Witness Name: Sapana Agrawal
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UK COVID-19 INQUIRY

CORPORATE WITNESS STATEMENT OF SAPANA AGRAWAL

I, Sapana Agrawal, of the Cabinet Office, will say as follows:

1. INTRODUCTION AND EXECUTIVE SUMMARY

1.1. I am a senior civil servant and serve as the Director for Modernisation and Reform in the Cabinet Office. I have held this position since 7 February 2022. I joined His Majesty's Government on 15 May 2020 as a member of the Covid Delivery Cell in No.10. In August 2020, I moved to the Cabinet Office to be Director of Health, Social Care and Delivery in the COVID-19 Taskforce (CTF), until starting my current role.

1.2. This corporate witness statement is produced to address queries that have been raised in a Request for Evidence pursuant to Rule 9 of the Inquiry Rules 2006 and sent to the Cabinet Office on 7 August 2023 (the 'Rule 9'). The statement has been prepared with the assistance of Counsel, the Government Legal Department (GLD) and its appointed legal firm, Pinsent Masons LLP.

1.3. The relevant period for Module 3, as specified by the Inquiry, is 1 March 2020 to 28 June 2022. During the initial months of that period, until 14 May 2020, I was not in government, so for that time my statement relies entirely on papers and accounts provided by others who worked in the Cabinet Office including No.10 at the time. From 15 May 2020, my statement draws in part on my direct experience, as well as on papers and accounts provided by others who worked in the Cabinet Office including No.10 at the time. For the final months of the relevant period, from 7 February 2022, I was not involved in the COVID-19 response and therefore my statement relies entirely on papers and accounts provided by others who worked in the Cabinet Office including No.10 at the time.

1.4. This statement is not a detailed account of every way in which the Cabinet Office's work encompassed matters concerning the healthcare system during the COVID-19 pandemic. Nor is it a detailed account of every piece of advice or decision that was made by the Cabinet Office in respect of the healthcare system. Rather, it presents a high-level overview of the Cabinet Office's role in this area. It also describes, more broadly, the governance structures that existed within the Cabinet Office during the COVID-19 response, explains how those structures evolved in response to the changing nature of the pandemic and details a number of key equalities considerations.

1.5. To understand the Cabinet Office's role in respect of healthcare I think it is important to bear the following points in mind. Not all of these are detailed within this statement - I understand, for example, that there will be future modules covering the social care sector, vaccines and testing.

1.5.1. **The Cabinet Office including No.10 sits at the centre of government (sometimes referred to as 'the centre', and which also comprises HM Treasury)**. The Cabinet Office including No.10 fulfils a core coordination rather than a delivery role - supporting and advising the Prime Minister and Cabinet Office ministers, and facilitating Cabinet and collective decision-making across government. As such, it monitors the delivery priorities of other departments, seeking to ensure they remain on track, while also brokering decisions between departments and building consensus on policies across other government departments, who in turn have relationships with organisations in respective sectors.

1.5.2. **Healthcare is always a key topic for the centre of government** in or out of a pandemic. Every year, for instance, the centre engages with the Department of Health and Social Care (DHSC) and NHS England (NHSE) to understand plans and risk mitigations for winter pressures. While I acknowledge the remit of this Module of the Inquiry, it is also important to note that, in practice, the Government considers health and social care holistically, given that the flow of patients between hospitals and the care sector can have an impact on NHS capacity as well as having other knock-on implications.

1.5.3. There is an important distinction between those **decisions which were informed and influenced by issues relating to healthcare systems** (e.g

lockdowns and the Government's overall COVID-19 response), and those **decisions taken within or which were directly about healthcare systems**. The Cabinet Office including No.10 had a more direct role in the former, but I understand that for Module 3, the Inquiry is predominantly interested in the latter.

1.5.4. **The Cabinet Office including No.10 did not in the relevant period have, and does not outside of that period have, a role in day-to-day decisions on the delivery of healthcare services**. The Cabinet Office including No.10 is not part of the UK's healthcare system and it is not directly involved in operational decisions made 'on the ground' in healthcare settings.

1.5.5. Published guidance on the structure of the NHS makes clear that the "top-level priority setting" of the NHS is decided by the UK Government for which the Prime Minister has overall responsibility.[1] However, **many issues and decisions related to healthcare will be addressed routinely by DHSC and the NHS without the involvement of the Cabinet Office**. The DHSC has "overall financial control and oversight of NHS delivery and performance" and "oversight of health and social care policy".[2] The Cabinet Manual[3] states that health and social care are devolved to the respective legislatures and administrations in Scotland, Wales and Northern Ireland. During the COVID-19 pandemic, devolved leaders were routinely invited to relevant committees or collective agreement forums, as will be outlined in Section B and C of this statement, but the Cabinet Office does not routinely take decisions on the implementation of healthcare, including the delivery of those aspects which are ordinarily procured UK-wide, in the devolved administrations. The Cabinet Office did lead one health-related workstream, the UK-wide procurement of ventilators, which is described in Section F.

