Witness Name: **Johanna Churchill**
Statement No.: **1**
Exhibits: **JC/01** – **JC/13**
Dated: 07 January 2025

UK COVID-19 INQUIRY

FIRST WITNESS STATEMENT OF JOHANNA CHURCHILL

I, Johanna Churchill, will say as follows:

1. I make this statement in response to a request from the UK Covid-19 Public Inquiry ("the Inquiry"), dated 12 June 2024, made under Rule 9 of The Inquiry Rules 2006 ("the Request") asking me to provide a witness statement setting out the key aspects of my involvement in respect of my role. The Inquiry wishes to understand the role I played from 1 January 2020 until 28 June 2022 ("the Specified Period").

Background

2. I was appointed a Member of Parliament for Bury St Edmunds in 2015, I held this position until 2024. I did not seek re-election in July 2024.

3. Having been elected to Parliament in 2015, I held the position of Assistant Government Whip from 9 January 2018 to 26 July 2019.

4. Between 26 July 2019 and 16 September 2021, I held the position of Parliamentary Under Secretary of State for Public Health and Primary Care. I was Parliamentary Under Secretary of State at the Department for Environment, Food & Rural Affairs from 17 September 2021 to 6 July 2022.

5. I had no involvement with any of the pre-pandemic projects such as Exercise Cygnet or Cygnus.

6. My responsibilities included the supply of primary care, prevention and early intervention, major diseases, public health system and crisis response which would ordinarily involve PPE. PPE formed part of an overall focus, rather than my only focus. Additionally, I led the sponsorship of Public Health England (PHE).

7. Responsibility moved to Edward Argar, Minister of State for Health, on 16 September 2021. Mr Argar held the position of Hospitals Minister during the pandemic after I left.

8. I have been asked to describe my role in the procurement of PPE, ventilators, Lateral Flow Tests, PCR testing and oxygen. As regards procurement, if I received any enquiries regarding offers of supply, I passed these to the Cabinet Office. Edward Argar had responsibility for Oxygen and Ventilators. PCR and Lateral Flow testing was dealt with by Matt Hancock and Lord Bethell. Procurement was dealt with by the Cabinet Office and HM Treasury (HMT). I exhibit **[Exhibit JC/01 - INQ000514122]** which demonstrates the approach taken by me and my office to offers to supply PPE. I did not believe it was my role as a government minister to recommend procurement unless it had been through appropriate channels and justified. Even at a point of crisis a system is important, the need was for speedy decision making, not the Civil Service's default and not paralysis due to bureaucracy. The email also demonstrates that my office had access to my email address. I understood there were multiple people involved in any decision that was taken, individuals were not exposed to a situation where decision making was not checked. I believed there was oversight at every stage.

9. During the pandemic I had a front row seat as to the work and dedication of those who were, with me, committed to making sure that this country emerged from the pandemic with the fewest lives lost. What I saw were people who worked tirelessly to get the right PPE to the right place at the right time. I remember sometimes we had to tell people that they needed to take a break; the hours we all worked were punishing and took a toll on people's physical and mental health. The DHSC members of staff who worked on all aspects of the response to the pandemic are all unacknowledged heroes whose selfless and tireless efforts to save lives should be recognised. I thank them all.

10. The Inquiry has asked me a number of questions about PPE and procurement. The involvement I had with PPE was extremely broad and ranged from dealing with typical

PPE supply to hospitals, pharmacies and social care settings to Local Resilience Forums (LRFs). I would deal with issues both at a high level but also at a granular level involving specific queries from parliamentary colleagues. My role was fast-paced, dynamic and ever-changing. However, my involvement with procurement was far more limited, I was solely interested in PPE reaching where it was needed. It does not help when everyone tries to do the same job; it slows systems down.

11. At the outset of the pandemic, there was such little guidance that I received a small number of enquiries as to whether PPE should be procured. This was at the time that the message from the Prime Minister and the Cabinet Office was to purchase PPE at any cost. I never gave formal approval to purchase any items, but I did on occasion provide a view of the proposal, for example, in respect of the procurement of items from China which I exhibit as **[Exhibit JC/02 - INQ000514131**]. This opinion was in line with our instruction to procure PPE wherever we could. The email confirmed that Emily Lawson had considered it, which gave me comfort. There was also the additional safeguard of the requirement for HMT approval. It was not possible for government to work at its usual BAU pace, we needed to work quickly to obtain adequate resource and to put in place proper staffing.

12. Prior to the pandemic, we had a supply chain designed to accommodate delivery to 226 National Health Service Trusts. By August 2020, we were providing essential PPE supplies to 58,000 different settings, including care homes, hospices and community care organisations. Between 25 February 2020 and 18 August 2020, we delivered over 2.4 billion items of PPE across the health and social care system within England. This included over 198.5 million items of PPE authorised for release to designated wholesalers for onward sale to primary and social care providers, community pharmacies and dentists and 151 million items of PPE to LRFs. We did everything we could and more to try and save lives **[Exhibit JC/03 - INQ000106347**].

13. My portfolio included PPE but was far broader than this, and, I had a large constituency to represent. My role was extremely wide ranging, and I have given examples below of the types of issues I was dealing with:

a. The running of Primary Care, which was my key responsibility (doctors, dentists, pharmacists);

b. Public Health (including early years) which extended to the prevention strand (for example, drugs and alcohol, obesity, screening and vaccines);

c. Allied Health Professionals (including, for example, ophthalmic and physios);

d. Major Conditions (Cancer, Stroke, CVD and Diabetes);

e. Many other areas, such as Shielding, Medicinal Cannabis, areas of COVID-19 vaccine deployment.

