Witness Name: Sir Sajid Javid

Statement No: 5

Exhibits:SJ5/1-19

Dated: 31 January 2025

UK COVID-19 INQUIRY

DEPARTMENT OF HEALTH AND SOCIAL CARE

Module 5: Witness Statement of the Right Honourable Sir Sajid Javid

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I, Sir Sajid Javid, 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 30 September 2024.

2. This statement covers the period set out below. 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 by Mr Jonathan Marron where appropriate and necessary (referred to as Corporate-A, Corporate-B, and Corporate-C).

3. I have already made several witness statements in this inquiry –

   (i) Module 2 Witness Statement in respect of Core UK Decision Making and political governance **(INQ000302485)**;

   (ii) Module 4 Witness statement in respect of vaccines and therapeutics **(INQ000474381)** and;

   (iii) Module 3 Witness Statement in respect of Impact of COVID-19 Pandemic **(INQ000485736)**.

I exhibit those to this witness statement for assistance.

Producing this Statement

4. In preparing this statement, I have considered the Rule 9 request from the Inquiry and will focus on the matters relevant to this module and set out in the request.

5. The period referred to in the Request is from 1 January 2020 to 28 June 2022 and asks for evidence relating to my role as Secretary of State for Health and Social Care ("SoS"). As I was appointed to that role on 26 June 2021, I have focussed on the period from 26 June 2021 to 28 June 2022.

6. As can be imagined, as Secretary of State 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.

7. I can remember some events which took place during the relevant period, but I have had to rely largely on contemporaneous material from either my private office or from briefings and submissions to examine what decisions I made during this period.

8. 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.

9. As the inquiry will appreciate, the Department of Health holds a vast number of documents. To assist me in preparing this statement, the Department has

undertaken searches of internal databases in order to identify documents which may be relevant to the issues to which this witness statement relates.

10. 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.

11. 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.

Key Figures and Decision Makers

12. The "key figures and decision makers” in the department are set out in the Corporate - A witness statement of Mr Marron.

13. My Module 2 statement, at paragraphs 60-74, sets out the ‘rhythm’ of meetings and how decisions were made.

“Meetings during my time as Secretary of State

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

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

department and in discussions with No10 and other departments, and they assisted me in making difficult trade-off judgments that reflected the bigger picture

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

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

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

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

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

67. Before I announced key decisions on vaccination policy, I would speak with the Shadow Secretary of State for Health (during my time Jonathan Ashworth MP and Wes Streeting MP) to set out the decision I had taken and why, and to ask for their support. They did, in all cases, agree with the decisions I had taken and would support the government in respect of vaccination measures relating to Covid 19. I considered my

relationship with them to be constructive and that their support for the vaccination measures we had to take was helpful both for public confidence and to ensure cross party support. When it came to vaccination policy, Her Majesty's Opposition rightly put the national interest first.

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

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

Advice from the CMO and other scientific advisory groups

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

the phone. He would also solicit different views so that I had a rounded view of the decision to be made.

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

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

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

74. JCVI is a statutory advisory committee.4 It has existed since the 1960s and its role is to advise the Secretary of State for Health on the provision of immunisation and vaccination, and to provide statutory advice to the Department both in England and Wales. Appointments to this committee are public appointments. Their terms of reference are to advise about the need for such immunisation, vaccine safety, and the cost effectiveness of vaccines, and how to implement the vaccinations, but also to advise on knowledge gaps relating to immunisation where further research or surveillance is required. During my period in office, I considered that I would follow

their recommendations, as otherwise that would undermine public confidence in the system of advice, and because it was clear that they had significant expertise in respect of this subject. The JCVI wrote to me about their views on vaccination on a number of occasions [SJ/39: INQ000309438; SJ/40: INQ000066868 5J/41: IN0000309439; 5J/44: INQ000309502]."

BACKGROUND

Positions Held

14. 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.

15. 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:

"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."

16. My parliamentary career is summarised here **(SJ5/1- INQ000479876)**.

17. At the very start of the pandemic, I was Chancellor of the Exchequer (until 15 February 2020). As I set out in my statement for Module 2 at paragraph 16:

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

18. Once I resigned, 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.

19. 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.