1.5.6. **Given the scale and pace of the pandemic, the <u>intensity</u> of the Cabinet Office including No.10's engagement in healthcare issues increased significantly** during 2020 and in later phases according to the risks posed by COVID-19 (such as the emergence of a new variant). The Cabinet Office including No.10 was engaged in brokering several significant cross government interventions (relating to COVID-19 testing, for example) which

[1] SA/1 - INQ000421042
[2] SA/1 - INQ000421042
[3] The Cabinet Manual sets out the main laws, rules and conventions affecting the conduct and operation of government. SA/2 - INQ000182315/63-64

impacted on the healthcare system. As such, it worked with DHSC and others to ensure that the healthcare sector was considered fully in significant decisions. Similarly, given the sheer volume of guidance issued during the COVID-19 response, the Cabinet Office played a role in helping to ensure this guidance was joined up across other government departments. While in these and other ways the intensity of the Cabinet Office's coordination role was atypical, the nature of its role was not.

1.5.7. **Balancing the pandemic's health, economic and social impacts was a key consideration for the Cabinet Office, including No.10, during the COVID-19 response**. Monitoring NHS capacity and understanding the risks of the NHS being overwhelmed by COVID-19 admissions was fundamental to the broader COVID-19 strategy. More widely, the Cabinet Office sought to ensure - with the support of DHSC and NHSE - that the health impacts of the pandemic, including for instance mental health impacts, were understood. Its role was to provide advice for the Prime Minister and other Cabinet Office ministers which considered the impacts of the pandemic in the round.

1.6. The statement is divided into the following sections:

1.6.1. Section A provides the background context for this statement, setting out, at a very high level, the functions and structures of the Cabinet Office including No.10, as well as the system of Cabinet government;

1.6.2. Section B briefly outlines the core governance structures as they existed at the onset of the COVID-19 pandemic (up to 15 March 2020 - the first stage of structures for collective decision-making). During this first stage, collective decisions on the Government's pandemic response were taken through the Cabinet Office Briefing Room (COBR) mechanism which was supported by the Civil Contingencies Secretariat (CCS). Cabinet also considered the Government's response;

1.6.3. Section C describes the early Cabinet Office COVID-19 governance structures (16 March 2020 to 27 May 2020). During this second stage, collective decisions on the Government's pandemic response were mostly taken by the Ministerial Implementation Groups (MIGs). For Module 3, this statement naturally focuses in particular on the Healthcare Ministerial Implementation Group (HMIG). The MIGs reported into a daily 9:15 strategy meeting chaired by the Prime Minister;

1.6.4. Section D addresses the period from 28 May 2020 to the end of the relevant period (this third stage of governance was formally stood down in September 2022). From 28 May 2020, the four MIGs were stood down. Earlier that month the Government had published a phased roadmap out of lockdown ('Our plan to rebuild: The UK Government's COVID-19 recovery strategy'),[4] and it had become clear that a governance structure more sustainable for the longer term was required. The COVID Strategy Committee (COVID-S) and the COVID Operations Committee (COVID-O) were established. COVID-S and COVID-O were supported by a new unit, the COVID-19 Taskforce (CTF). This third stage, and the work of the CTF, has been explored in detail in corporate statements produced by the Cabinet Office for Module 2 of this Inquiry. Section D of this statement also notes other Cabinet committees over the Module 3 period which took decisions relating to healthcare;

1.6.5. Section E highlights two key foundational ways in which the Cabinet Office including No.10 supported the making and delivery of decisions during the pandemic: the COVID-19 Dashboard (the Dashboard) and the COVID-19 Programme Management Office (PMO);

1.6.6. Section F provides an overview of the role of the Cabinet Office including No.10 (operating through the structures outlined in sections A to D) in relation to key aspects of the healthcare system during the relevant period. This will be explored by reference to healthcare-related strategies and work streams that arose throughout the pandemic in relation to NHS capacity and hospital planning including: critical care capacity, Nightingales, the independent sector, staffing, ventilators, PPE, supplies and medicine; shielding and measures taken to protect the clinically extremely vulnerable (CEV);

1.6.7. Section G addresses some key equality considerations in decision-making on healthcare during this period. It looks at examples such as equality considerations relating to the implementation of healthcare-related legislation, work carried out in relation to Disproportionately Impacted Groups ('DIGs'), vaccine work streams, and programmes to address disparities among ethnic minority groups; and,

[4] SA/3 - INQ000089917

1.6.8. Section H sets out some of the internal review exercises carried out by the Cabinet Office, where elements of these related to healthcare systems. It notes that the Government's response to the pandemic adapted over time and was informed throughout by the ongoing lessons that had been learned.

