Alongside this work at a national level, I pushed the requirements for clinical trials involving all ethnicities at my discussions with my counterparts at the WHO, G20 and G7 meetings I attended.

70. I can't from this distance identify particular decisions I made because or a particular equality impact assessment or other impact assessment: the system does not work like that. They are part and parcel of policy making, and so will always be considered carefully by both ministers and policy officials before making decisions. Unfortunately, in respect of Covid it was the case that unpalatable and difficult decisions had to be made which did have differential impacts on some groups over others – for example decisions about closing schools, about placing services online, about working from home all had an impact. Even where I may not have had a

specific equality impact assessment, the disparate impact on different groups was usually a point of discussion and debate before the decision was made and was part of the policy development and thinking.

71. Alongside the work undertaken nationally, the DHSC operates global health programmes alongside the FCDO. I was keen to provide research monies and projects which focussed upon illnesses which historically would have been more likely to impact black and minority ethnic communities. So for example, the DHSC funded a programme run between Kenyatta University in Kenya and the University of Manchester focussing upon skin cancers which only affected the black African and Afro – Caribbean communities **(SJ/28-INQ000479833) (SJ/29- INQ000479834).** I met with President Kenyatta when he visited the YK to discuss and launch this work. I consider that the work on international health treaties funding for organisations like WHO and GAVI, and donations of millions of vaccines demonstrates the UK commitment to leadership on global health. Before I left DHSC, I was also working on plans to set up an Office for Global Health in the department. This would allow more focus on global health at DHSC, taking away more responsibility from FCDO, where focus on the agenda could sometimes wane – particularly in "peacetime" when pandemics or other crises were not taking place.

72. As well as these areas, I was involved in public communications for more hesitant communities in respect of vaccinations. I spoke to the Muslim community in particular, and also asked for specific advice to be shared around Ramadan. I also worked on ensuring that a variety of other inclusion health groups had equal access to the vaccine (such as migrants who may not have regular immigration status, the homeless, and those who did not have English as a first language). I was also keen to check and ensure that the vaccination went to those hard-to-reach groups (for example, women who may not speak English and may not spend large amounts of time out of the household), by setting up vaccination centres in shopping areas, in community centres and other places access is more convenient.

Meetings with individual hospitals and staff

73. When at the peak of Omicron wave and booster campaign had passed, I undertook a week-long series of visits during parliamentary recess in February 2022. This would involve 4 or 5 visits to hospitals and other healthcare settings per day. I was very

keen to conduct these visits as I wanted to understand what was happening on the ground. In these visits, I made a point of asking to meet with people working at the coal face, not simply those in leadership positions. At each hospital I visited, I met with nurses in group settings without any senior managers in the room. I made the purpose of the meeting clear at the outset, explaining that the nurses could raise anything at all, whether positive or negative, suggest improvements etc. and that their views would be taken seriously and not disclosed to their managers. From these discussions I understood that nurses were generally concerned about pay, the cost of living, and related issues such as parking costs. Many nurses also told me they felt very well looked after and supported in their hospitals, with small measures to boost morale particularly important. For example, I remember one nurse telling me the best improvement they had was an in-house barista to provide coffee to staff for free. I spoke with the relevant hospital's CEO about this idea, and they told me it was a great for morale and time saving, so worth the cost overall. I only conducted these feedback groups with nurses and patients. I would have loved to have done this with other hospital staff, but my time was limited.

74. I also had meetings with hospital CEOs via Zoom, particularly around the issue of delayed discharges. I asked officials in the Department to identify which particular hospitals were doing very well and which were struggling, because I wanted to have one-to-one meetings with those CEOs to find out exactly what strategies were working and what we could do to support those that were struggling. My approach was one of partnership: I did not want to be a Secretary of State who simply told hospitals they were not doing well and needed improvement, without providing any real support. Through this process I learned that the hospitals that were faring best and discharging patients more quickly were those that had good relationships with local Councils, enough senior doctors to authorise discharges, and those that had well-arranged internal pharmacies which could issue prescriptions 24/7. Many hospitals had issues that we could do very little about – for example London hospitals with patients from several local authorities, which made their administration much more complex. Looking back, these types of hospitals perhaps needed more long-term measures in place, for example working with the DLUHC to put in place cross authority working so that a group of authorities could work via a central system to make discharges easier.

75. I kept informed of how the NHS was coping with the pandemic primarily through the regular Covid meetings. A lot of data was provided in those meetings, including the latest data on overall NHS waiting times, testing within the NHS (as well as nation wide) and the number of operations carried out. We had statistics on urgent and emergency care, as well as waiting times for ambulances and for people once they arrived at A&E departments. Many of these waiting times were far too long when compared to acceptable standards (example of the relevant statistics I was sent set out at **(SJ/30-INQ000372786), (SJ/31-INQ000479860), (SJ/32-INQ000479846), (SJ/33-INQ000479840)**. I set up a group to meet with me once every two weeks for several months from February 2022 to check we were doing everything possible to reduce waiting times. Through these we could identify bottlenecks in particular hospitals or regions, as well as any measures we could introduce such as temporary staffing, recruitment, or even arranging a deal with BT to help answer phones and triage. I asked that the meeting information packs were provided to me the day before these meetings, so I could interrogate the data. While these information packs did not initially contain all the most important data, I believe over time the NHS got better at collecting and disseminating data, which improved our response. Alongside data from and about the NHS, I would receive weekly (and sometimes daily) data on surveillance and immunity from ONS and other data which showed changes in infection rates **(SJ/34-INQ000479843).**

76. We also had a weekly NHS meeting which provided a forum for the NHS to raise their concerns, particularly for non-covid related issues. We had several meetings on the monkey pox outbreak, as well as regular meetings on cancer with the NHS lead Dame Cally Palmer and her team. We had similar meetings on mental health and dementia. Other particular areas of focus were drug addiction and rehabilitation (following the report from Dame Carol Black **(SJ/35 INQ000485245** and maternity safety (following the interim report by the Ockenden Review **(SJ/36-INQ000479868)**). I carefully went through the interim Ockenden report and tried to the get the Department and the NHS in a position where we could accept the findings and recommendations. I also met some of the bereaved parents.

77. As I identified above, when I went into hospitals I sought to speak directly with staff on the ground – and to seek to put them into a situation where they could speak frankly and with candour. I also met the BMA, the Royal College of Nursing and the other Royal Colleges regularly and so got the views of their membership via their

leadership teams. I would also speak with colleagues in the Houses of Parliament who would have dealings with their constituents.

78. People also wrote to me. As I have described before, all work was "triaged" before it came to me. I would receive thousands of pieces of correspondence. I would therefore not have routinely seen much correspondence from individuals.

Relaxation of restrictions

79. At paragraph 24 of my witness statement for Module 2, I refer to some decisions that I was cautioned against but which in my view turned out to be correct. This was a reference to decisions around the relaxation of restrictions. When I started as Secretary of State and England was opening up, some public health officials cautioned that relaxing restrictions might lead to a rise in infections. Similarly, during Omicron, there was a view among clinical officials that more restrictions should be reintroduced. I understood the caution around the relaxation of restrictions, but also felt that restrictions could not go on forever – at some point we would need open up to some extent to allow people to return to some sense of normal life. In the end we managed to arrive at a middle ground in terms of restrictions, but this was nothing close to the level of restrictions which were being recommended by public health officials. In my view, my position later turned out to be correct as we managed to come through Omicron through the combined strategy of vaccinations, testing and antivirals, rather than lockdowns.

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

sure that I would have been able to make some of the decisions that I was cautioned against, but which turned out to be the right ones."