Other Ministers, UK Government Departments and Devolved Administrations

14. I have been asked whether I worked on the procurement and distribution of key healthcare equipment and supplies with ministers in the UK Government and devolved administrations. In particular, I have been asked about my involvement with specific individuals and bodies. At the outset, we were aware of the awful images from Lombardy in Italy which showed its hospital system was in free fall. We were determined that this would not happen in the UK. It was against this backdrop that government had to operate. There were regular calls with devolved administrations who both wanted to join us due to our superior purchasing powers but also wished to procure their own PPE. These calls would be attended by members of the Devolved Administrations, Health Ministers and officials. This led to conflict on occasion due to the finite resourcing primarily trying to avoid areas of the UK bidding for the same consignments against each other, I was not involved in resolving this conflict. There were daily meetings with different Chief Medical Officers, the NHS leads and the Emergency Response team.

15. My primary conduit into the Cabinet and wider government was through the Civil Service and Matt Hancock, then Secretary of State, who sat at Cabinet. My contact with the Prime Minister was limited. It was my role to ensure that Matt Hancock had the relevant information from the sources I interacted with. The message was consistent namely, to acquire PPE at whatever cost and to supply it as quickly as possible to those on the front-line. DHSC sponsored the Coronavirus Bill as it went through Parliament,

and I undertook substantial amounts of work in respect of the drafting of the Bill and its passage through Parliament.

16. I had a number of conversations with Penny Mordaunt about the Bill who became the Paymaster General in February 2020, discussing such issues as mortuary capacity.

17. I had very limited contact, if any, with the Chancellor of the Duchy of Lancaster, Michael Gove. I was occasionally in COBR meetings with him.

18. I did not have any meaningful contact with Ben Wallace, then Secretary of State for Defence. However, I did attend the set-up of the Ministry of Defence (MoD) logistics office in London as the MoD began to be called up to assist with distribution. As is typical during an emergency, they worked on resilience.

19. I had conversations with other Secretaries of State prior to when Parliament dispersed and I took on board their views, as I did with other ministers and parliamentarians across the House of Commons. We then began to work remotely. I worked remotely for as short a period of time as possible as I found it much better to be located in Victoria at the department.

20. In terms of discussions that I had internally at Parliament, these were varied. There were regular discussions that were raised with me about PPE stock levels. For example, body bags were part of PPE and there were discussions ongoing about whether we could use mobile Abattoirs as an additional chilled storage capacity if required. There were, as I have said, broad conversations which would then touch on PPE. I recall having them with DEFRA regarding food production operatives, the Department for Education (DfE) as teachers and students were still attending school, the Department for Transport (DfT) regarding drivers, MHCLG and bin men. Each department had written policies regarding the use of PPE but not necessarily the access to stock or the resources to acquire it, these departments wanted their purchases to be funded by HMG. We were all placed with the impossible decision of trying to determine who was the most important out of the public sector workers, there was a poor perception of risk.

21. I did not have contact with Lord Alok Sharma who was in post as Secretary of State for Business, Energy and Industrial Strategy ("BEIS"). He also held the role of President of

COP 26. I did speak to members of his department regarding the need for certain critical industries to have PPE. I understood that, when we needed businesses to respond, the Secretary of State helped drive this. Private businesses tended to acquire their own PPE at the prices which were available; these prices had skyrocketed, and it was obvious that stock was being sold to the highest bidder, placing further constraints on the market HMG operated in.

22. There were demands across government, BEIS sought it for manufacturers and DfE were demanding PPE for teachers and personnel, DfT for bus and train drivers. There was a constant demand initially for paper masks and then complexities regarding FFP2 and FFP3 began to arise because scientific information or the understanding of it was inconsistent, even amongst medical professionals. There were regular meetings at the outset of the pandemic. In every meeting about any topic PPE would come up as a by-line, which made things challenging. One of the primary problems was that it was not clear who we were supplying to, the NHS was not defined. The NHS had evolved significantly over the years, this meant that it was unclear whether bodies such as private pharmacies and physiotherapists should receive PPE. In my view, they still provided a vital service and ensured that the delivery of Health and Social Care could continue. This led to ill-feeling from those professions which felt, understandably in some cases, they were not considered part of the NHS for PPE supply purposes. On the advice of the Chief Dental Officer, dentists were shut notwithstanding they had reasonable systems for the delivery of PPE and operated as commercial businesses, their closure was due to the assessment of risk due to aspirant procedures, a decision I supported.

23. Even once the Coronavirus Act was passed, individuals continued working physically in the Department of Health and Social Care (DHSC). There was a constant demand for supply, but SCCL was not designed to provide the PPE which led to problems at the outset. The systems were inadequate, antiquated, non-digitised and poorly run.

Key Appointments

24. I have been asked to provide reasons for various appointments during the pandemic. I was not involved in any of the following appointments; I assume these appointments

were made by the Prime Minister, Permanent Secretary and Secretary of State for Health and Social Care:

a. Lord Agnew;

b. Lord Bethell;

c. Lord Deighton;

d. Lord Feldman; and

e. Baroness Harding.

25. I did have contact with Lord Agnew regarding the structures and tightness in the system and the burn rate of PPE was causing such a difficulty. My contact with Lord Agnew quickly diminished as we were in different departments; it felt as though procurement was somewhat separate from DHSC overseen by Emily Lawson. We would provide our needs and receive sit-reps, I was a conduit for information sharing from the professions until things settled more. At the start of the pandemic, there were a number of meetings held known as the "Daily Procurement Meeting", I exhibit the initial email regarding this as **[Exhibit JC/04 - INQ000514115**]. My role in these meetings related to supply and the meeting was often referred to as the Daily Supply Meeting as per exhibit **[Exhibit JC/05 - INQ000514118]**. My understanding was that Lord Agnew took the lead on procurement due to the number of individuals in the Cabinet Office working on procurement. Subsequently, Emily Lawson appeared to be running the PPE cell with direction from the Secretary of State. My involvement with procurement was extremely limited.

26. I exhibit the meeting notes from 20 March 2020 as **[Exhibit JC/06 - INQ000514117]** which demonstrates that my involvement was focused on distribution and issues regarding fit-testing, this was particularly in respect of up-skilling fit-testers. As I have set out previously, one of my main roles was problem solving. The agenda also shows that the scope of the "Daily Procurement Meeting" was far broader than simply procurement, I exhibit this as **[Exhibit JC/07 - INQ000514116**]. The breadth of portfolios was enormous and we were all picking up additional issues to highlight. These

were fed up the Secretary of State's office if required. Our focus was on what we were personally dealing with, Matt Hancock had the oversight or helicopter view of the department.

