Witness Name: Simon Laurence Stevens

Statement No: 2

Exhibits: [SLS2/ 001- SLS2/027]

Dated: 9 June 2025

UK COVID-19 INQUIRY

SECOND WITNESS STATEMENT OF SIMON STEVENS

I, SIMON LAURENCE STEVENS, Lord Stevens of Birmingham, House of Lords, London SW1A 0PW, will say as follows:

Introduction

1. I joined the NHS in 1988 and later worked at the Department of Health and 10 Downing Street, as well as in a number of other countries internationally. I was Chief Executive of NHS England from 1 April 2014 to 31 July 2021, retiring from the NHS four years ago.

2. This statement is in response to the UK Covid-19 Inquiry's Module 6 Rule 9 request to me dated 6 February 2025, focused on specific aspects of hospital capacity in Spring 2020. It does not duplicate the extensive factual material provided in NHS England's Module 6 Corporate Witness Statement from Dr Amanda Doyle. Nor does it repeat wider points and lessons identified contained in my first written statement of 22 September 2023 **[SLS2/001 INQ000280647]**.

3. This statement relates specifically to England – not the decisions and judgements made independently in Scotland, Wales and Northern Ireland, similar though they were on many of the key issues discussed in this statement.

4. As set out in more detail in Dr Doyle's statement, specific measures for England were discussed and finalised in multiple forums with Government during Spring 2020. I was in attendance at some but not all of those. There is also extensive contemporaneous email and other correspondence relating to issues being considered in Module 6 - including Ministerial and officials' discussions - that I have

only now seen by virtue of the Inquiry having made them publicly available. There were also occasional phone calls with senior decision makers, including the Secretary of State for Health and Social Care, but these were not in place of, and did not cut across, the documented official and Ministerial meetings in which hospital and social care capacity was discussed. I can confirm that it is in these meetings that the main issues were debated and decisions made, rather than in any phone call or WhatsApp to which I was a party.

5. Below, as requested by the Inquiry, I therefore draw out key milestones in the chronology as far as I am aware of them. Given that the Inquiry has also asked questions relating to NHS England's involvement more generally, at times I have also referred to documents showing the process of decision-making even when I was not personally in attendance at the meeting in question.

Hospital capacity and action to reduce discharge delays - chronology

6. The Inquiry has asked about the genesis of action to free-up hospital capacity and reduce delayed discharges in Spring 2020.

7. As former NHS Chief Executive Amanda Pritchard noted when giving evidence to the Inquiry in Module 3, the key change to facilitate reduced discharge delays came in March 2020 when the Government suspended Continuing Healthcare Assessments and HM Treasury began providing public funding for the first part of someone's post-acute care regardless of eligibility.

8. This was not a novel proposal. As Public Health England's Dame Jenny Harries observed in her Module 3 witness statement, *"discharges were an anticipated part of pandemic planning*." **[SLS2/002 INQ000489907_0016, paragraph 5.10].** Reduced delays in hospital discharges were specifically envisaged in the Pandemic Flu Bill, drafted as a product of the Cygnus exercise held in 2016.[1] Clause 3 deals with NHS Continuing Healthcare (CHC) assessments, relieving bodies of their duties to comply with selected parts of the Regulations and Directions governing NHS CHC assessments and delayed discharges provisions. There were also provisions in Clause 4, temporarily removing various duties on local authorities when carrying out needs assessments and developing care and support plans. A draft report from DHSC on the Pandemic Flu Bill, dated 16 December 2019, addressed the topic of

[1] See for example the draft Bill dated 8 August 2019 [**INQ000057455**].

increasing hospital capacity (p11) and then at page 14 explained the clauses just referred to:

> *"These provisions are intended to make it easier to discharge patients from hospital during a pandemic. They make two changes to the usual discharge procedure for those with a social care need from an acute hospital setting. Firstly, allowing NHS providers to delay undertaking the assessment process for NHS continuing healthcare...until after the emergency has ended. Secondly, allowing local authorities to prepare a care and support plan for the patient whilst they are in hospital, without the involvement of the patient, carers, family etc., until after the emergency has ended. This will in turn both support the patient as they will be in a more appropriate setting and ensure that acute care resources are used in the most efficient way during a time of hugely increased demand."* **[SLS2/003 INQ000184060].**