RETURN TO NON-COVID-19 TREATMENTS

80. I understood when I came into office that NHS England had, along with the Department, been working on schemes to ensure the return of health services to "near normal". I was not responsible for setting operational decisions as identified, but I was involved in examining how things were performing and to provide accountability to the way that NHS England was operating. These would largely be dealt with in meetings between myself, senior officials from the Department and the NHS – by way of NHS England and also those from No 10, which included: (a) Provision of data and gaps in services (b) Any guidance to be issued in respect of services (c) Issues being reported by the CQC, NHS England or the media. I exhibit one such meetings during my time in office with regards to Non-Covid health implications of current wave**(SJ/37-INQ000479855).**

81. One of the actions I could take as Secretary of State was to bid for specific funding for the health service, care services and negotiate the best possible settlement with the Treasury as part of the spending review. The spending review negotiations took place both with my predecessor and with myself. As part of the 2021 review, both capital and resource funding included sums for elective recovery of some £1.5 billion pounds for the creation of surgical hubs and increased bed capacity, and £2.3 billion for diagnostics including community centres **(SJ/38-INQ000309463)**. This was a good start, but I considered that the settlement achieved was "tight" for non-NHS services and we were required to make savings that I would rather not have made. The Health and Social Care budget is interconnected. If money is frozen in capital budgets, then impacts long term productivity and standards of care. I understood the position of the Treasury, but I was frustrated that significant initial investments were not being made, which would ultimately be costs saving in the long term.

82. I had regular weekly meetings with Amanda Pritchard and her team on issues such as waiting lists. I also met twice weekly with Pauline Philip, the National Director for Urgent and Emergency Care, to discuss ambulances and Accident & Emergency. This was a regular meeting I set up given the issue of long ambulance waiting times. Ambulance waiting times went up considerably during the pandemic. I also instituted

a group to focus on delayed discharges in order to help free up beds and meet waiting lists. I had regular meetings and asked for regular information about delayed discharges during my time in office **(SJ/39- INQ000479861).**

83. The level of waiting for elective treatment increased significantly during the pandemic, so that the "standard" set out in the NHS constitution of 18 weeks from referral to treatment was not met in the majority of cases, as was the waiting time to receive diagnostic tests and scans.

84. Another step I took was to bring in 'outside' perspectives, where appropriate, to help bring the attention of those with wider expertise and experience to long- running problems. For example, I brought in Michael Barber, who had been head of the Prime Minister's Delivery Unit under Tony Blair's Government. I brought him in to set up a delivery unit within the Department (not the NHS). I found their support valuable and if they were allowed to continue once I left office, I consider it would have made a considerable difference to overall performance.

85. The corporate witness statement for this module 3 Statement D sets out statistics about the number of GP appointments available from summer 2021 onwards, showing that there was a significant increase in appointments available from September – November 2021, with an increase of around 3 million appointments available during those periods. As you can see, the number of appointments available throughout 2021 and into 2022 fluctuated. The information I was given was the appointments in general practice steadily recovered during the Autumn of 2021, as set out at paragraphs 13 – 19 of Module 3 D witness statement. I was kept informed about this (see for example **(SJ/40-INQ000479853)**).

"13. I am asked about the number of GP appointments available across the NHS in England as at 1 March 2020 and the levels of utilisation of those appointments at that time. I am further asked about whether and how the number of GP appointments changed in England during the relevant period and the reasons for those changes, if known.

14. NHSE publishes online data monthly relating to appointments in general practice (this was published by NHS Digital (NHSD) until it merged with NHSE on 1 February 2023). Each publication contains information about GP appointments for the previous

30 months. The Department had access to these data releases during the relevant period.

15. The data were and are collected from GP systems, which are designed for practices and Primary Care Networks (PCNs) to use in everyday work and not for the purpose of data analysis. This means that there are variations in data quality. These quality issues limit what can be inferred from this data and as such they are considered experimental statistics. For each publication, NHSE indicates the coverage for the data provided.

16. For the purposes of this statement, I will refer to data in NHSD's publication of 'Appointments in General Practice' for June 2022' ***(MS/1 - INQ000391385)****. This provides information which spans the relevant period. This includes scheduled practice appointments, scheduled telephone consultations, and other activity such as home visits, online consultations, and immunisations if they were recorded in a practice's appointment system for an individual patient. No information on demand (the volume of people attempting to book appointments) or capacity (the total number of appointments notionally available) is recorded as part of this data set.*

17. I outline below the total number of appointments in general practice for each of the months within the relevant period, excluding Covid-19 vaccination appointments. There is seasonal variation in general practice, with more appointments typically taking place during autumn and winter than spring and summer. This is due in part to the higher incidence of respiratory diseases during colder months, as well as seasonal vaccination campaigns, such as for flu, that take place in the autumn.

Month	***Total Count of GP Appointments (excluding Covid-19 vaccination appointments)***
February 2019	*24,329,279*
March 2019	*25,575,060*
April 2019	*23,865,779*
May 2019	*24,691,679*
June 2019	*23,197,410*
July 2019	*26,308,333*

August 2019	*22,846,393*
September 2019	*25,788,437*
October 2019	*30,054,362*
November 2019	*26,809,584*
December 2019	*23,606,506*
January 2020	*27,199,296*
February 2020	*24,104,621*
March 2020	*24,053,468*
April 2020	*16,007,881*
May 2020	*16,417,212*
June 2020	*20,690,805*
July 2020	*22,491,437*
August 2020	*20,150,520*
September 2020	*26,714,255*
October 2020	*28,301,932*
November 2020	*25,061,602*
December 2020	*23,535,936*
January 2021	*22,492,069*
February 2021	*22,399,569*
March 2021	*27,225,424*
April 2021	*23,879,932*
May 2021	*23,508,395*
June 2021	*26,784,182*
July 2021	*25,739,219*
August 2021	*23,852,171*
September 2021	*28,522,501*

October 2021	*30,303,834*
November 2021	*30,405,070*
December 2021	*25,140,776*
January 2022	*25,635,474*
February 2022	*25,355,260*
March 2022	*29,595,038*
April 2022	*23,913,060*
May 2022	*27,495,508*
June 2022	*25,828,078*

18. I outline below the total count of face-to-face appointments; home visit appointments; video/online appointments; and the number of appointments for which the mode of appointment is unknown. This data covers the mode of appointment for each of the months within the relevant period[5]*.*

19. The pandemic led to unprecedented changes in the work and behaviour of GP practices which were subsequently reflected in the GP appointments data publication. The variation in approaches to appointment management between practices was likely greater than usual during the COVID-19 outbreak, affecting data quality. Appointments conducted online or by video may not have been routinely captured in appointment books, so a move to these types of appointments could explain some of the observed decrease in appointment numbers. Reported appointments in general practice steadily recovered during the summer and in early autumn 2021."

86. By the time I joined the Department, many of the suspensions on day-to-day GP business had come to an end. I felt that it was important that patients, particularly elderly patients, continued to have the option to attend in person. By necessity, the pandemic increased the use of technology, and so where appropriate, I was also

[5] The mode of appointment as reported in the GP Appointments Data Dashboard (GPAD) is set locally by general practices so may not represent the actual care setting of the appointment. For example, some video conference appointments may be logged by the practice as face-to-face. In addition, certain system suppliers have technical limitations that mean the mode of appointment cannot be accurately reported in GPAD.

keen to increase the progress. For example, we sought to encourage repeat medication to be issued via pharmacies directly (see paragraphs 30 – 34 of Module 3, Statement D which describes this and the creation of an isolation note – for example **(SJ/41-INQ000399080)** to replace the "fit note when the requirement for mandatory self-isolation ended on 24 February 2022 (paragraph 36-38 of Module 3, statement D) (although the service could still be used after that date).

"30. The suspension of new patient reviews, over-75s checks, routine medical reviews, reviews of clinical frailty, engagement in PPGs and cleansing of dispensing lists came to an end on 30 June 2020. The suspensions were reintroduced in November 2021 until March 2022 in response to the Omicron variant.

31. The following changes were retained at this point in order to support the continued primary care response to the pandemic:

a. Suspension of the requirement to report FFT result was extended until 31 March 2022. The suspension was reviewed by the Secretary of State and extended on 30 June 2020, 30 Sept 2020, 31 March 2021, 30 June 2021, 30 September 2021, 30 November 2021 and 31 December until 31 March 2022, when the suspension ended.

b. The uplift to the number of directly bookable appointments into NHS 111 remained in place until 30 September 2021 and was reviewed by the Secretary of State and extended on 30 June 2020, 30 Sept 2020, 31 March 2021 and 30 June 2021 until 30 September 2021 when the uplift ended.