27. Lord Bethell was a health minister and there were meetings which were held; he and I would talk regularly as colleagues. He focused on life sciences, pharma and the testing side of things which would very regularly cross-over. Doctors and those working in hospitals wanted to know about testing so that we were able to monitor vaccine distribution and so forth.

28. I did not have any contact with Lord Deighton or Lord Feldman, I do not anticipate that they would have any knowledge of my areas of responsibility.

29. I had limited involvement with Baroness Harding and had limited formal contact.

Preparedness for the Pandemic

30. It was clear to me that once the pandemic had begun, there was minimal preparedness. The reality is that even if there had been preparedness, we were still dealing with something completely unknown to both the UK and the wider world. I am not sure that we can ever be fully prepared for a pandemic. In my view, we could be intelligent and honest about what might help in the future using the knowledge we gained during the pandemic. In particular, better IT and more consistent systems across organisations would have helped us understand supply and meet demand more effectively. Such as the ability to have an emergency 'bolt-on' into systems from outside the NHS but that are reliant on it.

31. There were acute issues with the dates of expiry. We became aware of equipment that had best before dates which were some years past. One of the key problems was that equipment had not been checked regularly. This did not mean that the product was defective by default, but it meant that the equipment had not been checked on the appropriate date. Communications were a key challenge in this respect between DHSC and the front-line NHS. Some items definitely should have been destroyed earlier, however there was no system in place. It meant that there were items which needed to be

checked in order for them to be used. This issue was the responsibility of PHE, dates were overlaid on items, and this did not help confidence in my opinion.

32. In my opinion, SCCL, PHE and the NHS all had substantial issues. For example, the North West distribution centre at Haydock was in a total mess. There were years of lack of preparation and the focus had been on a potential flu pandemic. The level of stock held at Haydock was not sufficiently inventoried for there to be any confidence that this represented the PPE which was needed. In fact, the stock level at Haydock was exhausted within a number of days of the pandemic beginning. It was obvious by the very swiftly that the need for PPE was societal, the private sector could move at speed, but it was much harder for us to do that. A future core-set of organisations that could be mobilised at short notice would be a recommendation that I would make, notwithstanding it has been 100 years since the last pandemic. It is not unusual to have "shadow organisations", in wartime situation these core organisations would have expertise in respect of procurement and the standards to be applied to products and the ability to move their production swiftly, e.g. Rolls Royce in WW2. We would be more resilient if we had companies on a retainer or are known to be able to step up and adapt as required. The companies would be those capable of manufacturing core PPE and assisting with distribution. However, this would require constant oversight.

33. I have been asked to set out the three principal issues that I consider in respect of SCCL, the NHS and PHE:

    a. The lack of inter-connectivity between the organisations and the lack of consistent technology meant that the bodies failed. The digital technology in SCCL was insufficient which led to hand-picking of PPE for delivery. Major hospitals in the NHS are permitted to choose their software provider (although it is ordinarily Epic and Cerner), this means that General Practitioners ('GPs') (predominantly EMIS and System One) do not interact with one another. There are entirely separate systems in place for social care which have completely separate systems. This meant that there was a lack of ability to share information across the bodies. There was a prevalent use of WhatsApp in hospitals as an operating system, this was not effective, but the best that could be managed in the circumstances.

b. The infrastructure in the NHS is insufficient, the standard of buildings and facilities is particularly poor. There were also issues in respect of discharge, in particular, of the discharge of patients prior to testing. There were also staffing issues, for example in Lincoln there would be a stock delivery at 10pm on a Friday evening but there was not sufficient staff or resourcing for stock to be collected or delivered.

c. The leadership and hierarchy of the NHS was inconsistent, there are differing levels of locum and bank staff as well as the structure of the senior leadership teams. There is no consistency across hospitals which means there is no allowance for fluidity.

34. As a result of the above issues, there was an inability to involve PHE in the NHS in a meaningful way in protecting the population.

35. One of the ways that the system was not prepared was that there was no monitoring of end use after an order had been placed. This was another reason the burn rate became so high. In my view, there was insufficient accuracy in the stock levels which were being reported. Stock levels across the supply network were inconsistent, individual hospitals and sites would seek to protect themselves. There were no or limited inventory or audit trails. We were driven by front-line demand, such as individual organisations who would demand PPE. I raised during the pandemic my concerns about the burn rate and that it was having an adverse impact on our ability to provide PPE **[Exhibit JC/08 - INQ000514123]**. This document demonstrates the breadth of the portfolio that I was responsible for and the variety of issues that I was dealing with and highlights the problems that we were facing. My key concern with the burn rate was that distribution needed to be fair, needs oriented and ensure that we could maintain oversight of stock levels, I did not want to restrict supply.

36. We were only able to properly understand the stock levels and data much later into the pandemic. This was a real flaw. There was limited data on front-line stock as NHS trusts operated as individual models and had responsibility for themselves. We would receive a daily update which was referred to as a sit-rep, this demonstrated the stock levels. These

levels appeared acute and as a result there were discussions about the movement of stock arising out of this. The biggest issue was that the data systems could not accurately monitor stock levels and relied upon accurate reporting from the front-line. Additionally, we had no checks from the government end. We could not confirm stock control levels, nor could we work on a buffer basis. We couldn't control deliveries hence by the end of the pandemic large amounts of stock sat at Felixstowe dock, delivery dates weren't honoured and early in the pandemic it appeared stock would be 'reallocated' to a higher bidder.

37. By the end of April/ May I was working more on BAU with the PPE team to understand what a 21st century system needed. There were various trials of PPE. For example, there were trials of different types of scrubs, masks and visors. The absence of laundries meant that there was limited re-use that could take place. Professionals told me stories of how they would strip in the garden so as not to infect their family if they had been dealing with patients. There was also a differing level of infrastructure between sites and how they were able to deal with the absence of PPE. We were without accurate data of the transmission rate of the virus and limited knowledge of what we were dealing with for the first few weeks.

