appreciate that the Cabinet Office would not be spectators but authors of how the country would cope. So while the Cabinet (and more significantly the public) were again assured that we were extremely well prepared; inside the secretariat part of the Cabinet Office we were becoming increasingly concerned about whether we would be able to cope with what might come. We were beginning to move at different speeds. This would intensify over the next fortnight.

55. Dominic Cummings and Lee Cain were rightly concerned about the capability and skills we had available on communications, particularly digital / social media expertise and testing of messaging given the centrality of communications to a public health crisis[35]. Lee Cain and I discussed and having spoken to the Chief Executive of the Civil Service I provided a paper on options.

56. Further concerns were raised by Lee Cain on the communications effort, including further indications that DHSC were overwhelmed (or appeared to be)[36]. DHSC was not able (or, perhaps, not willing) to provide anyone into the Cabinet Office to support the team led by Mark Sweeney to look at public sector preparedness, develop the policy on the NPIs or support on the Cabinet Office coordination effort. This was troubling because it meant that the Cabinet Office was operating without health expertise or good linkages. Although there were warning signs that there was a problem from the work on the legislation that Mark Sweeney had been doing, we were largely still operating under the impression that plans existed and they needed refreshing for the particular circumstances, including adapting to the way Mr Johnson ran his Government (as would be normal for any Prime Minister), rather than there not being plans for a crisis of this magnitude. We also – mistakenly – did not appreciate that DHSC had focussed and were focussing on DHSC and the impacts on the acute health system, rather than the wider and long-term health of the public. I do not think we fully understood this until too late to do anything to really remedy it.

57. I thought at the time that the use of the terminology "non-pharmaceutical interventions" was very unhelpful. I think this even more in light of what followed. How something is thought about matters, and one of the problems of using acronyms in government is that it allows decision makers to duck, or not engage at a human level with, what they are actually talking about. 'Non-pharmaceutical interventions" is a case in point.

[35] Email from Dominic Cummings re. need to improve communications leadership 4.3.20 [INQ000285984].
[36] Email to Mark Sweeney re conversation with Lee Cain 9.3.20 [INQ000285993].

terms of the substance of the response I could see that the next challenge was to shift out of the immediate "crisis response" phase. The pandemic was still being handled as an emergency health problem, including in the structures of the daily meetings. Particularly having been at home, it felt very much like an everything problem[53]. Over that weekend the Cabinet Secretary was proposing to minute the Prime Minister with his view on what next and we debated what that should say[54]. My response to him encapsulates my thinking at the time. I was catching up with the economic impacts and I remember this being the most sobering point – how far the pandemic might scar the economy for some time to come and all of the consequences that would mean for people and jobs. Poverty also costs lives. Mark Sedwill was also very straightforward about his view on historic structural underinvestment in e.g. critical care beds. I think it had surprised us (collectively) to understand the comparisons with other countries and that provision in the UK lagged other countries. As I recall the conversations at the time we were collectively somewhat idealistic and probably also simplistic about the NHS. I do not remember anyone working in the centre or who was part of the conversations who had a detailed understanding of the way the NHS operated. This is not unusual or unique to that time. Social policy and the "operational" management of the state is always under-represented in the centre of power whereas HM Treasury, foreign policy and national security are over-represented in line with what is normally the focus for a Prime Minister.

72. It was a fragile time. It felt like everyone was getting or recovering from Covid and the relief at knowing we could get back to work and not be infected or infect anyone was intense. Matt Hancock returned to work on the same day I did. I remember standing outside the Cabinet Room with him before a meeting. No 10 was eerily empty at that point. I was pleased to see him recovered and we talked about our respective experiences of the Covid and our families (like most of us his family had also had Covid after we had contracted it at work). I remember trying to reassure him that he did not need to be in the office, especially not in No 10, and saying that it must be very hard – as Health Secretary he could not have imagined the enormity of the decisions he would be involved in when he was appointed. Given it was a long way from the day job I wanted to know if there was more help or support he needed. He reassured me that he was "loving" the responsibility – and to demonstrate this took

[53] Email to Mark Sweeney 5.4.20 in response to his note 'random data list' [INQ000286019].
[54] Mark Sedwill's draft note to PM 5.4.20 'Covid-19':Turning the Tide' [INQ000286020]; Email exchange with John Owen discussing note [INQ000286025], Response to Mark Sedwill 5.4.20 [INQ000286024].

have been a better use of the Nightingale hospitals to put all maternity care outside the mainstream hospitals. Most strikingly in the early days, in terms of specific policy that only impacted on women, there was an attempt to tacitly restrict access to abortion by not making provision available outside of clinics that were closed.