32. The suspension of the requirement to obtain consent for moving clinically suitable patients to eRD was extended until 30 September 2021.During this time, the suspension was reviewed by the Secretary of State and extended on 30 June 2020, 20 September 2020, 31 March 2021 and 30 June 2021 until 30 September 2021 when it was made permanent on 1 October 2021.

33. The extension of the uplift to the number of directly bookable appointments from NHS 111 was intended to support the effective triage of COVID-19 patients. Patients with COVID-19 symptoms were directed to use NHS111 online or call NHS111 rather than call or visit their GP.

34. Patients were clinically assessed by NHS 111 Covid Clinical Assessment Service and those deemed unwell enough to need to see a clinician were directed to the appropriate clinical service, including to general practice via directly bookable appointments. Additional directly bookable appointments were therefore required to support this pathway. This reduced the volume of patients who approached their practice with symptoms and helped keep NHS staff and patients safe."

" 36. Prior to the pandemic, GPs issued around 10 million fit notes a year in England. On 20 March 2020, a new 'isolation note' was introduced by Government to protect GP services from a surge in demand for fit notes for COVID-19 related absence (MS/ - INQ000399080). Its purpose was to cover situations when individuals were required to self-isolate and needed to provide formal notification of their absence from work and the reason for that absence without needing to contact a doctor.

37. Isolation notes could be generated directly through the NHS website and NHS 111 online and were available across all nations. This kept patients with COVID-19 symptoms, or those sharing a household with someone with symptoms, away from surgeries and removed unnecessary additional pressures on GPs.

38. The isolation note service continued until the legal requirement for self-isolation was revoked on 24 February 2022. The service remained open for those employers who chose to accept the isolation note as a form of evidence."

In the Autumn of 2021, NHS England published a plan for improving patient access and supporting General Practice, supported by a £250 million injection into the NHS England budget to be distributed to help primary care, which included:

a. Expanding the role of the community pharmacists, by providing a service which referred patients to their local pharmacist for same day appointments;

b. The introduction of cloud-based telephone technology across primary care practices to improve systems and patient experience;

c. Provision of funds to improve security measures (see paragraph 62 of Module 3 Statement D);

d. Working with those practices that found improving access to their services the most difficult to provide them with tailored support – this involved for example expanding home visiting capacity, or funding additional sessions from staff.

"*62. On 14 October 2021, NHSE published 'Our plan for improving access for patients and supporting general practice', including a £250 million WAF (MS/ - INQ000391358). ICSs were initially asked to submit spending plans for the WAF by 28 October 2021. The emergence of Omicron and subsequent acceleration of the COVID-19 vaccination booster programme from early December led to delays in implementation. Revised plans were submitted by 11 February 2022 and led to a concerted effort to distribute funds ahead of the 31 March deadline*."

87. Although we took steps to help GP surgeries return to normal day-to-day business, I would not characterise this as "encouraging" in person attendance. What I cared about was people having a genuine choice – those that wanted in person attendance should be able to access it, but this did not mean in person attendance had to be the default position for everyone.

88. Throughout the pandemic, the NHS continued to treat emergency patients and those who were being treated for cancer and other serious illnesses. They were kept separate from those who were being treated for Covid. This often-involved operating separate "zones" within hospitals which did reduce the ability of hospitals to see as many people. I continued to monitor the relevant data (see for example **(SJ/42-INQ000479856),** which was the data to December 2021: the date for January 2022 is **(SJ/31-INQ000479860)**.

89. In February 2022 we also published the 'NHS England's Delivery plan for tackling the Covid-19 backlog of elective care' to address backlogs and long waits for care by increasing capacity for tests, checks and treatment **(SJ/02-INQ000087534).** This included rolling out diagnostic centres and deploying teams of specialists to help patients prepare for their operations and offer patients faster clinical advice. We also announced adding new surgical hubs to the existing national network to ensure patients with the longest wait times would not wait longer than a year for surgery by March 2025. It was already projected that waiting lists would increase before they could decrease. This plan was an important part of setting processes and

infrastructure in place to pay future dividends. Given some of these programmes, including diagnostic centres, have since been expanded, the plan was beneficial. In February we also published the 'Living with Covid-19' strategy **(SJ/43-INQ000086652)** which set out how we would support the NHS and social care sector. In respect of the NHS, the strategy was to continue to delivery and support the deployment of vaccines to manage the risk of Covid; invest in the research and treatment of Long Covid through £50m in research funding, provide specialist patient services backed by £100 million for 2021-22 and further investment for 2022-23; and provide free access to PPE until the end of March 2023 or until the guidance on PPE usage changed.

90. As well as the Delivery Plan and Living with Covid strategy, the Department was also focussing on longer term initiatives to help the NHS not only return to pre-pandemic operation but also become more sustainable and effective in the future. I announced a reset of the NHS Long Term Plan. The NHS Long Term Plan **(SJ/44-INQ000113233** published in 2019 set out to significantly increase investment in primary, community and mental health services. However, it was designed in a pre-pandemic world and was not sufficient to meet the challenges the UK would face after the pandemic as reference in my speech to the Royal College **(SJ/45-INQ000479865**). In 2021 I had also commissioned the NHS to produce a long-term workforce plan covering the next 15 years. This included work looking into streamlining training for doctors and consultants, ensuring they could join the profession quickly without unnecessary duplication and bureaucracy and ways to modernise the profession through roles such as physician associates. I was keen to publish this; however, the Treasury did not want this published as they feared it would trigger spending pressure. The workforce plan was eventually published when Jeremy Hunt became Chancellor after I left the Department and is exhibited as **(SJ/08-INQ000292664).**

91. As I have mentioned previously, I wanted to make a prevention agenda a focus of the department during my time as Secretary of State. The NHS Long Term Plan set out new programmes to help prevent and manage long term conditions. I also commissioned specific pieces of work to produce targeted approaches to smoking and the causes of health disparities. As this inquiry will be well aware, the majority of chronic ill health is caused by smoking, obesity and drinking, and tackling these issues would save hundreds of thousands of lives a year, it would save the NHS billions of pounds a year, and improve healthy life expectancy, economic

performance and social cohesion. My aim was to use OHID as a vehicle to seek to improve public health. I commissioned the Health Disparities White Paper, but the Department also worked with other Departments on the Health Promotion Taskforce. During my time in office, work on public health continued **(SJ/46-INQ000479847), (SJ/47-INQ000479866) (SJ/48-INQ000479867), (SJ/49-INQ000479839)**.

92. As part of the goals of improving efficiency, quality and choice in care, the Department published a White Paper to integrate health and social care in February 2022 **(SJ/03- INQ000468609)** alongside the Department for Housing, Levelling up and Communities (DHLUC). It emerged as one of the lessons of the pandemic which was to do more to bring the resources of the NHS and local government to work together. I recognised that the system of health and social care remained fragmented and often did not deliver joined up care to meet people's needs. That involved work on delivering integration workforce, data services and the pooling of finances to join up services.

93. In May 2022, Dr Claire Fuller, Chief Executive-designate Surrey Heartlands Integrated Care System (ICS), published a stocktake on integrated primary care **(SJ/50- INQ000479870),** looking at what was working well and how we could accelerate the implementation of integrated primary care. Her key findings focused on streamlining access to care and advice; providing more personalised and proactive care; and prevention. In line with this report, my ambition was that primary care, where the bulk of prevention already happens, had to be at the heart of this new agenda. I wanted to put prevention at the heart of how we hold ICSs to account in the future. I wanted NHSE and individual ICSs to commit to joint delivery plans to reduce the biggest preventable diseases – starting with cardiovascular disease, but in time, expanding to include diabetes, cancer, and poor mental health. Likewise, Community Diagnostics Centres would help to improve the health of the population means identifying risks as early as possible and intervening to stop them from getting any worse. I also wanted to put prevention at the heart of the NHS App, making it the front-door for preventive tools and services – including a new digital health check – along with further developments to give people direct access to the diagnostics and therapies. The report from Dr Fuller reinforced my existing view on challenges and some of the solutions. Although we managed to get a lot of this work underway, much of it was scrapped by my successors.