9. DHSC will be best able to explain the process by which in early 2020 they redrafted the Pandemic Flu Bill to become the Coronavirus Bill. While I was not personally involved in this work, I understand that material made available to the Inquiry in Module 2 shows a timetable for circulation and consultation described on 18 February 2020 **[SLS2/004 INQ000049391]** and a Ministerial submission to the Health and Social Care Secretary dated 24 February 2020 **[SLS2/005 INQ000109105]** which refers to the 'approved clauses' that had been discussed and approved by Mr Hancock on 7 February 2020. The summary of the approved clauses includes: "*Discharge: There are provisions which allow NHS hospitals/Trusts and local authorities to discharge patients early to free up hospital space for those who are ill*." (p2).

10. This suggests that Covid-related preparatory work to enable hospital discharges to be accelerated was being led from DHSC from at least early February 2020, with Ministerial oversight from the Secretary of State for Health and Social Care. So while the Government's Coronavirus Action Plan dated 3 March 2020 was perhaps the first public announcement of the hospital discharge plan, policy underpinning it had

clearly been worked up within the Department of Health and Social Care ("**DHSC**") for some time before that.[2]

11. The Government's subsequent Coronavirus Act 2020 ("**the Coronavirus Act**") introduced in March 2020 provided, amongst other measures, for the suspension of CHC assessment to further the objectives of expediting safe discharges of patients from acute hospital beds, reducing the CHC assessment burden, and releasing clinical and support staff to support the system to manage the Covid-19 outbreak. The explanatory notes to the Coronavirus Act explain that:

> *Currently, patients with social care needs go through a number of stages before they are discharged from hospital. For some patients, one of these stages is a CHC assessment, a process that can take a number of weeks. The Bill will allow the procedure for discharge from an acute hospital setting for those with a social care need to be simplified.*

12. At the same time, NHS England had also begun taking steps to prepare for increased demand for NHS services and increase capacity from early February 2020, including the collation and consideration of data and early modelling based on SPI-M-O's Reasonable Worst Case Scenario (RWCS).

13. As set out in more detail in the First Witness Statement of Professor Powis **[SLS2/006 INQ000116811]**, on 7 February 2020 NHS England's Incident Management Team produced an initial analysis of the ability of the NHS in England to free up beds if elective treatment was stopped except for urgent emergency care and cancer treatment services. The initial analysis estimated that out of circa 100,000 general and acute hospital beds, there were between 12,000 and 13,000 beds occupied by non-cancer / non-urgent elective patients, most of which could potentially be freed for emergency Covid patients.

14. I note that on 20 February 2020, SAGE met and considered estimates based on SPI-M-O RWCS for Flu Pandemic **[SLS2/007 INQ000087502]**. The next day – 21 February 2020 – NHS England's Two Steps Ahead Group noted an action to follow up with DHSC/Government (as subsequently happened) given that this initial modelling suggested that, even with continued mitigation work, the NHS would be

[2] Ms Pritchard's Second Statement for Module 3 [**INQ000409251**] notes that NHS England was provided with an overview of the proposed Bill on 6 March 2020, although by the time NHS England had the chance formally to comment the content of the Bill had been finalised.

overwhelmed well before the peak without significant offsetting interventions.

15. While I never attended SAGE, Professor Powis was invited to do so from late February 2020. At their 25 February meeting it was agreed that SAGE's SPI-M-O modellers should meet with the DHSC's Deputy CMO and NHS England. A modelling workshop co-chaired by DHSC's Deputy Chief Medical Officer and NHS England's National Medical Director (which I did not attend) was held on 1 March 2020. The workshop modelled the RWCS against various mitigations. I understand that modelling in that meeting indicated a RWCS for Wave 1 could mean that the NHS would need up to a million beds at the peak, and there could be 500,000 deaths cumulatively throughout the wave, without mitigation to reduce case numbers. I understand that analysis in that workshop also sought to quantify the effect of potential measures to free-up hospital beds currently occupied as a result of delayed transfers of care.

16. In light of the worsening situation in Italy and elsewhere, the COBR meeting of 26 February 2020 (which I attended) discussed HMG preparedness including progressing Covid-19 legislation, updating formal pandemic influenza plans, and public communications.