20. On 26 June 2021, I was appointed as Secretary of State for Health and Social Care ("SoS") following the resignation of Matt Hancock. I resigned from this role on 5 July

2022. I spent some time as a backbench MP, but I stood down at the 2024 General Election.

KEY DECISIONS

21. To provide some context, whilst Chancellor, I was concerned prior to my resignation about the risk to supply chain from China (albeit not specifically in relation to PPE) as set out in my Module 2 Statement at Paragraph 19:

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

22. I resigned shortly after this and was then a backbench MP until appointed SoS in June 2021.

23. Whilst I was SOS, I did not have a lot of involvement in decisions about PPE or procurement more generally. The minister responsible for PPE on a day-to-day basis was Edward Argar (at the time Minister of State for Health). He would have handled most of the meetings dealing with this matter. I agree with the evidence in Part A of the Corporate Statement of Jonathan Marron ("Corporate A"):

"…while ministers who were in post during this period (see sections xx to xx) were involved in approving strategy and policy, they did not take decisions on individual contracts nor on the purchase of PPE. Procurement decisions were made by the responsible Accounting Officers (AOs)…" (Corporate A para 12)

The Department ensures its activities are informed by the guidance set by the relevant bodies; this includes any decisions on procurement of PPE and what type of products to contract. During the pandemic, the guidance was updated a number of times, reflecting the pace of emerging evidence and the epidemiological situation, and impacting on the urgency to procure particular products…" (para 88)

24. Also, as I set out in my Module 3 statement at paragraph 120:

"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."

25. When I took over as SoS, the PPE programme had already been restructured beginning in August 2020, moving from the parallel supply chain that evolved to respond to the health emergency, into several core teams that would deliver the objectives of the PPE Strategy. The timeline of these developments is detailed in Corporate Statements A - C.

26. The Department was already aware of the likelihood of excess stock and had been since at least October 2020 (Corporate - C, para 85). Options were being explored to cancel or curtail contracts (Corporate - C para 98). Efforts were already agreed to reduce excess stock through sales, donations and disposals (Corporate - C para 87). I cannot comment further as I was not in post at the Department until June 2021.

27. A submission dated 28/7/2021 sets out the position around the time I took over as SoS **(SJ5/2 - INQ000534966).** This submission confirmed in summary that:

    - the Department had "*completed a procurement to secure almost 32 billion units of PPE, at a cost of £13.5 bn. This has given us a proven, resilient ongoing supply of PPE, including a healthy stockpile of all COVID-critical PPE to ensure we can continue to provide an uninterrupted supply. We are able to provide free PPE to all health and care providers until the end of March 2022.*

- The Department had *"established a resilient UK-based supply chain for all items of COVID-19 critical PPE, excluding gloves. We have signed contracts with 31 UK-based companies to manufacture around 3.9 billion items of PPE, with ongoing work to support these companies to innovate and adapt to needs in the UK market."*

- *"However, we have at least 6.9bn items of excess stock, over and above what we need to meet demand for the rest of this financial year and the next and to maintain a generous safety stock. This excess stock is incurring storage costs in the region of at least £120m a year and this will increase as stock expires, at which point it will need to be written-off and disposed of, incurring further significant costs."*

- *"The PPE programme will be transitioning back into the NHS Supply Chain between October 2021 and March 2022."*

Chronology of Key Decisions

28. By July 2021, I had agreed that we should seek to publish the list of the successful suppliers who were managed through the High Priority Lane, as well as their referrers into the lane. I received a submission on 13 July 2021 **(SJ5/3 - INQ000534969)** on the issue of publication. It was recommended in that submission - and I agreed - to pursue a "maximalist publication", where the Department would publish information on the different Buy Streams (such as Make and China Buy) alongside the HPL suppliers, their named referrers and suppliers to provide context.

29. This was not my decision alone because the procurement process was being run by the Cabinet Office and therefore their approval was required. On 15 July 2021 my team received an email on behalf of Michael Gove agreeing with my recommendation to pursue the "maximalist" approach **(SJ5/4 - INQ000534970)**.

30. My private secretary Oscar Baker replied on 16 July 2021 confirming my agreement to this approach **(SJ5/5 - INQ000534971)**. This email made clear my view that we should "*move forward with this very soon… aim for publication by the end of the month, rather than before recess*." I agreed with Michael Gove's suggestion of a meeting between representatives from both departments to discuss next steps.

31. This took place on 29 July 2021, where it was agreed that the maximalist approach should be pursued, with an aim to publish the list by the end of August, to allow for time to engage ministers further and ensure the accuracy of published information **(SJ5/6 - INQ000534972)**.

32. By 8 September 2021, the information was ready to publish **(SJ5/7 - INQ000534963).** A further submission dated 16 November 2021 **(SJ5/8 - INQ000534975)** confirms the plan to publish the information ahead of the 22 November deadline imposed by the Information Commissioner. Those details were published on 17 November 2021 (as confirmed in Corporate - B at paragraph 251).