94. One particular initiative that I did not manage to get underway was my plan for a radical reform of primary care. Covid had brought home to me the historic anomaly (designed as part of the compromise to bring the NHS into being in 1948) that GP's are independent practitioners providing services to the NHS and operating as private businesses, rather than being NHS employees. I found that this was a barrier to higher performance in primary care and the NHS. I pushed for an independent review of primary care as I wanted to examine whether this model was still the most effective for patients and the NHS. I was aware that certain areas were adopting a more integrated approach, which showed signs of improved patient experience and a greater focus on community care, still served our society well, and I was aware that in some areas (for example Wolverhampton), there was a Total Health Primary Care Network which involved a group of GP's working together to increase access to services and appointments. Although I had identified a candidate to lead the review, the Prime Minister blocked my proposal because he was concerned about the reaction from GP's and the BMA. Whilst his immediate assessment was probably correct, I thought this was an issue that would have to be dealt with at some point or another, so there was no reason to delay.

95. Information indicating a reduction in non-Covid related healthcare was typically brought to my attention in the usual ways through the weekly NHS meetings. I would be provided with the latest data in those meetings, and over time improvements were made to refine the data that was being provided. I was made aware at all times of the waiting times for A & E: the number of those attending A & E: the speed of cancer referrals and then diagnosis and treatment, and to seek to find those who may have not come forward because of concerns.

96. During the pandemic, a huge number of people understandably stayed away from healthcare services. Estimates indicated that by December 2021, approximately 10 million people had stayed away who would ordinarily have come forward **(SJ/51-INQ000479864).** I wanted to communicate the message that the NHS was still open, and people could still access services if they needed to. I along with other ministers appeared on television making it clear that the NHS was open.

97. To give an example, in early February 2022 I announced a "war on cancer" and launched a call for evidence to underpin a 10-year plan for cancer **(SJ/52-INQ000479859).** The call for evidence involved showing how the DHSC was

learning lessons from the pandemic and applying them to improve cancer services. This was, at least in part, because data had showed that there were nearly 50,000 fewer cancer diagnoses across the UK during the pandemic. I wanted to:

a. Increase the number of those diagnosed at an early stage;

b. Increase the workforce;

c. Tackle disparities and inequalities in cancer diagnosis times;

d. Intensify research on MRNA vaccines and therapeutics for cancer;

e. Intensify research on new early diagnostic tools.

98. As part of this "War on Cancer", we launched a Help Us to Help You cancer awareness campaign in mid-August 2021 **(SJ/53-INQ000479835),** which was directed at those from more deprived groups and ethnic minorities.

99. As well as this, I continued to use my role as Secretary of State to discuss, and talk about how to improve healthcare outcomes from those from health groups aside from Covid 19 – for example to provide advice on medication usage during Ramadan for the Muslim community **(SJ/54-INQ000479863)** in February 2022.

INCREASING CAPACITY FOR AUTUMN / WINTER 2021

100. I believe that some, but not all, of the contingency measures that were formulated for the Autumn and Winter Plan 2021 were helpful in preparing the healthcare system to respond to the pressures of Omicron. This plan was not a DHSC or NHS plan but was a cross governmental plan. Whilst it sought to identify how the healthcare service and the work of the DHSC and the NHS, as well as social care could help to support. Alongside this, the NHS had published operational planning guidance **(SJ/55-INQ000479836)** and an Urgent and Emergency Care Recovery 10-point action plan **(SJ/56-INQ000470550)** both published in September 2021.

101. In respect of the contingency measures set out in the Winter plan, these were designed for the whole population and not specifically designed to be delivered in healthcare settings or to prepare healthcare settings. Plan B was designed to deal

with a situation where the NHS was at risk of coming under unsustainable pressure, by way of greater communication, mandatory covid status certificates to enter into some venues, compulsory face mask wearing and advice on working from home.

102. I am asked to indicate how well the contingency measures prepared the healthcare system in respect of various specific factors which I set out below:

a. Workforce absences, I understood that the absence rate was far higher than pre-covid levels, especially in areas where a larger proportion of the workforce were from ethnic minority groups. I was told that this was partly because these areas contained higher proportions of people that were not vaccinated, as well as higher numbers of workers with caring responsibilities. There was unfortunately not much we could do in terms of contingency measures to tackle this other than ensuring infection prevention control measures were in place and encouraging vaccination uptake. We had obviously sought to maximise the return of the workforce from the start of the pandemic, by providing routes whereby recently retired staff or those who had taken a career break could return. The NHS reserves programme was launched in November 2021, and I considered that having a reserve scheme on a standing basis is helpful in times of crisis. By and large it was kept in place and still exists now, with the head of the NHS announcing an extension to the scheme in March 2022.

b. Bed capacity was an area where I feel there was a difference. During normal times, the NHS runs on a tight capacity (around 95%) and we have a low number of beds per head compared to many other developed countries. That 5% margin was not sufficient. I met with the CEO of NHS England and her team to address the issue of bed spaces and ill health of the NHS workforce. To increase capacity, there was a drive to free up bed capacity by moving delayed discharge patients out of hospital – who accounted for around 10-13% of all bed space. This had an effect on freeing up much needed bedspace. There was also a decrease in bed space caused by the need to separate covid and non-covid patients.

c. Virtual beds were an initiative that the NHS had already begun implementing and which they wanted to expand. I was happy with it in principle, but it

required a large investment in technology equipment and improving internet connectivity. This was more of a long-term measure for the NHS to keep using after the pandemic.

d. As for the use of private hospitals, I also personally wanted private hospitals to do more to fill the gaps in capacity. I therefore asked officials to negotiate a deal with private hospitals **(SJ/57-INQ000479852), (SJ/58-INQ000479854).** Initially, all but one private hospital group agreed. I wanted all the private hospital groups to agree to a standardised tariff, rather than striking separate agreements with each. The CEO of the largest private hospital group in the UK (HCA) did not want to agree to this, so I had to step in personally and speak to them to convince them into agreeing to a deal in early January 2022. The Secretary of State does have a power of direction under s253 of the NHS Act 2006 to issue directions in case of an emergency. They had been used during the Covid pandemic in respect of Nightingale hospitals, I was advised that they could be used now for a short period of time because of the pressure on NHS capacity.

e. I was informed that the way in which Nightingale hospitals were set up during the first wave of the pandemic in 2020 had not been effective as a primary reason was we simply did not have sufficient doctors and nurses to operate them. I discussed the issue around Nightingale hospitals with Amanda Pritchard **(SJ/59-INQ000479851)** and what could be done to generate temporary capacity. She suggested extending wards in existing hospitals, as well as a system of "step-down" care involving temporary units for people who were being prepared for discharge. The Prime Minister was very insistent on the idea that these new hospitals should be called "Nightingale "hospitals, and he was keen on resurrecting the original form of Nightingale hospitals. I sought to explain to him that the original model was not effective, but to appease him, we called the extended wards and step-down care units, "Nightingale" units.

103. Following the emergence of the Omicron variant, I agreed with NHS England that parts of GP's income would be protected for 2021/2022. This was done in order to try and ensure that there was not a drop of income for GPs because of a diminution of appointments, and also that they prioritised urgent and Covid-related appointments.

The corporate statement for this Module, Module 3 Statement D at paragraphs 40 – 47 sets this out in some detail.

"44. The QOF was introduced in 2004 and is a voluntary reward scheme for general practices which incentivises activity related to the management of long-term conditions (e.g. diabetes, asthma, cardiovascular diseases) and prevention activities (e.g. vaccination and cervical screening). General practices are awarded points, each attracting a payment, for doing specific activities or achieving outcomes described in a set of indicators. The number of points earnable varies by indicator. Some indicators reward practice-level activity (e.g. keeping a register of patients with specific conditions) and others reward the practice for the proportion of patients who have received the clinical care specified (e.g. the percentage of patients diagnosed with diabetes and a history of cardiovascular disease who are treated with a statin) or who have achieved a particular outcome (for example the percentage of patients with a diagnosis of hypertension in whom their last blood pressure reading was within a particular range). QOF indicators and points values for each financial year are published in the General Medical Services (Statements of Financial Entitlements) Directions ('SFE Directions') and come into force on 1 April every year and in NHSE guidance. In 2020/21 there were a total of 567 points available ***(MS/2 - INQ000339326)***.