17. On 2 March 2020 I attended another COBR meeting. The minutes of that meeting record that it discussed that the NHS would be severely disrupted by the outbreak, and that modelling for the potential hospital bed requirements was underway **[SLS2/008 INQ000056217]**. COBR agreed as part of its RWCS planning to bring forward emergency legislation, led by the DHSC, including to facilitate hospital discharge.

18. The next day, 3 March 2020, the Government published its Coronavirus Action Plan **[SLS2/009 INQ000057508]**. Similar to SPI-M and SAGE's use of a flu pandemic as the basis for their initial scenarios, the Government's Plan said that: "*…contingency plans developed for pandemic influenza, and lessons learned from previous outbreaks, provide a useful starting point for the development of an effective response plan to COVID-19. That plan has been adapted, however, to take account of differences between the two diseases*." In respect of NHS capacity, the Government's Coronavirus Action Plan envisaged that: "*when necessary, the provision of care may move from specialist units into general facilities in hospitals*",

and "*health and social care services will work together to support early discharge from hospital, and to look after people in their own homes*".[3]

19. Expert advice then evolved rapidly in the first fortnight of March 2020, predicting that the pandemic was about to impact the UK sooner and harder than they previously anticipated, overwhelming hospitals and critical care many times over. Indeed at that very moment that tragic reality was coming to pass in China and northern Italy **[SLS2/010 INQ000283176].**

20. On 4 March 2020, at COBR(M) Ministers decided that Government should engage with trusted parties and operational stakeholders on the proposed contents of the Coronavirus Act on a confidential basis to ensure the effective implementation of the Bill's powers **[SLS2/011 INQ000056218_0011]**.

21. A number of further significant meetings took place in the week beginning Monday 9 March 2020. That Monday I attended a COBR meeting where the Prime Minister expressed his gratitude to the NHS for "*responding effectively and at pace to the increasing challenge of coronavirus*". The minutes also record that, among other things, there was discussion on whether a Covid-19 specific team or unit would be needed in every hospital, and that further consideration was required on scaling up hospital capacity. The meeting also covered the potential impacts that full household isolation could have on the social care sector.

22. On 11 March 2020 I attended a COBR meeting **[SLS2/012 INQ000056220]**, where COBR considered the Coronavirus Bill prior to its intended introduction in the House of Commons the following week. Ministers approved the measures in the Bill, including those to free up hospital capacity by the legislative action to support "*Early discharge of patients from NHS hospitals/trusts and local authorities to free up hospital space for those who are ill.*"[4] The minutes of that meeting further record that in the context of NHS RWCS planning I noted that under that scenario services would be under extreme pressure, and amongst other measures elective surgery

---

[3] As is clear from the above chronology, significant work had been undertaken in the course of the previous weeks in DHSC, SAGE, SPI-M-O and NHS England analytical teams amongst others to understand the number of hospital beds that could be freed up by various policies, including temporarily deferring non-urgent admissions and reducing delayed discharges. In that context, and five years on, obviously I cannot state with certainty when this work was first discussed with me or by whom.

[4] See the Briefing Paper on the Coronavirus Bill dated 11 March 2020 [**INQ000056208**] and the list of measures at p10 – 11. The paper records the agreement to engage with stakeholders on a confidential basis reached on 4 March and continues: *"This engagement will be necessary to ensure the operationalisation of the Bill's powers. As a next step, officials are looking to engage on details of the Bill with operational organisations (e.g. relevant charities) now, in confidence and on a need-to-know basis."* (p4).

would need to be postponed. (The minutes mistakenly suggest this could release 30,000 beds, when that figure was the result anticipated from a number of steps; a similar noting error is identified below in relation to Cabinet minutes of 17 March 2020).

23. There was also a specific social care meeting (at which I was not present) chaired by the Secretary of State for Health and Social Care, Mr Hancock, at DHSC on 11 March 2020 which considered hospital discharges and care home support in detail. Notes of that meeting record that it considered a range of issues including hospital discharge mechanisms and the interface with social care providers, CHC easements, paying social care staff to self-isolate, social care guidance, and the "*importance of engagement with the* [social care] *sector*". **[SLS2/013 INQ000328131]**

24. More generally, throughout this period the DHSC had lead responsibility for social care support, and for considering the balance of risk and harm reduction across the English health and social care sectors holistically. Ministers and officials from the DHSC and the Ministry of Housing, Communities and Local Government rightly lead on consideration of the impact on social care and social care resilience, as well as sectoral involvement or consultation.[5] As far as I am aware, it was their decision on how and when to consult with and include social care stakeholders. In addition, as discussed in some detail in section 4 of Dr Amanda Doyle's statement, throughout the month of March 2020 NHS England staff also had extensive engagement with adult social care representatives.