1.7. Key healthcare entities that do not form part of the Cabinet Office, but were a core feature of the COVID-19 response, and that were impacted by the policies, strategies, decisions and actions in which the Cabinet Office was involved, include (but are not limited to) DHSC, Public Health England (PHE) and subsequently the United Kingdom Health Security Agency (UKHSA), and NHS England (NHSE). I shall make reference to these entities as appropriate through the statement.

1.8. I stand ready to provide the Inquiry with further assistance if required.

2. SECTION A: OVERVIEW OF CABINET OFFICE CORE FUNCTIONS AND STRUCTURES

2.1. In order to ensure that the role of the Cabinet Office including No.10, which is not part of the UK's healthcare system, is clear, this section begins with a high-level overview of Cabinet government and the key functions within the department. These functions were previously described in more detail in the Cabinet Office corporate witness statement of Simon Case for Module 2 of the Inquiry[5].

2.2. As the Cabinet Manual[6] sets out, "Cabinet is the ultimate decision-making body of government. The purpose of Cabinet and its committees is to provide a framework for Ministers to consider and make collective decisions on policy issues".

2.3. "The Cabinet system of government is based on the principle of collective responsibility. All government ministers are bound by the collective decisions of Cabinet, save where it is explicitly set aside, and carry joint responsibility for all the Government's policies and decisions". "Collective agreement can be sought at a Cabinet or Cabinet committee meeting or through ministerial correspondence". The Cabinet Manual does not give definitive criteria for issues which engage collective responsibility, but makes clear that "proposals will require consideration by a Cabinet committee if: the issue is likely to lead to significant public comment or criticism; the subject matter affects more than one department; and/or there is an unresolved conflict between departments".

2.4. The Cabinet Office including No.10 has responsibility for "supporting collective government, helping to ensure the effective development, coordination and implementation of policy". It also has responsibility for "coordinating the Government's response to crises".[7] The Cabinet Office including No.10 enables collective decisions and provides direct policy and implementation advice and support to the Prime Minister, the Chancellor of the Duchy of Lancaster (CDL) and other ministers. It draws on policy advice, expertise, data and analysis from departments with lead responsibility for specific issues, such as the DHSC for public health.

2.5. Each Cabinet committee has a senior official in the Cabinet Office, known as the Senior Secretary, who is responsible for ensuring the effective functioning of their respective committee. The role of the Senior Secretary is to support the effective

[5] SA/4 - INQ000092893
[6] All quotes are from the Cabinet Manual in paragraphs 2.2 and 2.3 SA/2 - INQ000182315
[7] SA/5 - INQ000086870

delivery of the meeting, to uphold the principles of collective agreement and to ensure that the committee does not take decisions outside of its Terms of Reference.

2.6. The Prime Minister is advised and supported by officials and special advisers (temporary civil servants appointed directly by ministers who can, in addition to other roles, provide political support) based in No.10. As the Government's website explains, together they help the Prime Minister "to establish and deliver the Government's overall strategy and policy priorities, and to communicate the Government's policies to Parliament, the public and international audiences".[8]

2.7. Teams based in No.10 are part of the Cabinet Office. Teams based in No.10 ordinarily include (but are not limited to) a private office, the 'PM Post' team and a press office. The precise configuration of teams based in No.10 evolves over time at the discretion of the Prime Minister. During the relevant period it also housed a policy unit (throughout), a data and science team (from summer 2020) unit and a delivery unit (from spring 2021). In addition, an interim COVID-19 team was set up in No.10 in March 2020 (and subsequently merged into the COVID-19 Taskforce). These teams, dependent on the Prime Minister's priorities, will have engaged with healthcare issues during the period. Hereafter, when describing the department's work I will typically refer to the Cabinet Office including No.10 with the shorthand "the Cabinet Office".

Meetings outside the ministerial committee structure

2.8. Given the role of the Cabinet Office across the breadth of the Government's response to COVID-19, the Prime Minister and other Cabinet Office ministers needed to have a wide set of meetings outside the ministerial committee structure to develop policy and strategy. The format, frequency of and attendance at these meetings were tailored to the issues at hand and the nature of discussion taking place. Issues considered during these meetings included matters relating to healthcare.