45. On 9 July 2020, NHSE wrote to GP practices, announcing their intention to make changes to the QOF ***(MS/3 - INQ000051183)***. *To help release GP capacity to focus on higher clinical priorities while ensuring practices remained financially viable, NHSE (with the agreement of the Secretary of State and the General Practice Committee (GPC), a committee of the British Medical Association), planned to income-protect elements of the 2020/21 QOF. These plans were confirmed in guidance by NHSE on 7 September 2020* ***(MS/4 - INQ000372783)***. *Specifically:*

a. *Some performance against indicators (worth 139 out of 567 points) continued to be paid on the basis of practice performance. These related to flu vaccination, cervical screening, maintaining disease registers and prescribing medication for long-term conditions.*
b. *Performance against indicators worth 354 points were subject to income protection based upon historical practice performance. It was expected that some of the activity that was income protected would continue and to be eligible for*

income protection practices were required to agree an approach to QOF with their commissioner that included the identification and prioritisation of the highest risk patients for proactive review.

46. On 3 December 2021, as part of a wider package of easements (further details at paragraph 73) announced following the emergence of the Omicron variant, NHSE (with the agreement of the Secretary of State and the GPC) announced that QOF would also be part income-protected for 2021/22, in a similar manner to 2020/21. Further detail was announced on 7 December 2021. 389 points (just over half) had conditions removed. The remaining indicators (e.g. cervical screening, immunisations) retained their conditionality.

47. To be eligible for this income protection, practices were required to agree with their commissioner a plan setting out how QOF care would be delivered wherever possible, with priority according to clinical risk and accounting for inequalities."

BMA and GP

104. The emergence of Omicron variant meant that the Covid-19 booster vaccination programme had to be more rapidly deployed than would otherwise be the case. This meant that primary care and general practices were asked to prioritise vaccinations and urgent care until the end of the booster campaign. This did lead to a diminution of appointments available to the general public, but practices did remain open and continued to offer services. I agreed on 3 December 2021 to provide some relaxations to GP to ensure that the vaccination programme could be expanded (paragraph 67 of Module 3 statement D. This included suspending various requirements of reporting by GPs, using something called the IIF (Investment and Impact Fund) **(SJ/60-INQ000479877)** to incentivise practices to sign up to the vaccine programme: in effect, monies which were usually used on other services were allocated to GPs via a PCN (Primary Care Support Payment Network) support payment if they participated in the vaccination programme. A programme was also devised so that GPs would not lose income if they stopped undertaking certain minor surgery during this period of time by suspending enforcement of those services under the GP contract, so that GPs would be paid the same amount of money. I also agreed that GPs could have reduced numbers of patients whose medication they reviewed on a regular basis under the relevant scheme.

"67. On 3 December 2021, the following additional measures were announced following the agreement of the Secretary of State and would run until 31 March 2022. These changes were made to release GP capacity to ensure delivery of the expanded COVID-19 vaccine programme:

a. *Part-suspending the QOF.*
b. *Part-suspending and repurposing the IIF to incentivise practice sign-up to the vaccine programme. Indicators introduced in April 2021 covering flu immunisation and appointment recording and categorisation were paid as normal. The remaining indicators were suspended and the funding repurposed. The majority of the funding allocated to these suspended indicators was instead allocated to PCNs via a PCN Support Payment, on a weighted patient basis, subject to confirmation from the PCN that it was reinvested into services or workforce. The remaining funding was allocated to a new IIF incentive to support PCNs whose practices fully participated in the vaccination programme.*
c. *Deferring routine health checks for new patients and patients aged 75 and over under powers of the Pandemic Regulations.*
d. *Income protecting the minor surgery Directed Enhanced Service (DES) and suspending contractual enforcement of the minor surgery additional service. Performing minor surgical procedures in general practice is an additional source of income and includes injections for muscles, tendons and joints, and invasive procedures such as incisions and excisions. It was anticipated there would be a reduction in non-urgent procedures during the pandemic period and income protection prevented a loss of anticipated income from delivering these additional services.*
e. *Reducing the percentage of dispensing patients whose medication needs to be reviewed from 10% to 7.5% under the Dispensary Services Quality Scheme (DSQS).*
f. *Increased "item of service fees" (i.e., a fixed fee paid per vaccine administered) for COVID-19 vaccination."*

105. I also increased the fixed fee paid for vaccine administered for Covid to incentivise GPs to undertake this.

106. Pandemic regulations meant that I also approved the suspension of routine health checks for new patients and those over the age of 75.

107. The Department also worked with other government bodies to try and free up the time of GPs so they could focus upon vaccination. This included a package of measures agreed in early December 2021 including liaison with the DWP that extended self-certification for sickness from 7 to 28 days for statutory sick pay and removed the requirement for a 'fit note' to be able to access various benefits **(SJ/61-INQ000479849)**. That made a big practical difference as GPs spent large amounts of time dealing with these issues [see para 68 of Statement 3 Module D]. The Department also extended automatic renewal of prescription charge exemptions, extending all certificates for six months (as otherwise GPs would have had to provide further information for their administration) and also to put on hold any firearms certification, which involved certification from the GP as to the person's capacity to hold a gun licence and requested that all applications wait until January 2022 (Home Office wrote). Furthermore, the DVLA agreed to suspend requested for medical information for the provision of driver's licences until 12 January 2022 (excluding essential transport workers such as bus and HGV drivers). They were all routine pieces of work for GPs that were stopped to enable them to focus upon Covid.

"68. On 17 December 2021, further time-limited measures to release capacity were developed with other Government Departments (OGDs):

a. DWP made legislative changes that extended self-certification for sickness from 7 to 28 days for statutory sick pay (until 26 January 2022) and removed the requirement for fit notes to access benefits.

b. A temporary auto renewal of prescription charge exemptions was introduced by the Department. This covered existing prescription charge exemption certificates that were due for renewal up to 26 January 2022. The certificates were extended for six months.

c. The Home Office wrote to shooting organisations to request that firearms certificate applicants who were about to submit a request wait until January 2022.

d. The Department for Transport/Driver and Vehicle Licensing Authority suspended requests for medical information for the provision of drivers' licenses until 12 January 2022 (excluding essential workers e.g., bus and lorry drivers)."

Hospital capacity during the Omicron variant

108. As set out in paragraph 122 of my witness statement for Module 2, the treatment of people hospitalised with Covid during the Omicron variant in 2021 caused a increase in waiting times for elective surgery and delays in treatment for patients with non-Covid conditions, but that this came at the expense of other treatments. I am unable to add anything further to what has been described already. NHS England would be able to provide detailed statistics about waiting times and delay in treatment. I knew that this would happen, but there were no radical steps that could be taken to increase capacity at very short notice to permit such surgery to be maintained, as far as I was aware. The NHS was already at full stretch even prior to the arrival of Omicron.

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

109. The Increasing Capacity Framework was set up by NHS England in November 2021 (and is still in existence now) was set up as a contracting mechanism for elective care services which provided a set of standardised terms and conditions (across England) for certain services for those contractors who had been appointed to the Framework. It was not a mandatory requirement, and whilst it would have provided a quicker system for identifying capacity and provision, it was not something which I was directly responsible for.

Primary care, ambulance care and pharmacies during Omicron 2021

110. I have already described the concerns about the response of primary care to the Omicron variant in Winter 2021.

111. Conversely, I had no such concerns in respect of pharmacies. I believed they were stepping up to the plate and making a big difference in delivering more vaccines to the public. I also worked with Simon Bolton from NHS Digital to explore what could be done to make it easier for people to book vaccination appointments through the NHS App, such as introducing a booking system and allowing people to getting timeslots with individual pharmacies 2021 **(SJ/62-INQ000479831).**

112. Concerns around the ambulance services were brought to my attention through twice weekly meeting with Pauline Philip, who was national Urgent and Emergency Care Director at NHS England. The primary concern was around ambulance stacking, with ambulances arriving at A&E departments and having nowhere to put patients. People were therefore stuck in ambulances outside hospitals. This only increased the waiting time for others. We also discussed call handling, as it was apparent that there were a lot of issues that NHS 111 could deal with, but we simply did not have sufficient call handlers available. There was therefore a big recruitment drive to bring in more people to deal with NHS 111 calls. I received regular data around A & E waiting times, NHS 111 calls and ambulance delays (see for an example **(SJ/31-INQ000479860),** 9 February 2022).