33. On 28 July 2021 I received a submission setting out the overall position in relation to PPE and seeking my steer on several issues. This is exhibited as **(SJ5/2 - INQ000534966)**. In summary, it confirmed that:

    a. The department had secured almost 32 billion items of PPE at a cost of £13.5bn. However, we had at least 6.9Bn items of excess stock. This was incurring storage costs in the region of at least £120m a year and this will increase as stock expires, at which point it will need to be written-off and disposed of, incurring further significant costs.

    b. The Department had developed a distribution network and a UK-based supply chain.

    c. 78% of products had been cleared for release into the system. DNS (do not supply) was running at 6.8%, of which 0.84% was not fit for any use.

    d. The PPE programme would be transitioning back into the NHS supply chain between October 2021 and March 2022.

    e. The department was planning to publish a strategy on future PPE supply in the Autumn.

    f. HMT's assumption is that there will not be further funding for COVID-PPE. Details on PPE finances are contained at Annex A.

34. Annex B **(SJ5/2 - INQ000534966)** covered UK PPE manufacturing, confirming that:

a. at that time, the Department had signed contracts with over 30 UK-based companies for 3.9 billion units of PPE, 2.5 billion of which have been successfully delivered.

b. In December 2020, DHSC's UK Make team established the Innovation Hub which facilitates two-way communication between manufacturers, end users and clinicians, with the aim of transitioning to more reusable and sustainable PPE products on the frontline.

c. In the first half of 2021, a transparent face mask working group was set up.

d. Efforts to increase sustainability were underway. The department was exploring the use of reusable Type IIR masks in acute settings, using existing laundry services to reduce the need for single use products. As well as introducing these new products, we have been exploring ways to sustainably dispose of PPE as part of our zero to landfill programme of recycling.

35. The submission **(SJ5/2 - INQ000534966)** set out the following proposed approach to UK make, to which I was asked to agree:

"*continue to ensure UK manufacturing is in a good place to meet these conditions, which will allow us to sustain a mix of resilient domestic and international suppliers. We are working collaboratively with other government departments to outline and strategically align these conditions with wider government aims, and to understand what wider support we can offer UK manufacturers to enable them to competitively meet these conditions.*"

36. I cannot specifically remember my response to this submission. However, believe that I would have agreed with that proposal.

37. Annexe C **(SJ5/2 - INQ000534966)** dealt with excess stock and storage and confirmed that:

a. Excess stock was calculated at 6.9bn items. "*Based on our very cautious assumptions of continuing demand in these categories over 21-22 and 22-23, this will leave us with 4.9bn items*".

b. "*The PPE network in the UK is currently storing 1.3m pallets of PPE. This costs DHSC in the region of £300m per year in operational costs (mainly storage) of*

which £120m is attributable to excess stock. At current pandemic usage, we estimate that £3.8bn of stock (603k pallets) will expire before it can be used."

38. The submission set out the steps being taken to dispose of excess stock including sales to the private sector, buyback, sales to other governments, and donations via FCDO. Work was also being undertaken to extend expiry dates, to reduce disposals.

39. The submission **(SJ5/2 - INQ000534966)** noted that:

"*To date our focus has been on stock which is not fit for any use. The main disposal approach has been through recycling with the rest disposed through a process which generates electricity and/or heat from waste where recycling is not an environmentally sound option.*"

40. The submission recommended continuing to push the sales and donations route, as well as optimising stock use and extending shelf life. As confirmed by Corporate - C at paragraph 87, I agreed to continue the efforts to reduce excess stock through sales, donations and disposals.

41. Annex D **(SJ5/2 - INQ000534966)** dealt with future supply to non-acute services (e.g. General Practice and the care sector). A new portal was in the process of being developed to continue the supply of PPE. There was discussion about moving to charging for PPE supply to non-acute services from 1 April 2022, which would require funding to the sector. The submission therefore recommended exploring a potential extension of free PPE in some PPE categories where we have excess stock if COVID-19 PPE is still required. I do not specifically remember my response to this submission, but I believe it likely that I would have agreed to that proposal.

42. The submission discussed "future supply options" from (a) a return to pre-COVID supply routes to (f) continuing with the portal through which NHS Supply Chain sells and distributes directly to health and care providers. Option (a) was not recommended. Options (e) and (f) (continuing the portal after the provision of free PPE) would maintain the infrastructure needed to support the sector but could increase NHS Supply Chain's market share compared to pre-COVID-19.