2.9. The aim of these meetings varied but overall they sought: to provide lead ministers with data, analysis and expert advice; to make or prepare for decisions; to coordinate other government departments; and, to take 'deep dives' into specific issues. These meetings necessarily evolved in structure and rhythm according to the path of the pandemic and the Government's response to it. In these meetings the Prime Minister, CDL and other Cabinet Office ministers would from time to time request actions or make decisions not judged as needing collective agreement.

[8] SA/6 - INQ000086873

2.10. The following list highlights the key meeting formats but is not exhaustive:

2.10.1. **Daily meetings with the Prime Minister:** Throughout the relevant period, the Prime Minister would typically chair a daily morning meeting to provide steers on the key issues for the day. From early March 2020, this daily meeting focused increasingly on COVID-19, bringing in other key ministers, as well as officials and advisers, such as the Chief Medical Officer (CMO) and Government Chief Scientific Adviser (GCSA). These meetings typically decided what the key policy elements of the response needed to be on that day and how to communicate them to the public. The daily meeting evolved into the 9:15 strategy meeting between 17 March and 15 May 2020 (covered in more detail in Section D, which explains its interaction with the MIGs which operated at that time). The Prime Minister's 9:15 meeting evolved into a Dashboard meeting where key ministers and officials would review the latest Dashboard of data. The Dashboard is covered further in Section E.

2.10.2. **Quads:** The Prime Minister chaired meetings, sometimes referred to as 'Quads', with a small number of Secretaries of State most closely involved in the strategic response. This was to prepare for and align their approach to key strategic decisions in the response to the pandemic. The Chancellor, the CDL and the Secretary of State for Health and Social Care (Health Secretary) usually attended and at times, other ministers were present;[9]

2.10.3. **Ad hoc and in depth meetings:** These meetings, held by the Prime Minister and attended by key ministers, advisers and officials, enabled the Prime Minister to prepare ahead of wider collective meetings, taking stock informally of the strategy, plans and approach, in light of the data;

2.10.4. **Bilateral meetings with key ministers:** As is routine, the Prime Minister had bilateral meetings with the Health Secretary and other key ministers. While the exact pattern of these meetings varied, they took place at a high frequency with the key ministers involved in delivering the pandemic response. These meetings enabled the Prime Minister to hold key ministers to account and to explore topics in depth with them to inform ongoing development of policy options;

[9] As was the case with the daily 9:15 strategy meetings, in the period during which the Prime Minister was hospitalised with COVID-19, these meetings were chaired by the First Secretary of State who was appointed to deputise in the Prime Minister's absence.

2.10.5. **'Stocktake' or 'Deep Dive' Meetings**: On an ad hoc basis, or regularly for periods of time, the Prime Minister had meetings on specific policy and operational issues, with the attendance tailored to those issues. In these meetings, the Prime Minister considered, and sometimes made decisions on, the policy approach or operational implementation. Examples of issues covered in these meetings, sometimes referred to as 'stocktakes' or 'deep dives', include health and social care, PPE, ventilators, testing and vaccines.

2.11. Health stocktakes were typically led by the Prime Minister. The objective of these meetings was to review the latest information about the healthcare system's COVID-19 and non-COVID-19 capacity and delivery of healthcare, identify areas of risk, vulnerability, and improvement, consider future actions, and determine the ways in which NHSE, DHSC, HMT and No.10 would work together on delivery. These meetings provided an overview of the current healthcare landscape, the healthcare system's response to the pandemic, healthcare data and statistics from DHSC and NHSE, emerging issues, and a progress update for ongoing actions. For example, the stocktakes over this period considered: NHSE resilience and capacity; healthcare winter preparedness; and the NHS Elective Recovery Plan.

3. SECTION B: THE FIRST GOVERNANCE STAGE (UP TO 15 MARCH 2020)

3.1. This section deals with matters mostly outside the relevant period, however, it is included to provide information, background and context relevant to the subsequent sections of this statement.

3.2. As the novel coronavirus was identified and began to spread globally, the first collective ministerial decisions about the response, as distinct from those decisions within the responsibility of a single department, were taken at ministerial COBR meetings. The first ministerial COBR meeting on the novel coronavirus took place on 24 January 2020, convened by the Cabinet Office and chaired by the Health Secretary[10]. The Senior Secretary to ministerial COBR meetings was the Director of the CCS, Katharine Hammond.