25. Later on 11 March 2020 in a statement to the House of Commons, Mr Hancock was then asked about accelerating hospital discharges to social care and he stated: "*It is critical that we ensure that discharges are as fast as possible. That is important in normal times, but when large proportions of those in hospital could, with the right support, leave hospital and be in a setting that works for them in social care, we have to make sure that that happens*" **[SLS2/014 INQ000283169]**.

26. To that end, also on 11 March 2020, the Chancellor Mr Sunak presented his Budget in which he committed additional resources for the NHS and social care which were used to fund this enhanced discharge from hospital.

[5] See for example the readout from the meeting of 12 March 2020 [**INQ00087307**], which referred to the need to work up any social care proposal with MHCLG and HMT, including an analysis of the funding situation, and the need for "*a further meeting on social care soon, including the resilience of the provider market given the pressures expected.*"

27. On 12 March 2020 I attended a further COBR chaired by the Prime Minister with the Chancellor and other senior ministers **[SLS2/015 INQ000056221]**. That meeting focused primarily on interventions to reduce the spread of the Covid-19.

28. Later on 12 March I further attended a separate meeting relating to NHS resilience at 10 Downing Street with the Prime Minister, Mr Hancock, other senior ministers and officials to agree the details of expanding NHS surge capacity, deferring non-urgent operations, reducing hospital delayed discharge, use of the independent sector, and government funding for social care providers **[SLS2/016 INQ000087304]**, **[SLS2/017 INQ000087307]**.[6]

29. Work continued the following week. After a COBR meeting chaired by the Prime Minister on Monday 16 March 2020 (which I did not attend) **[SLS2/018 INQ000056210]** and a Quad meeting with the Secretary of State for Health and Social Care and others, he announced in an oral statement to the House of Commons that these agreed measures to free up hospital capacity would be announced "*later today*" **[SLS2/019 INQ000283170]**. However, the notification to the NHS setting out those actions (which also requested that "emergency admissions, cancer treatment and other clinically urgent work should continue unaffected") was in fact deferred until the next day, 17 March 2020, when the full package was considered and approved by the Cabinet. By that stage, as the preceding chronology shows, it had been under discussion in various ministerial and official meetings for some weeks.

30. Minutes of the full Cabinet meeting on 17 March 2020 (at which I was not present) record that it discussed "*to free up hospital beds, over 30,000 patients [sic] were expected to leave hospital into social care imminently*" **[SLS2/020 INQ000056135]**. (In fact the 30,000 figure was an estimate of the total beds that might be freed from a wide range of actions, as against the estimated 15,000 or so beds attributable to

---

[6] I have been asked what I remember of conversations with Mr Hancock at around this time. Here I restate what I said in my first Witness Statement of September 2023. Paragraph 265 of Mr Hancock's Module 2 second witness statement suggests that it was in a phone call on the evening of 12 March 2020 that he in some way persuaded me of the need to scale-up NHS capacity. As I pointed out in my first Witness Statement at page 11, the chronology of multiple preceding ministerial meetings with him, and the fact that by then work was already under way on both facilities and workforce expansion, including use of clinically-qualified returners, health professions students and volunteers, shows this is not accurate. Furthermore, if paragraph 270 of Mr Hancock's second witness statement implies that it was in a call on 13 March 2020 when he first heard about and agreed measures to free-up beds, and that this had previously been discussed with the Prime Minister rather than him, the above chronology of formal minuted meetings shows that is also not correct. I have also been asked to comment on further conversation on Saturday 14 March about hospital capacity, including the London Nightingale. Amanda Pritchard's Second Statement (Module 3) outlines the chronology and work that was done on this concept, including approval of the London Nightingale on 23 March 2020 [**INQ000409251_0259 et seq**].

discharge delay reductions. I understand that the latter figure of 15,000 was a broad estimate based on the numbers of patients known to have delayed transfers of care plus a proportion of patients whose length of stay exceeded 21 days.) Cabinet minutes record the Prime Minister as supporting this action, noting that individuals occupying hospital beds who would otherwise be in social care should be supported to leave hospital. The Secretary of State for Health and Social Care confirmed the NHS was significantly increasing its capacity to respond to rising case numbers.