43. The submission noted that more work was needed to understand the impact of these options and come to a recommendation.

44. On or around 28 July 2021 I received a submission **(SJ5/9 - INQ000534961)**, about a contract with a supplier, for 3M N95 face masks, which had been terminated.

I was provided with legal advice in that submission, which I cannot share as it is subject to legal professional privilege **(SJ5/10 - INQ000534965).**

45. On 13 August 2021 I received a submission on "*COVID-19 response SR [Spending Review] strategy and costings*" **(SJ5/11 - INQ000534973).** This followed on from work I had commissioned to inform funding negotiations with HMT and No.10 on the options for the departmental COVID-19 response over the next three years from March 2022. The assessment from the CMO on the likely course of the pandemic had been received on 5 August 2021. Based on the CMO narrative and in view of the uncertainty, the department made certain assumptions for policy teams to plan against (paragraph 5) and set out various policy options.

46. Much of this work was outside the scope of this Module. In relation to PPE and procurement the submission noted that, for all 3 scenarios, there was sufficient stock of PPE, save for gloves. The submission set out costs to consider including for gloves, warehousing and distribution, and the expansion of FFP3 fit testing. It was noted that novel antivirals were expected to be licensed, following clinical trials.

47. This submission noted that further work was required on the detail, risks, and benefits of the various policy options and that the forthcoming spending review would impact on what would be affordable for the department.

48. As I outlined in my Module 2 witness statement, this spending review took place at the end of 2021, because health was the largest part of spending in this review, one of my roles upon taking office in the department was to finalise this in discussions with the Chancellor and Prime Minister. None of us could have special advisers in these meetings. The Prime Minister's Chief of Staff would attend, and someone from the Cabinet Office to take minutes.

49. As I stated at paragraphs 53-54 of that statement:

"*53. The money that the Treasury wanted to provide to the Department was significantly less than I, and the Department, considered justifiable to meet objectives. As part of the negotiations, the Permanent Secretary wrote to the Treasury to identify the concerns that the Department had with this spending review. From the DHSC's perspective, the health service had been stretched prior to the start of the pandemic, and the settlement proposed by the Treasury would not assist with the additional costs required to tackle the large waiting lists, to invest in the*

workforce on a longer-term basis and to invest in technology and diagnostics for the future. There was no dispute over the money needed to respond to Covid 19, but there was dispute over long term funding. This was also a period of time when the Prime Minister had made a pledge about the reform of social care by the introduction of a cap on the costs of such care and that also had to be funded. I was particularly concerned that the Treasury had not allocated any contingency for greater funding in case the unpredictable nature of Covid required more than was anticipated."

54. "I knew that the settlement that the Treasury wanted to provide meant that I would have to find savings in the NHS budget, and I wanted to be sure that the Prime Minister and No. 10 would recognise that this was the case and be prepared to stand by and indicate that this was a collective decision. In the summer of 2021, I was concerned that the Prime Minister was seeking to avoid responsibility for the cuts that would be inevitable by stating to me that it was "up to me what was to be cut". I knew that the settlement which the Treasury wanted to impose would mean that we would have to cut things like tobacco cessation programmes, sports programmes to encourage activity agreed with the Department for Education, and to delay decisions already taken in respect of health spending. I wanted to make sure that No. 10 would not then seek to backtrack and/or to disagree with those cuts at a later date, which would have led to the DHSC having an unbalanced budget [SJ/33: IN000309460; SJ/34: IN000309461; SJ/35: INQ000309459; SJ/36 INQ000309463; SJ/37: INQ000309521; SJ/38: INQ000309516J."

50. On 17 August 2021, I responded to a submission which had been received on 22 June 2021, prior to my appointment as SoS. The submission is exhibited as **(SJ5/12-INQ000534960)**. The submission advised that there was a need to procure new rubber gloves, given the ongoing 'burn rate' of 155m single gloves per week. It was noted that Malaysia was the location for the largest manufacturers, and that there were concerns about employment practices in the region, but that the tendering process was aligned with best practice on the issue, and that staff had worked with commercial lawyers to ensure due diligence was strengthened further.

51. The submission also advised that U.S. Customs and Border Protection (CBP) had information that one manufacturer, Top Glove, had been using forced labour practices in the production of gloves. The U.S> CBP issued an import ban on all disposable gloved originating in Top Glove factories and ordered the seizure of good produced by Top Glove. It was noted that the department had not purchased gloves

from Top Glove since June 2020, and held only a small stock of gloves from this manufacturer.