3.3. The Cabinet Manual explains that COBR, run by the CCS during the relevant period, is "the mechanism for agreeing the central government response to major emergencies which have international, national, or multi-regional impact. Meetings at COBR are in effect Cabinet committee meetings, although there is no fixed membership, and they can meet at ministerial or official level depending on the issue under consideration. In general, the chair will be taken by the secretary of state of the Government department with lead responsibility for the particular issue being considered".[11] It is standard practice for ministers from the devolved administrations to be invited to COBR meetings where there may be impacts in the devolved administrations.

3.4. COBR meetings facilitate cross-government decision-making and provide information and advice at times of crisis. COBR meetings are ordinarily provided with a Common Recognised Information Picture (CRIP), including facts and figures, the main developments and decisions, trends, and upcoming decision points. COBR meetings are supported (as necessary) by a number of separate cells and groups providing specialist input and advice.

3.5. On 27 January 2020, the CCS set up its response to COVID-19 in line with its standard practice, including a policy cell, operations cell and an information cell, with links to key departments via liaison officers[12]. The CCS national security watchkeeper team (which monitored national security and civil contingencies risks) and CCS crisis management team (which provided technical and operational support to the COBR facility)

[10] SA/7 - INQ000056200; SA/8 - INQ000056214
[11] SA/2 - INQ000182315
[12] SA/4 - INQ000092893

augmented the response. The CCS had a number of responsibilities in relation to COVID-19. These evolved over time as new structures were established and included:

3.5.1. the CCS, with contributions from relevant government departments, produced a daily cross-department Situation Report (SitRep) on the novel coronavirus. It included information on the current domestic and international situations and response, the latest scientific advice and communications. It was shared with staff based in the Cabinet Office, other government departments and the devolved administrations;

3.5.2. the CCS carried out work on the Coronavirus Bill (outlined in Section F);

3.5.3. the CCS supplied a single, authoritative Reasonable Worst-Case Scenario (RWCS) (based on scientific advice) to departments, devolved administrations and local responders in order to guide planning; and,

3.5.4. the CCS operated a health and science team, which formed part of the 'Readiness and Response' team whose responsibility it was to understand emerging short-term disruptive challenges and coordinate the cross-government response as needed, including by acting as secretariat for COBR meetings.

3.6. The First Ministers of Scotland, Wales and Northern Ireland (and the deputy First Minister of Northern Ireland) were invited to attend all ministerial COBR meetings on COVID-19, in this first stage and throughout the relevant period. The respective health ministers, CMOs and officials for each nation were also invited as appropriate. Representatives of local government attended on occasion when the issues discussed had a local impact.

3.7. The first discussion of the novel coronavirus at a formal Cabinet meeting was on 31 January 2020[13]. COVID-19 was considered at further Cabinet meetings during the first stage. The Cabinet Secretary was the senior official for Cabinet, responsible for its effective functioning.

3.8. Ministers continued to meet in COBR and Cabinet structures throughout the relevant period.

[13] SA/9 - INQ000056125

4. SECTION C: THE SECOND GOVERNANCE STAGE (16 MARCH 2020 – 27 MAY 2020)

4.1. The scale of the crisis and the breadth of the response, as a whole-of-government effort, continued to grow. The volume and scale of decisions that needed to be taken within a whole-of-government response demanded a bespoke architecture, which became the principal way by which decisions were made (alongside COBR meetings and Cabinet).[14]

4.2. Four new Ministerial Implementation Groups (MIGs) were set up to lead the Government's key lines of operation during this stage,[15] each chaired by a different Cabinet minister. The MIGs had the status of Cabinet committees and took collective decisions. They were: the Health Ministerial Implementation Group (HMIG); the General Public Services Ministerial Implementation Group (GPSMIG); the Economic and Business Response Ministerial Implementation Group (EBRMIG); and, the International Ministerial Implementation Group (IMIG).

4.3. On 17 March 2020, the MIG structures were announced publicly.[16] The MIGs remained in place until late May 2020.

4.4. The Health Ministerial Implementation Group (HMIG) was set up, according to its Terms of Reference to "focus on: policy interventions to protect public health, including monitoring and implementation of current interventions, and consideration of any future interventions; oversight of NHS capacity; social care preparedness, notably ensuring capacity in the critical care system for those worst affected; and medical and social support for those to whom we will be providing the shielding intervention"[17]. The Chair was the Health Secretary, and the Deputy Chair was the Secretary of State for Housing, Communities and Local Government. Relevant ministers from the devolved administrations were invited to HMIG meetings as required. The Senior Secretary for the HMIG was Simon Ridley.