EU Exit

38. In my opinion, this was irrelevant in comparison to the challenge that we faced. This was a global pandemic. There were conversations which took place with other members of the G7 because the challenges were worldwide. There were conversations between health ministers about the challenges that they faced. Examples of non-collaboration were global and were invariably to protect their own populations. Italy would restrict the export of masks if they were running short, and the USA restricted the export of medicines. Conversations would be had as possibly trades could be done.

39. Whilst the pandemic started in Wuhan, it very quickly spread to Europe. The majority of PPE was procured from outside the EU. Due to manufacturing and the location of raw materials, glove manufacture had centralised in Malaysia, for example. Once Malaysia was impacted by the pandemic and global demand rose exponentially, it meant that exports were acutely reduced. As a result, there were challenges importing PPE from

countries which were ahead of the UK in the pandemic cycle, these countries tended to respond differently. Also, purchases were being made from private companies swamped by demand the result was prices rose – it is a basic example of supply and demand.

40. There was an acute demand and there was a need for supply; the role of the Cabinet Office was simply to see where they could obtain supply of PPE from. The NHS was heavily involved with DHSC and Cabinet Office and the procurement of PPE. Every country was restricted by acute demand and finite supply.

Principal issues with procurement as the UK entered the Pandemic

41. I have already explained that I had very little involvement with procurement during the pandemic. There had been a change at PHE staffing at the end of 2019 which led to a further complexity in terms of organisation. There was a consistent lack of stock control through PPE systems, we had no oversight of the location of the stock that was held.

42. One of the key difficulties with supply was that there was such a high burn rate of PPE. PPE was largely single use gloves, aprons and masks for example. There was also a move towards using scrubs rather than simply using gowns and we simply did not have the availability of scrubs. This was another area where we saw manufacturers of goods begin to be more dynamic, we ended up in a situation where clothing manufacturers were now providing gowns for PPE, as well as altruistic well-meaning sewing groups although we had no control of the quality of these products. Once we were able to calculate the burn rate and compare it to the number of patients, it was apparent that the usage was differing wildly between different hospitals. This demonstrated that there was an enormous variation that was beyond possibility, it showed that some hospitals may well have been stockpiling.

43. I made it clear to others that there was a need for procurement processes to speed up at the outset of the pandemic. The current system of procurement, in my view, remains too slow and costly, this bureaucracy needs to be reviewed to have flexibility for emergencies. As I have set out, I was not closely involved in the procurement process, but any system required a substantial number of checks and balances. There was insufficient time to carry out enhanced due diligence and doing so would have cost lives.

The usual glacial pace of decision making in the Civil Service was not appropriate. I was often told it was due to 'due diligence', but failures still occurred. There was an implicit feeling from the outset that the failure rate would be higher. It was inevitable that there would be a percentage of contracts where performance and quality issues arose, I anticipate there is a level of non-delivery outside of a pandemic. There was an overwhelming need for PPE to be procured. In the cold light of day, four years later, it is impossible to relate to the conditions we were working under.

44. It became apparent within days of the pandemic beginning that there was a serious issue in respect of PPE. It became obvious that there was a shortage of items of which there was a finite supply. The acquisition of PPE was driven by the financial capability of a country which was looking to acquire it and the systems and people who operated it.

Key decision-making forums and groups

45. There were back-to-back meetings which were held, as well as answering written and oral questions that were submitted. Portfolios were substantial and required a substantial amount of input.

46. I am asked to explain my view of the role and effectiveness of a number of ministerial bodies:

   a. Cabinet

      i. I was not present in Cabinet meetings and so I do not feel it is appropriate for me to give a view on this. The Inquiry has the benefit of the evidence of a number of Secretaries of State who are best placed to give their version of events as they recall them. The outset of the pandemic now took place 4 years ago.

   b. COBR

      i. I did attend some COBR meetings pre-January 2020 and into the pandemic;

      ii. I remember attending COBR, I would occasionally attend in place of Matt Hancock or in addition to him; there was a move towards explaining that people were surviving COVID-19 and that we were not facing a "black death" equivalent. It was discussed how we could encourage people to better understand the severity of

the issue and environments which may have a higher propensity to result in harm. For example, it was important to explain that there were certain individuals who were more at risk.

iii. There were occasions when I felt individuals were playing politics and there were lots of big personalities in the room during COBR meetings rather than a complete focus; in my view, there was a lack of clarity as to who was in charge between Secretary's of State in DHSC and the Cabinet Office. There was a lack of understanding of how the NHS worked in practical terms by the majority of those in COBR.

iv. In the early days of the pandemic, there was a sense that there may well be an easy fix and that we were dealing with a bad case of flu. There was a hope that the pandemic would be over in weeks rather than months (or years). The NHS is a unique body and has its own frailties. It must be remembered that the NHS is the largest single patient body in the world we were dealing with a single system catering for 68 million people. I am not sure the NHS and its structure was well understood by those seeking to run things.

v. The purpose of COBR was to bottom out details and to seek solutions but I could not say hand on heart that it always had the right people in the room. One of the difficulties is that Secretaries of State did not always have the granular detail which would have been held by other ministers.

c. General Public Sector Ministerial Implementation Group

i. I do not recall this Group.

d. Covid-19 Daily Strategy Meetings (the 9:15s)

i. I was involved in a number of these, but it would depend on the subject that was being dealt with on the day;

ii. These were a meeting for us to be briefed by SPADs on key issues;

iii. Problems generally arose multiple times during the day, we had to ensure that we dealt with these and prioritised them. PHE had input across the breadth of government;

iv. There would regularly be updates given at these meetings regarding PPE from across government, for example body bags getting low in numbers and mortuary space;

v. There were a number of different projects ongoing; a minister has an extremely broad portfolio. They were an opportunity to discuss issues across portfolios which interacted with one another, care homes were under a lot of pressure, and it was helpful to understand other perspectives when looking at the whole system;

vi. In my opinion, these meetings were useful to share views across portfolios and also to understand how the issues each of us were dealing with interacted with one another;

vii. These meetings drove my focus and impacted on my workload, for example the clarity which was reached regarding asymptomatic transmission.