52. My private secretary set out my views on this issue in an email on 17 August 2021 **(SJ5/13 - INQ000534974).** This stated:

"*Secretary of State is clear that Top Glove are not to be used at all, unless and until satisfactory and comprehensive external audit is done and completed.*

In addition,

- *Ministers would appreciate an update on progress towards domestic production of gloves, given reliance on overseas manufacturers and the possibility of supply being cut off if multiple organisations are found to be failing to meet acceptable workforce standards.*

- *It was commented that assurances from colleagues should be given as to whether attempts to clawback payment will take place, if Top Glove are found to be in contravention of modern slavery standards*."

53. On 19 August 2021 I received a submission on freight contracts **(SJ5/14 - INQ000534962)**. This advised that the department had undertaken an open procurement to put in place 'zero commitment' contracts for international freight services as part of ongoing Covid response arrangements. I do not specifically remember how I responded to this submission, but I believe I would have agreed to the proposal.

54. On 15 September 2021, I received a submission **(SJ5/15 - INQ000534964),** proposing a consultation on extending the provision of free PPE to the health and care sector beyond its current end date of 31st March 2023 **(SJ5/16 - INQ000534967)**. This would have been a large financial outlay which I remember agreeing to.

55. On 7 February 2022, officials requested that I approve accelerating disposal activity through recycling and generation of energy from waste (as set out in corporate-C at paragraph 96) **(SJ5/17 - INQ000534968)**. On 28 February 2022 my private secretary, Dylan Kirkland, emailed Rhonna Spindley, who was working on PPE Policy and Strategy at DHSC, to confirm my overall approval for officials to expand work on disposals and engage with lead waste partners to assess disposal options

(SJ5/18 - INQ000534976). I requested that an option was worked up to dispose of waste as quickly as possible with a strong preference for recycling, that the Minister of State for Health should assess the best, lowest cost plan, and that I would have a meeting that week to discuss further. This meeting took place on 14 March 2022, where I requested that all recyclable stock should be disposed through recycling, and the remaining stock should be disposed through Energy from Waste (EfW) at the greatest rate possible **(SJ5/19 - INQ000534977)**.

56. On 31 March 2022 operational management of PPE supply and distribution returned to the control of SCCL from the Department.

57. I am aware that the inquiry is interested in the use of WhatsApp in government. As I confirmed in my Module 2 statement at paragraph 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."

58. In any case, I can confirm that a search has been undertaken by the Department of my WhatsApp messages from this time and nothing of relevance to this module has been identified. Throughout my time as SoS, health inequality was a priority for me. In 2022, commissioned a major review of health inequality. As set out in my statement for Module 2 at paragraph 85:

"85. Some other steps I took whilst I was Health Secretary was to commission a review about inequalities in respect of the efficacy of medical equipment on the grounds of race, which was chaired by Professor Dame Margaret Whitehead …

This consultation ran between August 2022 and October 2022, and I understand the panel of the independent review were to provide advice to the government by June 2023.6 I had read that pulse oximeters gave incorrect readings on darker skin and asked about why this was the case. I found out that this was because such oximeters

were tested upon white skin because they are seen as the biggest global market by the manufacturers of such equipment. I talked about this publicly, which helped to raise awareness of these issues within the NHS. The main policy proposal that I thought of to tackle this was that if the US and the UK – who are the two biggest purchasers of medical equipment in the world insisted that it would only purchase products which had been tested in all races, then global manufacturers would do so. I discussed these matters with my US counterpart, but it did not come to fruition because I resigned as Health Secretary. I still consider that the UK should consider making this a requirement of procurement of medical equipment."

59. This was the first study in the whole world that addressed this. By the time this review was received I was no longer in office. I also commissioned a major White Paper on health disparities and upon reducing inequality in health outcomes between geographic areas (further detail is in my Module 3 statement at para 55-65).

"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'. 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. 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.

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 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, 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."

60. I have previously mentioned to this Inquiry some of the other steps I took while in office to address health inequalities (Module 3 statement, paragraph 52-69):

"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-INQ00000000), (SJ/16-INQ0000000000). 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 at the G7 in June 2021 to establish a twinning arrangement 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 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.

[…]

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."*

[…]

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 UK 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."