104. There was also a failure to appreciate some of the longer-standing institutional biases against women e.g. in how data was collected. This was particularly significant given the value put on the data in understanding and decision making. In exasperation I bought multiple copies of Caroline Cariado Perez's book "Invisible Women" and started handing them out to people to read. I'm not sure how helpful this was (or how many people had time to read any of it) but it led to some interesting and useful discussions especially with Ben Warner about what we could do to improve the data[74]. Partly because of that book but also the commentary on Twitter I raised issues about e.g. the inadequacies of PPE for women, and tried to make sure this was taken into account in any new supply[75]. The Prime Minister raised this with Simon Stevens on April 30th and he reassured the Prime Minister and Ministers that the issues with PPE fitting women's bodies were mis-reported and there was not a problem[76].

105. I do not know if the culture was always more sexist than we had noticed and just more obvious under pressure, and/or if there was something in the nature of the crisis response (I'd hazard a guess at both) but there was clearly a problem with women working at every level being excluded and shut down. I cared about this in and of itself and I also cared about the consequences for decisions. Quieter male voices and perspectives were also being lost. I crystalised what I thought I had been told and made some suggestions about what needed to change, and given it was a pretty sensitive topic I took care to check back with some of the women who had raised concerns[77]. Just raising the issue made people behave better but I do not think it changed the fundamentals.

106. I remember at the time feeling as if while there was undoubtedly sympathy for the differential impacts on women, poorer people and how Covid was disproportionately harming Black and Asian communities, when it was raised it was

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[74] See e.g. email exchange with Ben Warner re Invisible Women 18.4.20 [INQ000286054].
[75] Emails with Simon Ridley and Mary Jones re PPE & Women 15.4.2020 [INQ000286049].
[76] Email from Cleo Watson 30.4.20 [INQ000286059].
[77] Email to women in No 10 and Cabinet Office – "Women at the Centre" 13.4.20 [INQ000286041].

not rolling towards us in a November. Buying time to get to the summer had been a cause for hope in the early part of the response, just as the shortening days and the colder weather were then a cause for concern in the autumn.

179. The Covid taskforce was in dialogue with the DHSC and NHS over the autumn of 2020 to establish a better way of tracking NHS capacity and seeing early indicators in order to help them to advise on managing the response (when to act and what to do). Separate but related to that and through the winter cell I was trying to establish a plan for what we would do if the NHS went into severe crisis – particularly if there was compound demand because of e.g. a major incident or a particularly harsh winter[151]. There was not a plan ready for either what to do if the NHS itself got overwhelmed and/or if that happened when other things were also going wrong. I thought we needed to be ready for an emergency response either system wide or (more likely) in a particular place. The impact of the weather was important so CCS did keep close to what the pattern might be both in the long and short term. Thankfully the UK was relatively fortunate that year and the winter was relatively mild but we did not know it would be.

180. What I was trying to do with the emergency response was have a well-understood set of protocols and ways of operating in the centre, so we did not have a repeat of what had happened in March. I needed to know how we would know that we were getting close to a point where help would be needed and have a plan for what that help would be[152]. Essentially this could only be by relying on the military for mutual aid of some sort but that would need to be properly planned and prepared for and it would be essential to make sure when it came to the operational management of a situation (if for example a whole series of hospitals in a particular geography could no longer accept emergency admissions) there was a plan for what to do that involved all the relevant local authorities[153]. This in itself is pretty normal contingency planning (see above).

181. It was difficult to get the right kind of engagement from DHSC or the NHS. There was an inbuilt reluctance to accept that it was possible to get to a point where the

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[151] See email exchange with Kathy Hall and Alastair Whitehead regarding a NHS crisis 11.01.21 [INQ000308371].
[152] See e.g. email exchange with Kathy Hall and Sapana Agrawal about NHS capacity 12.01.21 **[INQ000308374]**
[153] See email to Simon Case NHS Capacity Contingency Plan 2.1.21 [INQ000308358].