e. Ministerial Implementation Groups

i. I believe we referred to these as 'MIN' meetings when cross government ministers, often in the place of the Secretary of State, would sit and discuss the problem of the day;

ii. For example, shielding was an issue dealt with by DHSC, DEFRA, MHCLG, and the Cabinet Office – multiple MIN's would have been held regarding this.

f. Covid-19 Strategy Committee

i. I could well have attended these Committees, but the reality is that there were vast quantities of meetings during the period. It may also be that there were meetings with individuals who were on the Committees, but these were not formally characterised always as committee meetings.

g. Covid-19 Operations Committee; and

   i. Please see above (f), I was heavily involved in operations but cannot remember if there were particular names for these meetings or Committees.

h. The Quad.

   i. These were held on a Monday morning although my focus at this stage was on COVID-19 legislation;

   ii. Ed Argar would attend at times, and I believe I can recall Matt Hancock, Sir Chris Wormald, Simon Stevens and Sir Chris Whitty being in attendance;

   iii. My view of these is that they were tightly run due to the sensitivity of what they were talking about.

47. It is extremely difficult for a committee or department to be action-focused during a period such as the pandemic. This was due to the situation we were dealing with and the continuing developing challenges. Decisions could change hourly when the focus was on saving lives.

48. In addition to the meetings I have been asked about, we would have daily all-colleague meetings (particularly when running tiers) where we would have open teams calls to meet with the Chief Medical Officer or Steve Powis. These meetings would last for an hour led by a 20 minute presentation by me, Jenny Harries or Jonathan Van Tam followed by 40 minutes of discussion. Such was the demand for information they often overran.

Your key decisions and policies during the pandemic

49. I did not make any key decisions nor implement any policies regarding orders/procurement during the pandemic it was not a good use of my time given my broader portfolio. During the period of prorogation in 2019, I had completed my initial meetings with the relevant stakeholders for my role.

50. I was focused on actions rather than policies; I came into Parliament as a cancer campaigner. I had sought to ensure that data transferred with a patient. I finally became a health minister but shortly thereafter Parliament was prorogued. I was extremely

excited at the outset of my role to do work on prevention of cancer and to improve the cancer journey and to play my part in the better integration of hospital, community and social care. I intended to be focused on these areas as well as the prevention agenda. However, the pandemic then hit, and everything was shelved that I had intended to prioritise.

51. The making of decisions during the pandemic was an organic approach. This meant that decisions and policies developed over a period of time. There were so many stakeholders involved that this was the only way that processes could be put in place. We had to act immediately and acted as best we could. My role became incredibly varied, for example we needed to resolve the need for speech therapists to have clear masks. There was also a need for different fit masks to be used for individuals with beards. Furthermore, there would need to be a different fit for respirators where individuals wore turbans, gender differences and differing protocols needed for each item introduced. I recall there was an up-skilling process that was carried out in respect of fit testers. This was an area that I had involvement with, there was particular expertise needed to ensure there was an appropriate fit. My role was to note that there were insufficient fit-testers and to put in place the up-skilling which I believe was operated by NHS England as they were the end-users. It was not raised with me at any stage that fit testing had arisen as an issue in the past, there were no protocols or documents which were capable of expressing the different types of gowns and masks were available. By the summer of 2020, the approach had improved significantly and there was a better understanding of need across genders and other characteristics. But whilst there was understanding there was not yet necessarily the bespoke supply. There were little or no designs or documentary evidence showing the materials required to produce PPE. Once things had settled, the PPE leads and I had meetings at least every two weeks to work on issues of materials, gender specificity, sustainability or the like.

52. I would receive calls constantly from parliamentary colleagues about shortages of products, it was impossible to manage. We were simply seeking to deal with as many issues as we could. This was not business as usual. As supply lines strengthened and we had increased domestic production, we were able to have separate workstreams for different items of PPE.

53. We were also having to work with the ever-changing guidance that came from different sources, these sources included SAGE, Chief Medical Officers, the Department of Health and Social Care and the Cabinet Office. This then introduced new challenges and requirements; the landscape we had to deal with never remained consistent. I focused on what I was told by SAGE and the communications which were forthcoming regarding the risk and modelling. I spoke regularly to the Chief Medical Officers who were on daily calls with colleagues to inform myself as best I could.

54. There was a tussle at the outset of the pandemic between DHSC and the Cabinet Office as to who would be responsible for procurement. This arose as the Cabinet Office was the procurement department for Her Majesty's Government. I anticipate it was due to the resourcing available but even so recruitment went on at pace to meet demand, those individuals would be better placed than me to describe its effectiveness. This led to the formation of a PPE channel in the Cabinet Office which was to determine which of the offers to supply PPE were legitimate and worth pursuing. This was an inbox to which all enquiries about PPE were to be sent and colleagues were referred to it. However, the quality of a product could be very different when it arrived as I am sure many have experienced with a purchase on the internet. There had been a lack of investment in PHE historically. Emily Lawson and a number of other individuals including Sir Christopher Wormald salvaged and drove the system to achieve some functionality. I did not have close oversight of the work being done by Emily Lawson, but it was clear that she had taken charge alongside Matt Hancock. As a result of the passage of time, the system began to cope, and demand lessened which allowed for a degree of control to be regained. As a result of the breadth of my portfolio, it was appropriate for me to have an overview.

55. At the outset of the pandemic, I worked to introduce the Coronavirus Act. In the early stage of the pandemic, my role was to sort problems which arose rather than to resolve or critic outdated systems. I did not have any influence on SCCL as it was an internal NHS system I did report back to the Secretary of State it was not fit for purpose though once I had visited a site and watched its operation. LRFs were via local government and MHCLG. I would report back into the system, to talk to Emma Dean and the emergency response team. The emergency response team did a huge amount of work to arrange for systems to standup.