4.5. Thirteen HMIG meetings took place, with the Health Secretary as Chair, between its establishment on 16 March 2020, and the standing down of the MIG structures on 28 May 2020, which is outlined in Section D. The Cabinet Office has provided the Inquiry

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[14] On 13 March 2020, the Director General, Cabinet Secretariat (Mark Sweeney) and the Deputy Cabinet Secretary and Head of the Cabinet Secretariat (Helen MacNamara), on behalf of the Cabinet Secretary, submitted advice to the Prime Minister recommending a new approach to structures to support the COVID-19 response [SA/10 - INQ000087166]. The Prime Minister agreed to this advice.

[15] Terms of Reference (ToR) for each MIG [SA/11 - INQ000087167]

[16] SA/12 - INQ000086849

[17] Terms of Reference (ToR) for each MIG [SA/11 - INQ000087167]

with a full chronology of these meetings[18]. A summary of topics discussed at each meeting are also provided below, as requested by the Inquiry, with agendas, briefing papers, minutes, decisions and actions exhibited:

4.5.1. 18 March 2020[19] - Topics discussed were: Introduction and objectives of the committee, the shielding policy and social care funding and discharge process;

4.5.2. 20 March 2020[20] - Topics discussed were: an update on the Dashboard, shielding measures (implementation and key risks) and supermarket support for shielded people;

4.5.3. 22 March 2020[21] - Topics discussed were: an overview of the overall strategic approach to the epidemic, a three-month healthcare strategy to tackle COVID-19 and options for enforcing legislation requiring the closure of specified businesses and other venues during the coronavirus emergency.

4.5.4. 24 March 2020[22]- Topics discussed were: the HMIG action tracker, healthcare supplies, and the support offer for the extremely vulnerable on medical grounds;

4.5.5. 31 March 2020[23] - Topics discussed were: performance review, updates on actions, shielding progress update, and coordination of volunteering efforts for the healthcare system;

4.5.6. 2 April 2020[24] - Topics discussed were: ensuring a consistent UK-wide approach to COVID-19 and an update from DHSC on meeting public sector demand for PPE;

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[18] SA/13 - INQ000176782
[19] SA/14 - INQ000055919; SA/15 - INQ000055939; SA/16 - INQ000055912; SA/17 - INQ000055917; SA/18 - INQ000055918; SA/19 - INQ000055914; SA/20 - INQ000055916; SA/21 - INQ000055915
[20] SA/22 - INQ000055946; SA/23 - INQ000055935; SA/24 - INQ000055934; SA/25 - INQ000055940; SA/26 - INQ000055920; SA/27 - INQ000055924; SA/28 - INQ000055923; SA/29 - INQ000055947
[21] SA/30 - INQ000055941; SA/31 - INQ000055945; SA/32 - INQ000055942; SA/33 - INQ000055937; SA/34 - INQ000055927; SA/35 - INQ000055926; SA/36 - INQ000055925
[22] SA/37 - INQ000055929; SA/38 - INQ000055938; SA/39 - INQ000055943; SA/40 - INQ000055944; SA/41 - INQ000055931; SA/42 - INQ000055928
[23] SA/43 - INQ000083629; SA/44 - INQ000083700; SA/45 - INQ000083690; SA/46 - INQ000083628; SA/47 - INQ000083627; SA/48 - INQ000083685
[24] SA/49 - INQ000083689; SA/45 - INQ000083690; SA/50 -INQ000083632; SA/51 - INQ000083701; SA/52 - INQ000083636

4.5.7. 7 April 2020[25] - Topics discussed were: adult social care system readiness presented by DHSC, update on delivery of shielding support presented by MHCLG and health impacts of social distancing policy;

4.5.8. 9 April 2020[26] - Topics discussed were: testing and the PPE plan;

4.5.9. 15 April 2020[27] - Topics discussed were: the NHS Volunteer Responders Programme and health impacts of social distancing presented by DHSC;

4.5.10. 17 April 2020[28] - Topics discussed were: performance review, updates from the last meeting, the Dashboard, an update on shielding from MHCLG and an oral update on volunteering;

4.5.11. 1 May 2020[29] - Topics discussed were: 'Test, Trace and Certify' presented by DHSC and a shielding update from MHCLG;

4.5.12. 7 May 2020[30] - Topics discussed were: performance review and updates from previous meeting, the updated Dashboard, a PPE oral update from Lord Deighton and a DHSC update on the effectiveness of shielding as a public health intervention; and

4.5.13. 26 May 2020[31] - a paper on Test and Trace presented by DHSC was discussed.

4.6. As the Senior Secretary for the HMIG, Cabinet Office Director General Simon Ridley coordinated wider advice on healthcare issues across the Cabinet Office working with relevant departments across government.