31. This was again discussed on 18 March 2020 at a meeting with the Prime Minister, the Secretary of State for Health and Social Care and senior Cabinet Office, Number 10, DHSC and Treasury officials **[SLS2/021 INQ000056123]**.[7] The minutes record as an Action: *"DHSC to take forward work on ensuring the maximum number of people possible should be discharged from hospital. DHSC to report back to the PM on a target date for when all excess stay patients will have been discharged from hospital. DHSC, MHCLG and HMT to agree final package on social care resilience, and ensure closest possible working between local authorities and the NHS across the country."*

32. The underlying briefing document at **[SLS2/022 INQ000056051]** sets out the detail of steps being taken to prepare the NHS and increase capacity, including action to reduce discharge delays. For those needing social care, the briefing said that emergency legislation before Parliament would ensure that eligibility assessments did not delay discharge. It mentioned new government funding to support these discharge packages and to support the supply and resilience of out-of-hospital care more broadly. Separately, the Secretary of State for Housing, Communities and Local Government had written to the Chancellor seeking an injection of funding to local government to support pressures more generally, including allocation for Adult Social Care. On 19 March 2020 the DHSC published multi-agency Hospital Discharge guidance **[SLS2/023 INQ000087450]**.

33. From 21 March 2020 onwards, I attended regular (often daily) meetings with the Prime Minister, Secretary of State for Health and Social Care, senior Cabinet officials and ministers, the Chief Medical Officer and the Government Chief Scientific Adviser.

[7] I have also been asked by the Inquiry whether the hospital discharge policy was discussed at the COBR meeting held on 18 March 2020 [**INQ000056211**]. I am advised that as recorded in the minutes the focus of that meeting seems to have been on school closures.

34. On 23 March 2020 I and other NHS England colleagues attended a further meeting with the Prime Minister, Chancellor and other senior ministers to review the situation, discussing amongst other items the creation of Nightingale hospitals designed and equipped as open-plan dormitory-style facilities for sedated / unconscious ventilated Covid-19 patients as a back-up to other efforts, in line with similar approaches internationally.

35. That same day the Secretary of State for Health and Social Care told Parliament that: "*The [Coronavirus] Bill also allows for an expansion of NHS critical care by allowing for rapid discharge from hospital where a patient is medically fit. NHS trusts will be permitted to delay continuing healthcare assessments, a process that can take weeks, until after the emergency has ended. The people who need this support will still receive NHS funding in the interim*" **[SLS2/024 INQ000283198].**

36. It was these Government legal changes to continuing care assessment processes and HM Treasury's allocated earmarked funding for social care support that enabled reductions in delayed discharges, since neither local authorities or NHS bodies had the statutory or funding authority to bring about these changes by themselves.

37. In respect of the Government's testing policy, a chronology is included in Dr Amanda Doyle's statement. It records that whilst the NHS National Medical Director was included in discussions on Covid-19 testing, throughout the pandemic testing policy was determined by DHSC on advice from PHE. NHS guidance issued during the relevant period in relation to Covid-19 testing sought to follow PHE advice and DHSC policy on Covid-19 testing prioritisation.

38. As set out in more detail in Dr Doyle's statement, as of 11 March 2020, DHSC/PHE identified that national testing capacity was limited to around 3,000 tests per day nationwide. In response to the anticipated wave of Covid-19 infections and hospitalisations PHE identified a prioritisation list for Covid-19 tests for periods when demand for diagnostic testing might exceed local laboratory capacity and a triaging of requests would be required. Given the limited national testing capacity at that point in time, the list recommended by PHE prioritised the use of testing capacity on the basis of clinical need. Accordingly, the list focused on case detection in symptomatic patients requiring critical care or hospital admission (Groups 1 and 2). Given the constrained testing capacity at that time, I understand that PHE's testing prioritisation was accepted by the CMO, DCMO, and senior clinicians and endorsed at a meeting with the SSHSC on 11 March 2020.