56. I had regular meetings with Dr Nikki Kanani (NHS England's Medical Director for Primary Care) who would inform me of the need in the NHS on a regular basis. Nikki Kanani would hold calls with the entire profession and would pass on information which had arisen in these meetings. Nikki Kanani would inform me that across the system there were shortages of specific categories of PPE. I was also informed by Nikki Kanani that individuals were regularly removing work clothing prior to entering their home due to the unknown of the transmission of infection. Nikki Kanani and I worked very closely throughout the relevant period. We had cross-departmental workings on shielding. I met with Sara Hurley, Chief Dental Officer, incredibly regularly because of challenges with dentistry which was shut down at an early stage. I sought to resolve issues in terms of provision of PPE to dentists. This was one of the vast number of queries I received during the pandemic which I sought to troubleshoot. I exhibit an email from Edward Leigh MP **[Exhibit JC/09 - INQ000514126]**.

57. I met regularly with a cross-board of pharmacies and GPs. The RCGP head (Martin Marshall) and I had regular meetings. This was with a view to resolving multiple issues they had including access for patients, PPE, opening hours and who was responsible for paying for Perspex screens.

58. There was work with parliamentarians in respect of tiers. This work originally had to be done on a regional basis. I worked to understand policies and guidance in respect of the tiers during lockdown and help its operationalisation which wasn't easy.

59. It was extremely difficult to deliver objectives that were part of my portfolio during the pandemic. The priority became the delivery of services, accessibility for patients and PPE, and this was the focus of my work. Locally, I worked with care homes and businesses which were expected to acquire their own PPE. Care homes were ever present as a topic of discussion. I can recall that, during the pandemic, a Care Home Operator in my constituency lost more patients during a single week than they would usually during a year. There was a push for care homes to receive PPE as a priority. Processes internally and externally were insufficient to meet with the demand for PPE and to handle the supply of PPE. I sought with others to improve these processes. As I have previously set out, there was a grey area where institutions such as care homes delivered a vital service but were considered either a private business or the responsibility of the local authority.

This meant they were not considered part of the NHS. Due to this, they struggled to obtain their own PPE due to shortages and they could not access it through the NHS. There were high levels of exposure in care homes. Again however, there was a lack of IT infrastructure and a lack of knowledge as to how organisations interact with each other.

60. In my view, the government could have introduced a hierarchy of distribution due to the level to which demand out-stripped supply which led to increased prices. This could have assisted care homes in obtaining PPE. Due to the increased prices, smaller care home operatives could not obtain PPE and this was a situation which we regularly grappled with and tried to supply PPE to care homes.

61. I did engage in some work regarding the re-use and recycle research, I exhibit an email dated 19 May 2020 which shows that I was pursuing this. This also included gender specificity work **[Exhibit JC/10 - INQ000514127]**. I also worked on a team to establish whether it would be possible for women to have bespoke gowns as this had been an incomplete set but there are multiple examples.

Call to arms

62. I did not have any involvement with the implementation of the 'Call to Arms' including Operation Moonshot and the Ventilator Challenge.

63. The Ventilator Challenge was dealt with by Ed Argar. As respirators were in hospitals very rapidly it was determined that their effectiveness was limited. Matt Hancock tended to deal with the testing side. I was involved in the early discussions regarding vaccine research. That was taken over by Nadim Zahawi when the Prime Minister made him vaccines Minister.

Overall value of the contracts awarded and spending controls

64. I did not have any oversight of the value of any contract awarded, nor the negotiations of any contract. As such, I did not have any influence on spending controls, nor did I have any knowledge of how these were applied. I was focused on ensuring the PPE that had been procured got to its end destination.

65. I was not involved in the spending decisions that were taken. In my view, the message that we gave that PPE would be provided for anybody that needed it was a mistake. This was a self-determination for people who were understandably in panic mode, it failed to prioritise the front-line and caused problems. I flagged the language at the outset because of the clear impact it would have on demand. In my view, the message should have been that PPE would be provided to front-line staff and those who were high-risk who continued working. There should not have been a blanket approach which included business where it was possible to employ social distancing. The approach meant that demand very quickly out-stripped supply which created a suppliers' market.

66. I did not undertake any work to determine funding envelopes.

Steps taken to eliminate fraud and the prevalence of fraud

67. I did not have any involvement in measures to eliminate fraud. In my view, there were difficult decisions that had to be taken – people were dying, and PPE was something that would help limit the mortality rate. Whilst it was not necessarily fraud, one of the key problems was that purchasers were 'gazumping' where offers had already been agreed driving prices up.

Conflicts of interest

68. I did not have any input into how conflicts of interest were managed.

69. I was asked whether I had any conflicts of interest, which I did not.

Contractual provisions and performance by suppliers and manufacturers

70. I did not have any involvement with the negotiation nor drafting of contractual provisions. I did not have any involvement with the effectiveness of these procedures, nor did I direct the Cabinet Office regarding them.

Compliance with public law procurement principles and regulations

71. I was not involved with the compliance requirements nor were public law procurement principles and regulations part of my remit.

72. We were not operating inside a vacuum; the focus was on the acquisition of PPE at the fastest rate possible in order to ensure that the public were protected. We were doing this in a market against private industry in the UK and acute global demand.

Operation and effectiveness of regulatory regimes

73. As per the above, this was not an area that I was involved in.

Decisions as to what to buy at what cost

74. As previously explained, decisions in respect of procurement were not made by me and as such I did not make any decisions regarding what PPE to purchase or the cost of these items.

75. The reality was that the majority of people were not 'on the take' in my view, but there will always be bad actors in any market. Everybody was trying to obtain whatever PPE they could and there were very altruistic offers to assist with provision of PPE. However, there were issues which slowed the system down, such as the bureaucracy I have described, which meant the stock needed was not provided and, as ever, some offers to supply were spurious in their nature. We could have worked more smartly potentially but that should be part of future resilience work should we face a similar threat again.