Additional 5.4 billion in the winter plan 2021

113. In short, the £5.4 billion funding was designed to help the NHS catch up on waiting lists and to manage the additional need for capacity over the winter of 2021 **(SJ/63- INQ000485241 .** This was obviously agreed in advance of the arrival of the Omicron variant. The discussion with the Treasury was fairly straightforward, as it was agreed that this would be a one-off funding arrangement. These sums included £478 million to assist in freeing up beds by moving those who are clinically safe to be discharged into step down facilities or to receive packages of care in the community and £700 million to expand wards and surgery theatres.

INFECTION PREVENTION AND CONTROL

114. I would receive daily data on infection numbers generally, including how many were infected within hospitals – or nosocomial infections. Over time, the quality of the

data improved, and the NHS would provide more specific data which identified the number of nosocomial and non-hospital acquired infections, among other matters. IPC guidance did lead to increased bed spacing in wards caring for patients with acute respiratory infections, and the need to keep some beds empty to maintain "Covid" and "non Covid" wards may have had an impact on inpatient bed capacity but this was not seen as certain in the information I was given (for example **(SJ/64-INQ000479858)**, paragraph 19).

115. While the NHS would monitor data as part of its IPC procedures, the system was deliberately designed to ensure that there was some independence around what IPC rules were to be followed in hospitals. UKHSA was therefore responsible for setting the rules around IPC, unless I intervened and directed otherwise. An IPC cell-maintained oversight of Covid 19 IPC guidance for healthcare settings, which was a body made up of UKHSA, the DHCS, NHSE and the devolved administrations. As set out in paragraph 154 and 158 of Module 3 Statement B indicates that UKHSA provided scientific expertise on infection risk to the IPC Cell which was overseen by NHSE and which created guidance for the NHS and other healthcare settings. The IPC publications were published on behalf of the IPC Cell by UKHSA. It reviewed the evidence on IPC issues on a regular basis **(SJ/64-INQ000479858).** As Secretary of State, I did not believe it was appropriate to get involved with such decisions, as they were best left to experts, and my role was more limited to monitoring what was being set by UKHSA.

"154. Protection of staff and patients from nosocomial infections within the NHS is informed by local IPC policies. Individual providers base these policies on standardised best practice national guidance created by NHSE infection control specialists then use risk assessments to reflect the local potential for infection transmission to provide targeted mitigations to control that specific risk. During the relevant period scientific expertise on infection risk was provided by PHE and later UKHSA to the IPC Cell which was overseen by NHSE (see below for detail) and which created guidance for the NHS and other healthcare settings."

"158. I am aware of a subsequent series of IPC publications collaboratively formulated by NHSE (including input from NHS bodies from Wales, Scotland and Northern Ireland and PHE), (UK IPC Cell) during the relevant period and published on behalf of the IPC Cell by Public Health England (and later UKHSA). The

Department was not involved in the formulation of these publications. Department officials, on occasion, attended UK IPC Cell meetings, but did not participate in the making of guidance. The guidance set the relevant standards and the guidance was followed by the Department at all times, informing its related functions. For example, the level of PPE that the IPC Cell deemed necessary directly impacted the amount of PPE the health and care system required and, therefore, the Department's procurement and distribution efforts. The guidance also informed operational decision-making by the NHS to mitigate nosocomial risk, such as hospital reorganisation to separate COVID-19 from non-COVID-19 patients. Set out below are the most consequential updates."

116. In relation to Nosocomial infections additional testing where there were nosocomial outbreaks including for high-risk groups including NHS staff **(SJ/65-INQ000110209).** Obviously, the NHS had significant numbers of healthcare workers from minority ethnic communities, and I recognised and knew that many healthcare workers had become seriously unwell and died with Covid 19. It was important that infection prevention and control ensured that all groups of healthcare workers had as minimized risk as possible for the virus. We were also aware that where vaccination rates were lower, nosocomial infections were higher and there was more hospitalisation. I also understood that UKHSA had undertaken modelling (annex A) **(SJ/64-INQ000479858).** I was also told (paragraph 22 (**SJ/64-INQ000479858)**) that those working in NHS England on infection and prevention control and the Chief Nursing Officer did not report any workforce recruitment or retention issues relating to IPC measures.

117. I was informed about rates of nosocomial infection on a regular basis, both as part of the NHS data I received, but also information provided by UKHSA. During the Omicron wave there were increased cases of nosocomial infection: in part that was because the Omicron variant was much more transmissible than other variants and vaccination did not prevent individuals transmitting the infection to others. Where community prevalence was high (and it was very high in the community during Omicron) then infection rates in health and social care settings would also be high. I was provided with information that during the Omicron wave there were much higher levels of mental health and learning disabilities healthcare placements and community NHS trusts, with around 35-40% of all nosocomial cases being in those settings during Omicron and I was informed of this (paragraph

11**(SJ/64-INQ000479858)**). The reasons for this were described as varied but involved lower vaccination rates, difficulties with complying with social distancing, testing difficulties on admission and that individuals receiving care in these settings spent lots of time in the community.

118. What the Department did do was continue to provide free PPE to all health and social care settings throughout the Omicron wave. I was also informed that the UK IPC cell provided a "consensus" statement during the time of the Omicron wave reaffirming the provision to be used by healthcare settings, including the use of masks if a local risk assessment found that the risk of infection for staff warranted its use in December 2021 (paragraph 8 **(SJ/64-INQ000479858)**).

119. At the same time as the Omicron variant was being discovered, we were undertaking consultation as to whether there should be vaccination as a condition of deployment within the NHS. When I arrived in office, there was already a policy that those working in care homes, with regulations having been introduced on 22 June 2021 (to come into force in November 2021). I was asked by the Prime Minister to look at making such vaccination compulsory for those working in the NHS. I was not sure why this had not been considered at the same time as the introduction of the policy in social care, but I assume (and it is an assumption) that this was because the take up of vaccination within the NHS was much faster than for those in social care, and so the concern about unvaccinated staff was less acute. I consulted with the NHS who agreed that this would be a positive policy, and so during the winter of 2021 the Department issued a consultation as to extending the relevant regulations (to make vaccination as condition of deployment within health provision, and regulations were due to be issued in April 2022 **(SJ/66-INQ000257250).** The policy was not brought into effect because the vaccine's ability to prevent transmission of Omicron was less than it was for other variants. I do, however, consider that it was an appropriate policy to pursue and should be considered in future pandemics where vaccinations are part of combatting the disease. I was aware that the relationship between nosocomial infections and local vaccine uptake rates was related to age profile: those admitted to hospital settings are much more likely to be elderly: elderly people were more likely to have been vaccinated.

Sufficiency of testing capacity /Infection prevention/Ventilation/PPE

120. I do not recall any particular issues being brought to my attention around insufficient testing capacity and delays in receiving results; difficulties in implementing NHS measures in the NHS hospital estate; the adequacy of ventilation in hospitals; or concerns around the quality and suitability of PPE. I did receive submissions about the supply of PPE, and the need, for example for restocks, but not about the quality and suitability of PPE as far as I can remember. This does not mean that any such issues were not known to the Department, simply that they did not ultimately reach the level of the Secretary of State. These types of concerns may have more appropriately been directed to junior ministers in the Department, such as the NHS minister, social care minister and testing minister. It is worth noting that the UK had enormous testing capacity compared to many other countries, and the budget dedicated to it was considerable.