39. When the draft Hospital Discharge Guidance was considered by NHS England's National Incident Response Board ("**NIRB**") on 17 March 2020, NIRB recommended that further consideration be given to the application of the approach for care homes. Ultimately, however, for the reasons set out above, DHSC and PHE considered that testing capacity was insufficient at the time to support the introduction of such a policy at that stage. By late March more testing capacity was becoming available, but was unevenly distributed across NHS labs – in the main dependent on what PCR platforms the labs had previously, and availability of supplies for those particular platforms. PHE had issued guidance as to who should be tested, and this was being followed by the NHS. On 29 March 2020 I understand that the Pillar 1 system reportedly held a testing capacity of 15,000 PCR tests per day, and staff testing for those working in critical care, emergency departments and ambulance services and any other high priority groups (as determined locally) was enabled. The Government's testing policy in respect of the discharge of hospital inpatients into care homes was then ultimately set out in DHSC's Adult Social Care Action Plan published 15 April 2020 **[SLS2/025 INQ000358460]**.

Concluding observations

40. Given what the pandemic revealed about the disproportionate impact of Covid-19 on older people – in the community, in hospitals and in care homes - it is entirely right to consider carefully the facts, feasible options and balance of risks confronting policy makers in Spring 2020.

41. Whether various measures taken to create at short notice emergency hospital treatment capacity for the very sickest and generally oldest patients were reasonable under all the circumstances is a question that has been examined by the High Court in Judicial Review proceedings (*R (Gardner and others) v Secretary of State for Health and Social Care and others [2022] EWHC 967 (Admin)*). While criticising DHSC/PHE for not issuing guidance to care homes on isolating residents, on the hospital discharge policy per se the Court found as follows:

> *"We regard the sustained attack on the Hospital Discharge Policy as quite unrealistic. As we have noted, [the Government, PHE and NHS England] were extremely and understandably concerned by the prospect of the numbers of seriously ill patients requiring intensive care rising so rapidly that the NHS's intensive care capacity would simply be overwhelmed. In Italy, where the disease had spread some two weeks earlier than in England,*

hospitals had run out of beds and patients were being left to die at home. It must be remembered that, at this stage of the emergency, vaccines lay far in the future and the experts were unable to predict whether the graph of serious infection would go on rising exponentially for a long period. […] At this stage there was a shortage of PPE (both in this country and worldwide) and of tests. […] The Government was advised by experts that there was a real risk of the NHS being overwhelmed and it could not afford to wait to see whether that advice was over-cautious. […] *It was properly open to the Government to regard the need to discharge from hospital those who appeared medically fit to be discharged as paramount. That could not sensibly wait for every care home to be assessed. Similarly, the suggestion that the Government should have made provision in March for the testing of each patient before discharge to a care home is hopeless.*"

42. It is also important to note – as paragraph 272 of Dr Doyle's evidence points out – that action to reduce hospital discharge delays was not intended to increase the overall number of people discharged into care homes, and nor did it. It simply reduced the time that vulnerable and typically older people who would have gone to care homes anyway remained in hospital against the clinical decision of their doctors while typically stuck in multi-bedded bays and large wards (NHS hospitals having far fewer single bedrooms than care homes). In fact Dr Doyle records that the overall number of people discharged from hospital to care homes between mid-March and mid-April 2020 fell, both compared to the months preceding the policy and compared with the same period the year before. The action did free up a great number of NHS staff at a time of urgent need: over 11,000 staff including around 6,800 qualified nurses.

43. Furthermore, in subsequently assessing the epidemiological and genomic evidence, the UK Chief Medical Officers' Technical Report found that "*hospital discharge does not appear to have been the dominant way in which Covid-19 entered most care homes*". Instead the evidence review finds that "*outbreaks in care homes were closely correlated with community prevalence throughout the pandemic*" **[SLS2/026 INQ000203933].** Indeed in late 2020, even with testing, widely available PPE, guidance on isolation in designated settings and other protections, there is evidence that the new SARS-CoV-2 variant spread quickly in care homes as it increased in the general population. **[SLS2/027 INQ000283187].** This experience is sadly consistent with extensive international evidence showing that many countries with high levels of

community SARS-CoV-2 infection ended up with high levels of care home infections. Arguably it was Covid-19 vaccinations — for which care home residents and staff were rightly prioritised — which ultimately constituted the most effective immunological 'protective ring'.

44. None of the foregoing, however, should detract from two fundamental truths. The Covid pandemic had a disproportionate and devastating impact on the most vulnerable, particularly older people. It should serve as an urgent national wake-up call for comprehensive action to better support social care provision and staffing in this country.

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 9 June 2025