76. I did become involved with issues which arose on the front-line in respect of quality control. I would be informed of instances where goods were not fit for purpose. I can recall specific examples of where I was informed that ties on face coverings had perished. I was also informed of instances where products had expired but were subsequently re-stickered and this dented trust. I believe PHE had responsibility for this and I raised any issues I became aware of with the Secretary of State's office. There was an expectation that PHE would have their own systems of stock control and quality management but the lack of these was not exposed as an issue until the pandemic. It was extremely difficult to obtain specifications for PPE to pass onto organisations for domestic production to begin. These were not held in a central repository and were not necessarily in writing. We were dealing with unique procurement circumstances and there was a scarcity of raw materials. This all impacted on the ability to comply with specifications.

77. We were able to pick up stock and replace it rapidly through the system. Our focus was on delivering whatever PPE we were able to deliver. Front-line workers were placed in an extremely difficult position and as a result I wanted to ensure that we gave them whatever support we possibly could, but the system was incredibly stretched, particularly at the start.

Disposal strategies

78. There were different lines of disposal. The disposal of single-use items such as single-use plastics was straightforward in hospitals as they had the appropriate bins. However, community health workers did not have access to these disposal systems. It was not possible for items to be put into domestic waste. This is yet another example of the problems that we were dealing with. The items needed to reach incineration. There were additional challenges for carers working in domestic situations or where patients required one-to-one care.

79. There was disposal of goods which were not fit for purpose.

80. I did not have any involvement with disposal of over-purchasing. We had PPE over-stocked because lead times were not in our control. The impression I had was that we were purchasing at pace to ensure that we had PPE to meet the needs of the country. However, by the time orders arrived there were examples of where demand had calmed, and domestic production had improved. The demand reduced for a multitude of reasons, including a reduction in panic and a decrease in the burn rate. If indeed there was an over-purchase, that was because we did not wish to run out of what was our first line of protection. The alternative to over-purchasing was under-purchasing, which would have left us in a far worse situation.

Distribution of key healthcare equipment and supplies

81. The methods in place in respect of distribution were unprepared and unsophisticated. I can recall flying from Wellington Barracks to Rugby at an early stage in the pandemic to visit the SCCL operation. It was clear that it was not fit for purpose. For example, SCCL would not dispatch if there was a single item missing from the picklist. This was one of many examples. In respect of distribution, at an early stage, items were simply being

picked from a paper-list. This was sought to be remedied. I can recall the Royal Logistics team from the MoD coming in to assist with distribution. This was predominantly managed by Emily Lawson's team.

82. I was aware at an early stage that there was a lack of inventory control. There was no information as to what stock levels certain hospitals had for specific items. There were some examples, in my view, of where certain hospitals were stockpiling at a very early stage and in the pre-pandemic period.

83. My focus was on delivery. In the early days of Clipper, it was suggested that we did not tell individuals they would be receiving supplies because there was no confidence that items would be delivered. I was not involved in the decision to move from Unipart to Clipper. I believe this was handled by Emily Lawson and the Secretary of State. I did raise concerns from LRFs which had been passed to me by Members of Parliament and I sought to inform the Member of the answer to any query. We were being told by Clipper that PPE could be delivered to LRFs but that there was a bottleneck at this point. I had no reason to doubt this information and it is right to note the broad spectrum of capability of the LRFs. One issue I observed in respect of LRFs was that there was often an unclear chain of command.

84. We distributed through LRFs – some were highly organised, and some were completely unfit for purpose. On 8 April 2020, I suggested that this was a long-haul process, and we have to understand how we can have a better system afterwards. I recall that the delivery through LRFs was better in mayoral areas than through local councils, this is likely because they were over a smaller geographical area although there were outliers were an LRF would perform particularly well due to being driven by strong individuals. I was very concerned that there was a total lack of data being provided by the LRFs and chased this on a number of occasions, including on 5 April 2020 by email which I exhibit as **[Exhibit JC/11 - INQ000514125]**. LRFs varied wildly in their maturity and the quality of leadership also varied.

85. There was also involvement of Local Government (for example, LRFs were managed by Local Government). There was already a lack of oversight of LRFs because of the layers

of instruction; visibility was poor. We did not have oversight of supply on the ground, we would not know if specific locations had received PPE once stock had been supplied.

86. Another example of the difficulty is that so many people sought PPE, for example, police officers and bin men all wanted PPE in order to complete their roles. There was an uprising of self-appointed public health experts which we had to deal with, and the consequences of concepts being published. It was the complexity of the operation that caused the difficulties. There were so many different organisations that required PPE, and it was not clear how PPE would be supplied to them or who would pay for the PPE. There was no clarity on how PPE would be supplied to any of the following examples.

    a. Air Ambulance;
    b. Hospices;
    c. Pharmacies;
    d. Care homes;
    e. Dentists;
    f. Bus drivers;
    g. Bin men;
    h. Food processing workers; and more.

87. We tried to resolve these issues across the supply network but the complexity of it was beyond anything anyone had experienced or expected.

88. SCCL and NSDR were too small to cope with demand. There were no automated pickers, and everything was done manually. There was manual picking with clipboards, if there was not a complete stock level for a procurement list it was simply not delivered. This was an issue that we tackled very early on. There were discussions regarding whether there was an alternative which was then picked up by the Secretary of State's office.

89. There was no 'Just in Time' system which meant that there was a tendency to over-promise. At an early stage of the pandemic, there was also an issue with who would fund the purchase of the PPE in respect of entities such as pharmacies, care homes and physiotherapists. They could be considered part of the NHS but are actually private businesses. They were clearly key institutions that needed to function. There was a risk

that care homes would become insolvent as a result of the cost of PPE during the pandemic.

90. The devolved administrations also had to be considered. They no longer wished to be considered independent necessarily for PPE acquisition and so we worked more closely with them than we had previously. Alongside this, the devolved administrations continued to try and acquire their own PPE separately. We had no line of sight into their stock levels, this meant that devolved administrations had two sources of procurement and again who would pay was an issue.

91. There were cyclical issues during the pandemic; there would regularly be different challenges that we faced, and these had to be resolved.