4.7. The three other MIGs were as follows. The General Public Services Ministerial Implementation Group (GPSMIG) was set up to "coordinate and advise on public sector issues relating to the C-19 pandemic across the UK, excluding the NHS and social care". The Economic and Business Response Ministerial Implementation Group (EBRMIG) was set up to "coordinate and advise on business-related regional, sectoral

[25] SA/53 - INQ000083693; SA/54 - INQ000083637; SA/55 - INQ000083640; SA/56 - INQ000083638; SA/57 - INQ000083633; SA/58 - INQ000083639; SA/59 - INQ000083702; SA/60 - INQ000083694
[26] SA/61 - INQ000083643; SA/62 - INQ000083647; SA/63 - INQ000083704; SA/64 - INQ000083705; SA/65 - INQ000083645; SA/66 - INQ000083644
[27] SA/67 - INQ000083649; SA/68 - INQ000083655; SA/69 - INQ000083650; SA/70 -INQ000083706; SA/71 - INQ000083695
[28] SA/72 - INQ000083659; SA/73 - INQ000083661; SA/74 - INQ000083697; SA/75 - INQ000083663; SA/76 - INQ000083660; SA/77 - INQ000083658
[29] SA/78 - INQ000083667; SA/79 - INQ000083666; SA/80 - INQ000083665; SA/81 - INQ000083707; SA/82 - INQ000083670
[30] SA/83 - INQ000083673; SA/84 - INQ000083671; SA/85 - INQ000083698; SA/86 - INQ000083677
[31] SA/87 - INQ000083680; SA/88 - INQ000083681; SA/89 - INQ000083682; SA/90 - INQ000083699; SA/91 - INQ000083683

and corporate-level issues relating to the C-19 pandemic". The International Ministerial Implementation Group (IMIG) was set up to "coordinate and advise on UK's role in the coordination and delivery of the international health and economic response to the C-19 pandemic, bilaterally and through multilateral (e.g. G7/20) and international (e.g. World Health Organisation, International Monetary Fund, World Bank) organisations. The IMIG was also responsible for "setting the UK's strategic approach to the threats and opportunities arising from the pandemic and setting the course for the longer term strategic national recovery".

4.8. During this stage, the four MIGs reported into a daily 9:15 strategy meeting of key ministers, officials and advisers chaired by the Prime Minister which was the key forum for oversight of all issues and strategy.[32] At each 9:15 strategy meeting: the Dashboard was presented; there were discussions of priority issues from the ministerial implementation groups and any other priorities; and, a standing item covered the daily communications narrative and press conference. The Senior Secretary was Mark Sweeney. Other Directors General in the Cabinet Secretariat - Jonathan Black, Jessica Glover and Simon Ridley - would sometimes cover this meeting, to allow for resilience and illness (the central COVID-19 secretariat ensured that there was a clear "central Director General" for each day).[33]

4.9. The Cabinet Office has provided the Inquiry with a chronology of the 9.15 meetings, including those which updated the Prime Minister on healthcare issues at a high level[34]. Some meetings which discussed healthcare issues are also provided below, with papers exhibited, but this is not intended to be an exhaustive list of every meeting:

4.9.1. 18 March 2020[35] - Topics discussed were: NHS capacity and resilience;

4.9.2. 20 March 2020[36] - Topics discussed included: the DHSC battleplan;

4.9.3. 22 March 2020[37] - Topics discussed included: the DHSC battleplan

4.9.4. 23 March 2020[38] - Topics discussed included an update on NHS staffing

[32] From 6 April until 25 April 2020 (inclusive) the Rt. Hon. Dominic Raab MP, in his position as the First Secretary of State, deputised for the Prime Minister as Chair of the 9.15 Strategy meetings and the Quads.
[33] Other Directors General in the Cabinet Secretariat - Jonathan Black, Jessica Glover and Simon Ridley - would sometimes cover this meeting, to allow for resilience and illness
[34] SA/92 - INQ000151280
[35] SA/93 - INQ000056051, SA/94 - INQ000056261, SA/95 - INQ000056123
[36] SA/96 - INQ000056066
[37] SA/97 - INQ000056094, SA/98 - INQ000056110, SA/99 - INQ000056087, SA/100 - INQ000056086
[38] SA/101 - INQ000056264, SA/102 - INQ000056096

4.9.5. 24 March 2020[39] - Topics discussed were: updates on the overview of staffing in hospitals and construction of new hospitals

4.9.6. 25 March 2020[40] - Topics discussed were hospital construction and staffing, PPE, ventilators