121. On the whole, issues concerning inequalities around PPE (such as in relation to age, sex, disability, race, pregnancy and other characteristics) were dealt with before my time at the Department. I do remember one particular issue which came to my attention during a Conservative association dinner where a Sikh doctor told me about being asked to cut his beard in certain clinical situations. I took the doctor's details as I thought this was a reasonable issue to look into, and I wanted there to be a workaround if there were other healthcare workers experiencing similar issues. I cannot recall the outcome.

Review by Professor Dame Margaret Whitehead

122. As I have mentioned previously, I commissioned a review about inequalities in the efficacy of medical equipment on the grounds of race, which was chaired by Professor Dame Margaret Whitehead following a rapid review of medical devices **(SJ/67-INQ000309465) (SJ/68-INQ000309519).** This was an area I was particularly interested in and felt it was important to act swiftly to seek to minimise and extinguish any material inaccuracies in medical devices based upon the colour of someone's skin. I had previously read that pulse oximeters gave incorrect readings on darker skin and found out that this was because such oximeters were tested upon white skin because they are seen as the biggest global market by the manufacturers of such equipment. As I discussed in my Module 2 statement, I had discussions about this

with the US Health Secretary. My idea was that if the US and the UK – the two biggest purchasers of medical equipment in the world – insisted that it would only purchase products which had been tested in all races, then global manufacturers would follow suit. Ultimately, my policy ideas were not followed through because I resigned as Health Secretary. Professor Dame Whitehead's final report was only published in March 2024, long after I had left my post. The final report, however, confirmed many of my initial concerns, including extensive evidence of poorer performance of pulse oximeters on those with darker skin tones, albeit there was no evidence from studies in the NGS of this differential performance affecting care. I still consider that the UK should consider making it a requirement of procurement of medical equipment that products should be tested on all races to minimise inequalities in health outcomes.

SHIELDING

123. The shielded patients list came into existence from March 2020 onwards. These were individuals who the UK CMO had identified by reason of their medical condition would be more susceptible to Covid 19: NHS clinicians could also identify those patients they considered to be at highest risk based upon their knowledge of the patient and in February 2021, a predictive risk model was used to identify a further cohort of the highest risk individuals based upon a combination of demographic data (such as age ethnicity, gender and clinical conditions). By the time I came into office, Covid O (at a meeting held on 17 May 2021 **(SJ/69-INQ000111203)** had decided that shielding guidance should be kept as a contingency option along with the support package until March 2022.

124. I received submissions to consider whether to end the shielding policy in late July 2021 **(SJ/70-INQ000061458)**. I note that since April 2021, which was before my time in office, the advice towards those who were clinically extremely vulnerable – called "shielding" advice – had been "paused" because of the low prevalence of the virus, and those individuals were advised via governmental advice to think particularly carefully about additional precautions to take but to follow the same advice as any other person.

125. The advice I was given is that whilst shielding may have limited the contact of the 3.8 million people who were classed as clinically extremely vulnerable, the advice is

very restrictive, and that there was evidence that it has had a detrimental impact upon people's mental health, social life and economic wellbeing. I was also advised **(SJ/70-** **INQ000061458** that 88% of that group had been vaccinated with two doses and 91% had one dose and that there was not a reduction in vaccine efficacy for this population (or such reduction was limited). The Deputy CMO – Jonathan Van Tam, and Jenny Harries, the Chief Executive of the UKHSA both advised that it was appropriate to return to the approach taken to those who were immune compromised prior to the pandemic, of taking and making individual risk assessments in consultation with their clinician, which would allow all individuals to have appropriately tailored advice. By this time, there was a Covid risk management tool available which then enabled better information to be fed to GP's and clinicians about who has been more vulnerable to Covid on the basis of the statistics of those who had been infected. Alongside this there would be ongoing access to vaccine boosters, anti-body testing and treatment, and potentially new antibody therapies and antivirals.

126. There was no perfect time to stand down the shielding programme; however, my view was that shielding could not go on forever. A key factor behind my recommendation was that we were dealing with a vastly different situation than when shielding had first been introduced. Vaccines were available and had been rolled out which meant Covid-19 was less transmissible than before. Treatments were available. The number of cases was falling. I felt we had reached a point where the risks (albeit still present) had been reduced dramatically so as to justify ending the policy. Other than this decision, I do not recall making any other key decisions during my time as Secretary of State.

127. In terms of the impact of the end of the shielding programme, I had discussions around the psychiatric impact of shielding with the CMO, the DCMO, other officials and other clinicians understood that some people at that point had been shielding because they thought that they needed to, and if they did not then this meant they were at risk. Ending the shielding programme meant that many people who were not at risk finally felt more confident about going out and resuming their social lives again. The capacity of the healthcare system to treat those who had been shielding would still have been a challenge, but by September 2021 capacity was in a far better place than at the start of 2021. I do not recall seeing any specific analysis of the impact of the shielding programme, whether on those who were shielding or the

capacity of the healthcare system but I note from the submission I received on this topic **(SJ/70- INQ000061458** that during Spring 2020 more than 1 in 3 CEV people had described their wellbeing and mental health had worsened.

128. The anti-viral task force had been set up in early 2021. By the end of September 2021, the Treasury had agreed to fund 480,000 doses of mulnupiravir and 250,000 course of Paxlovid which were both anti-viral designed to help those who were immunosuppressed or who would be particularly vulnerable to serious ill health if they contracted covid. We already had some stocks of these anti-virals by the time that the Omicron variant was identified, and further stocks (of some 4.25 million doses) of anti-virals were funded by the Treasury on 22 December 2021 **(SJ/71-INQ000257221).** During the Omicron wave, those who required these drugs (who had been identified by the NHS – 1.3 million immunosuppressed individuals , determined by reference to an expert advice were given priority access to testing and treatment with monoclonal antibodies and antiviral therapeutics) were able to ring a special service, had a stock of PCR tests which they could use and then send a courier to pick up the test results so that they could be processed within a very short time period. If the person had covid, a courier would arrive the next day with the anti-virals. This system was specifically designed to provide additional protection to many of those who had been shielding.

129. The end of the formal shielding programme did not lead to the end of provision of advice or consideration of issues for those who were immunosuppressed. Whilst shielding was not reintroduced when the Omicron variant emerged, work was undertaken to identify and communicate those likely to be at highest risk from Covid 19 to provide targeted guidance (paragraph 4 of **(SJ/72- INQ000067588)**) should the situation change, and to make contingency plans if such became necessary (which luckily did not happen).

130. UKHSA and NHSE held meetings and provided public health advice in December 2021 **(SJ/73-INQ000067725)**. Advice was given to a group of individuals (of around 1.46 million individuals) to work from home, and to take additional precautions such as reducing social contacts, practising social distancing, ventilation and face coverings/testing. That was smaller than the cohort of clinically extremely vulnerable (which was approximately 3.7 million).

131. I would also note that in February 2022, the self-isolation regulations ended, so that individuals having no legal requirement to stay at home when they had covid. However, the guidance was not changed at this point in time for NHS settings – including independent healthcare providers, so that staff should continue to stay away from work when symptomatic and test when they had been in contact with someone who had covid. There was also continuing guidance for self-isolation for patients **(SJ/74-INQ000112244)** and was agreed **(SJ/75-INQ000479862)**.

OTHER MATTERS

Long Covid

132. The Department had provided monies for research into Long Covid from August 2020 (**SJ/76-INQ000283372)** and again in July 2021, and NHS England had launched the covid recovery guidance in July 2020 (**SJ/77-INQ000283370),** with the UKHSA publishing research and information on the long-term effects of Covid 19 on 3 September 2020. A policy was put in place by the DHSC through the mapping of Long Covid activity in healthcare and having Long Covid roundtables from July 2020 onwards, with the ONS providing plans to estimate Long Covid symptoms from December 2020 (**SJ/78-INQ000283393).** There had been a set of NICE guidelines on Long Covid since December 2020 (**SJ/79-INQ000283459).** NHS England had a Long Covid Task Force by October 2020. A lot of work had therefore, been done by the time I came into office. By mid - 2021 research had showed that although many people made a full recovery following covid, a significant proportion of people continued to experience chronic symptoms for months **(SJ/80-INQ000479828)**. In June 2021, my predecessor launched the Long Covid Plan for 2021/2022 which included £90 million on covid clinics, £30 million for enhanced GP services for those with Long Covid and care co-ordination and children's hubs for undertaking treatment and research into Long Covid. There were 145 hubs put in place by the NHS at that time. I made a public statement in July 2021 announcing 15 new studies backed by £19.6 million to help improve understanding of Long Covid and identify effective treatments **(SJ/81- INQ000283460).** The projects focussed on better understanding the condition; evaluating the effectiveness of different care services, better integrating specialist, hospital and community services for those with Long Covid; identifying effective treatments; improving home monitoring and self-management, including examining the impact of diet; and further research into particular symptoms such as breathlessness and 'brain fog'. In November 2021, NICE published updated

guidelines in respect of Long Covid, showing that children and young people had different symptoms to adults on occasions **(SJ/82-INQ000479826).** In July 2022, the NHS announced a further £90 million in its plan for Long Covid 2022/2023 **(SJ/83-INQ000238590)** including improvement on health support.