Suitability and resilience of supply chains

92. There was as much an issue with supply as there was of distribution. One issue that we faced at the outset of the pandemic was that the PPE we had ordered simply did not arrive or it would arrive late creating confusion as to stocks and what was needed to be ordered. As I was a Suffolk MP, I was aware of the delays of incoming PPE and then the stockpiling of excess stock on Felixstowe dock later in the pandemic. One of the reasons we focused on domestic manufacture of PPE was because of the delays in importing items. I was concerned with the delays in material being provided as is evidenced in **[Exhibit JC/12 - INQ000514115]**.

93. In my view, there were challenges very early on in respect of distribution – once goods had been procured – which were vast. One of the key issues was that there were so many consumers of PPE, for example care homes, which did not receive PPE from the NHS. The processes did not work.

94. The supply and distribution network was an area that was quickly focused on to try and find a solution. The only solution to the challenges we faced was for the pandemic to abate or for stock lines and supply chains to stabilise. We reached a stage that we had sufficient flow within the system and individuals stopped panicking and stockpiling within their own organisation. Individual hospitals were carrying stock which would go

out of date, even though they would be charged for it, and which may not have even been required.

95. One of the key issues we faced was that different organisations, such as major businesses, would try and procure their own PPE. This led to an increased competition for PPE at the outset of the pandemic. The reality is that there was a finite quantity of PPE and there was limited quantity and quality control. We encouraged domestic PPE production in order to increase quality control at the point of manufacture and accessibility. It also gave us a better understanding of supply and we rapidly reached self-sufficiency in aprons.

96. It meant that the processes became far more streamlined. One of the key issues that we sought to resolve was that there was such limited information from the front line on stock levels.

Changes to procurement processes

97. There was an increased provision of information during the pandemic as to who was at an increased risk both of transmission and fatality.

98. In my view, there was a change in the scope of procurement during the pandemic, for example, screens became increasingly in demand. Whilst not overly effective regarding infection control, they helped staff feel less vulnerable to droplets. There was an exponential demand curve for PPE and the same products were being sought worldwide.

99. There were various examples of where working was changed, for example, pharmacists worked extremely quickly to put in place good working measures to remain open. There were challenges faced regarding whether ethnicity increased the risk of infection and severity of conditions, e.g. the immunocompromised, we were learning every day.

Reflections on the Pandemic and Lessons Learned

100. Once the pandemic had begun to ease and was slightly more under control, I was keen that we carry out a lesson learned exercise and explained this in an email to Matt Hancock which I exhibit as **[Exhibit JC/13 - INQ000514128]**. These exercises are always better done at the point of relevance rather than retrospectively some years later.

101. As I have said earlier in my statement in my view, there is a lack of proper appreciation for the conditions that the entirety of government and the public sector were working under during the pandemic. In my view, teams worked extremely hard to achieve a common good, but mistakes happened as we were all dealing with unknown unknowns.

102. We were simply working every hour that we could and had to arrange to have food delivered into the office. Every effort was focused on seeking to improve the public health situation. I know that the procurement team's focus was simply on obtaining whatever PPE they could.

103. Because of the pressure of trying to get the job done this was not government business as usual, we were unable to write everything down, although we did discuss matters amongst ourselves, we didn't have time to necessarily have formalised meetings always, and we focused on carrying out actions. If I was to have had everything noted or recorded, we would never have got on with the job. We got things done because everyone worked every available hour to get things done, that was the reality of what we all did.

104. It became clear at an early stage that we were dealing with a situation which was like nothing we had faced before. I travelled to Liverpool to meet the first flight from Wuhan; my family felt I was being irresponsible, but I felt that the PPE arrangements in place were sufficient, I was happy to go, and we had asked others to step forward and I felt I should. I was a lead minister and I felt it was important. From my recollection, nobody developed the disease in the first quarantine areas. Internally, it became immediately clear that there was a sense of panic about the pandemic.

105. Whilst the pandemic was ongoing, we sought to re-work the entirety of cancer treatment across London. There were doctors from multiple hospitals operating from the Brompton who would work alongside one another. It was described to me that, whilst it was an appalling time, it was a time when individuals who otherwise would not have come into contact got to work together. There was a feeling that developments would come from cross-interaction of doctors from different organisations. The same learning experience has been discussed with me by GPs and care homes that I still speak to, and many articulate that they are still dealing with the trauma. The after-effects of the pandemic have not gone away.

106. There was no grasp across the NHS of how to deliver PPE. The fragmented structure of the medical system in the UK means that the system is fractured. There were bodies which were used to being private bodies such as pharmacy, physiotherapists, speech-therapists and many others which then needed to be supplied with PPE. The situation was extremely complex with dreadful IT enabling these different organisations and archaic systems.

107. In my view, there was a real change in industry during the pandemic. It was clear that manufacturers who were not typically involved in the manufacture of PPE began manufacturing PPE. A good example of this is when I visited a printing company who completely altered their operation to manufacture masks. There were companies who had dealt with Perspex then began to manufacture screens. These companies were ordinarily able to manufacture at speed, high volumes and low costs but this was because they were driven to keep their businesses afloat. At the outset of the pandemic, manufacturing companies were forced to close, and the manufacture of PPE became a way to sustain their existence and support livelihoods. I am not aware of any government support that was available in this respect, although the broader financial support that subsequently came in across all industries is well documented.

108. The pandemic led to a period of extreme emotion across the country. I came into politics because I wanted to help people. I am phenomenally proud of how people worked during the pandemic and what we delivered, including the billions of items of PPE that were supplied. The solution we put in place was imperfect, but it was the best that could be achieved under the circumstances, and I hope that this exercise will help improve future responses.

109. I had genuine concerns for civil servants and parliamentary colleagues. They worked for lengthy periods without any break. All their meals would be delivered into the DHSC offices. We were working in excess of 90-100 hours per week.

110. I would like to also record my thanks for the support I received from my constituency office at Bury St Edmunds during the period I was privileged to be the Member of Parliament for Bury St Edmunds, especially during the duration of the pandemic.

Statement of Truth

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

Signed: Personal Data

Dated: Tuesday 7th January 2025