61. I also set out in my module 4 statement, at paragraph 156:

"*For those within the South Asian community, I was able to use myself as an example, and I felt that my background was helpful in enabling me to communicate with a community I felt I understood. I spoke in mosques and talked to the Muslim community about the importance of vaccinations, particularly given that some vaccinations do have a porcine content. The concern about porcine content was also explained to the Jewish community who had the same concerns."*

62. Additional steps were taken by the department are set out in Corporate-C at paragraphs 71- 74. In relation to PPE specifically, by the time I was appointed, the decisions about what would be procured and how had already been made.

63. I do not recall taking any decisions in relation to making use of reusable PPE as opposed to single use PPE.

64. The cause of the excess stock was not something I personally investigated. The relevant decisions related to PPE procurement predated my time as SoS. By the time I was appointed SoS, the National Audit Office had produced a report on the matter in November 2020. The Public Accounts Committee heard evidence on the issue in June 2021 and a further investigation was undertaken by the National Audit Office from August 2021.

65. However, my personal view is that excess PPE stock was an inevitable consequence of my predecessors pursuing a rational response to an unprecedented health crisis. At the start of the pandemic, we had no idea how bad the virus would be, and initial estimates suggested vaccines could take 5-6 years to develop. Given this

uncertainty, and the disastrous consequences for the country had we run out of PPE, the obvious thing to do was to buy as much PPE as possible at whatever price we could to insure ourselves for a worst-case scenario. Indeed, if one looks at how global PPE use grew exponentially during the pandemic, it stands to reason that had we not developed and deployed the vaccine as quickly as we did, we actually might have run out of PPE.

66. This approach may have involved paying what may seem a lot of money, but it is important to remember the context: Everyone across the globe was suddenly scrambling for PPE and, as a result, prices were skyrocketing. There simply was no option to procure PPE at pre-pandemic prices, and so my predecessors took the rational approach of paying whatever price was necessary, procure from wherever they could, and hope that they had overbought rather than underbought. There was no impropriety or self-enrichment: Just public officials making the choices they had to make, to keep the country safe.

67. If I had been in office at the time I would have pursued broadly the same approach. I liken it to the approach we took with the vaccine, where we contracted with 10-12 companies who were developing vaccines, knowing that whilst many of them would not succeed, if one of them did, we would be in a strong position. We 'lost' tens of millions of pounds doing this, but most of the country would agree that this expense was necessary to give us the best chance of delivering a successful mass-vaccination programme.

68. I do not recall having any involvement in decision-making around replenishment and management of the PPE stockpile after stockpile items had been distributed in the early stages of the pandemic.

69. I do not recall any work undertaken by or on behalf of DHSC to deal specifically with recouping costs of contracts for PPE that was no longer required and to dispose of excess PPE. I believe that this would have been under the remit of the Cabinet Office.

CONFLICTS OF INTEREST

70. I was not directly involved in any processes or procedures to ensure an effective system of managing conflicts of interest with respect to the procurement of key healthcare equipment and supplies during the pandemic.

71. I am not aware of any company receiving preferential treatment in accessing the system for procurement or Award of Contracts as a result of their status as a donor of or with a connection to the Conservative Party.

LESSONS LEARNED

72. I did not produce or commission any internal or external reviews, lessons learned exercises or similar related to any of the issues in the Scope for Module 5 since January 2020. I have not been involved or consulted as a part of any such reviews.

73. As I mentioned at paragraphs 69-70 of this statement, my personal view is that the procurement strategy taken by the government before my appointment as Health Secretary was largely the right one. I would advise this Inquiry to remember the critical situation that we faced at the outbreak of the pandemic and judge the reasonableness of actions taken in that context. I believe that it would be seriously problematic for future pandemic planning if it were to be decided that, because some PPE was eventually thrown away, it was wrong to spend what we did on the quantities of PPE that we did.

74. I would add to this to say that we do not know what the next pandemic is going to be, only that there will certainly be one. Therefore, there is no real benefit in stockpiling supplies that we do not even know that we will need. Instead, we need to put in place a plan for how we will deal with the issues that arise in all pandemics, including the method of procurement of vital supplies.

75. Future governments need to think about how to enact massively expedited decision-making in a crisis and put the system in place now to enable that. As Health Secretary, I was fighting for increased spending on preparedness, particularly around vaccines and antivirals. Elements of this approach are relevant to procurement of PPE.

76. I would add that, throughout my time as SOS, and as outlined above, I was in favour of full transparency around procurement of PPE. However, there have to be some limitations to this, because the private sector, and government, need some degree of commercial confidentiality when negotiating contracts.

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: 31 January 2025