133. I (along with my junior ministers) was sent regular data about referrals to Long Covid clinics, and the number of specialist assessments completed, alongside who was attending the relevant clinics and their length of wait **(SJ/31-INQ000479860 (SJ/32- INQ000479846 .** This enabled me to be able to discuss the adequacy of provision and need for further clinical research/help with the NHS and researchers. There were monthly Long Covid round tables involving ministers (to which I could attend although they were chaired by the Minister for Health) and providing me with updates on Long Covid and vaccination, Long Covid and work and relevant research. I also worked extensively on the condition, Myalgic Encephalomyelitis, which had similar symptoms to Long Covid. In May 2022, I announced a new strategy would be brought forward increasing investment and research into the condition.

DNACPR

134. I do not recall concerns being brought to my attention around the use of DNACPR notices during my time in office.

Nightingale Hospitals

135. As explained above, Nightingale hospitals were not effective as there were not enough doctors and nurses available to operate them. “Surge hubs” were separate and consisted of extensions of existing hospital wards – and were successful in increasing bed capacity. They were named “Nightingale surge hubs” to appease the Prime Minister who was insistent on the idea of Nightingale hospitals despite the workforce problems having been explained to him.

136. I was aware that CQC had suspended routine inspections, but I do not recall personally taking any specific steps in this area.

LESSONS LEARNED

137. The pandemic offered many lessons, but domestically and internationally. I concluded my reform speech in March 2022 **(SJ/06-INQ000479841)** stating "we are at a turning point in history. We must not fail to turn." As the pandemic seems to fade from memory for many, it is vital we learn these lessons, of which there are numerous. One such area is the importance of strengthening public health, and radically improving health outcomes in the UK. Poor public heath contributed to the impact of the pandemic, and will no doubt slow our recovery too. As the demographics of the country change, it also places an unsustainable burden on the NHS too. Public health is not an issue just for the Department of Health and Social Care: it is something which is the responsibility of schools, workplaces, local government, the private, the public and charitable sector all have a role to play. Personal responsibility is important, but Government has a role to play in setting the example, and where necessary, more muscular interventions. During my time in the department, I set some of this policy in process, including the smoking ban. This agenda will also benefit from new institutional focus on OHID, and I hope to see the White Paper on Health Disparities brought forward one day.

138. The focus on this agenda will also help advance progress in other areas of health policy, including mental health, cancer and dementia. The pandemic increased the severity of some of these issues, particularly mental health. The experience of the pandemic, and out recovery means healthcare is touching the lives of more individuals and families than ever before. There is a groundswell of support for tackling these conditions. The opportunity to build on this with dedicated strategies must not be missed.

139. One of the ways of delivering better healthcare is to embrace digital technology. Whilst I was Health and Social Care Secretary, I announced a plan for digital health and care **(SJ/11-INQ000479872).** This ranged from improving the NHS app so that it was the "front door" to NHS services, by giving them access to their own health

records and to manage hospital appointment, but also to have heart age and blood pressure tools. I wanted some 75% of all adults in England to be registered on the app by March 2024. I could see how important it was for the momentum of digitalisation necessitated by the pandemic to be sustained, but I was concerned the NHS was not taking up this opportunity fast enough. I also wanted digital technology to be embraced by all those providing health services to improve performance. There should be a single digital health and care record so that patients can easily access their own data. There should be electronic patient records which are integrated across all care systems to have a complete view of someone's health record. There can and should be more development of virtual beds and remote monitoring. AI can and is already providing profound changes in health research and in manifest other areas, and this technology should be developed within the UK.

140. The pandemic shone a light on how other Western European countries had more capacity in healthcare in respect of bed capacity, workforce, ventilators, and equipment than we had. We need to look at how other comparable countries managed and how they have approached their recovery. There are immense challenges to address, but we are also entering another technological revolution, with tremendous opportunities too. Alongside this, health and public health is in the public consciousness more than ever before. I feel there is real appetite in the country for a conversation about reform. To aid this, and avoid continued politicisation, my view is that we need a new cross-party consensus on the NHS. A Royal Commission should perform this task and undertake a comprehensive review of the NHS. It should assess the structures and practices of this institution, and establish clear recommendations for reform. I would respectfully invite the Chair of this Inquiry to make a recommendation for Royal Commission in her final report.

141. As I have explained in witness statements for other modules, my view is that the issue in our healthcare system is, at its core, an issue of demand and supply. Demand is increasing at a much faster rate than supply, and during the pandemic demand surged to an extent which the healthcare system struggled could cope with. Demand is continuing to increase, exacerbated by an ageing population and more chronic and infectious diseases. I recognise that all emerging economies face similar issues, but more often than not, we end up a worse position than others. One of the primary drivers of this is because our system is funded almost entirely by way of general taxation. This means that in every spending round process, the Department

has to compete with the other priorities of the day, which inevitability leads to the shaving of budgets, including day to day and capital budgets. We have no other source of funding, and no rationing mechanism other than queuing. The only reason our healthcare system does not collapse is because people who require care have to wait and join the queue. Health spending has risen over the past 25 years from 27% of day-to-day public service spending to nearly 44%, but we have not seen an equivalent improvement in outcomes.

142. To reach the capacity to meet the health needs of today, we need to fund the NHS on a path which is sustainable and have conversation about funding from sources other than just general taxation.

143. I made a comprehensive case for major, radical reform in the 'Dorchester Address' speech as Health Secretary on 8 March 2022, informed by having seen the strain in the NHS during the pandemic. My position remains unchanged from what I set out in that speech. In particular, I remain convinced that the primary care system is not fit for purpose. NHS primary care should be more of a part of the NHS, rather than the half-way arrangement we have currently. We need a joined-up approach, which best serves patients and increases efficiency across the system. This 75-year-old system of primary care does not offer the flexibility, or value for money, that is required to meet the population challenges of the next 75 years. Hundreds of thousands of pounds are spent training each individual GP, but the flexibility in the system means they do not work sufficient days during the week to justify this level of spending, and substantial money has to be spent filling the gaps with doctors working as locums. I believe we should look very closely at GP's being employed by the NHS just as junior doctors and consultants are, with minimal contractual hours that they must meet. I also consider that there must be a way to ensure access to relevant records for a patient from all the providers that they may use (GP's, hospitals, community health care). At present, the ability of one health provider to access the records of another is patchy and incoherent. This caused delay and sub optimal patient experience. I also consider that patients need to recognise that it is both legitimate and necessary for their data to be kept whether centrally or otherwise, so that it can be used for long term research projects which could make vital differences to the health of the nation. I recognise, however, that this would only be scratching the surface, and reforming the primary care system would require a radical reform of the entire healthcare system.

144. As I have identified elsewhere in this witness statement, my reform speech offers the most comprehensive insight into all of my views on this agenda "*First, that services are redesigned around the patient by prioritising prevention and personalisation. Second, is clear performance standards and accountability. Third is more choice, power, tech, and funding in the hands of patients. And finally, backing our people with more freedom and support for system leaders and front-line innovators to partner and to deliver.*" **(SJ/06-INQ000479841)**

Statement of Truth

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

Signed: Personal Data

Dated: 17.06.2024