4.9.7. 31 March 2020[41] - Topics discussed were: the PPE strategy and DHSC's analysis of the UK demand for PPE;

4.9.8. 1 April 2020[42] - Topics discussed were: the Dashboard figures on COVID-19 deaths; ICU admittances at a national level; London Nightingale capacity;

4.9.9. 2 April 2020[43] - Topics discussed were: Scottish critical care bed capacity; an update on testing and PPE plans for publication from DHSC;

4.9.10. 3 April 2020[44] - Topics discussed were: death rates due to COVID-19; Scottish ICU capacity; the Cabinet Office communications team's work with DHSC and the CMO on public messaging that "people with serious health conditions should still go to hospital for necessary treatment; an update on PPE and ventilators;

4.9.11. 4 April 2020[45] - Topics discussed were: the delivery plans of the Nightingale Hospital in Birmingham; data on self-isolation compliance in the non-shielded over-70s group;

4.9.12. 10 April 2020[46] (chaired by the First Secretary of State) – Topics discussed were: the Dashboard and critical care capacity; a communications update;

4.9.13. 13 April 2020[47] (chaired by the First Secretary of State) – Topics discussed were: DHSC's Adult Social Care Strategy; PPE levels across the UK;

4.9.14. 14 April 2020[48] (chaired by the First Secretary of State) - Topics discussed were: DHSC's Adult Social Care Strategy and its publication;

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[39] SA/103 - INQ000056107, SA/104 - INQ000056105
[40] SA/105 - INQ000056260
[41] SA/106 - INQ000146698; SA/107 - INQ000088320; SA/108 - INQ000088604; SA/109 - INQ000088323
[42] SA/110 - INQ000088325; SA/111 - INQ000088324; SA/112 - INQ000088328; SA/113 - INQ000088329; SA/114 - INQ000088605
[43] SA/115 - INQ000088331; SA/116 - INQ000088332; SA/117 - INQ000088333; SA/118 - INQ000088334; SA/119 - INQ000088606; SA/120 -INQ000088339
[44] SA/121 - INQ000088338; SA/122 - INQ000088340; SA/123 - INQ000088607
[45] SA/124 - INQ000088608; SA/125 - INQ000088342; SA/126 - INQ000088625; SA/127 - INQ000088345
[46] SA/128 - INQ000088364; SA/129 - INQ000088611; SA/130 - INQ000088379
[47] SA/131 - INQ000088387; SA/132 - INQ000088388; SA/133 - INQ000088629; SA/134 - INQ000088696
[48] SA/135 - INQ000088390; SA/136 - INQ000088391; SA/137 - INQ000088697; SA/138 - INQ000088695

4.9.15. 27 April 2020[49] – Topics discussed were: an update on PPE and priority products by the Department for International Trade and DHSC;

4.9.16. 4 May 2020[50] – Topics discussed were: PPE demand across the NHS; PHE guidance on PPE; DHSC and NHS communications to individual trusts on purchase of PPE; and

4.9.17. 6 May 2020[51] - Topics discussed were: DHSC's support package to care homes; the infection prevention and control board assurance framework provided by the NHS; and nosocomial infections.

4.10. Some healthcare issues and interventions were discussed at the Prime Minister's 9:15 strategy meetings or at other specific meetings as well as or instead of at the HMIG meeting. This was necessary given the volume and scale of issues that required input and decision by the Prime Minister.

COBR

4.11. Ministerial COBR meetings continued to review overall progress and make important decisions during the second stage. This was the key forum to take strategic decisions on issues including Non-Pharmaceutical Interventions (NPIs) which were implemented to help protect the NHS. Meetings during this stage were, therefore, usually chaired by the Prime Minister. Subjects covered in these meetings included, for example: social distancing measures (on 16 March); closure of schools (on 18 March); and, enhanced social distancing measures (on 20 March); and the first national lockdown (on 23 March). The Cabinet Office has provided the Inquiry with a full chronology of these meetings[52], and COBR meetings related to healthcare are provided in this statement as appropriate.

4.12. Some COBR meetings sought consensus on a UK-wide measure (such as the first UK-wide lockdown) which was within the competence of the UK government. Other COBR meetings aimed to provide a shared understanding of plans as they were being developed across the UK, but did not seek consensus on those plans, as the powers to take action were devolved (for example, certain aspects of social distancing measures).

[49] SA/139 - INQ000088680; SA/140 - INQ000088482; SA/141 - INQ000088678; SA/142 - INQ000088497
[50] SA/143 - INQ000088669; SA/144 - INQ000088536; SA/145 - INQ000088672; SA/146 - INQ000088671
[51] SA/147 - INQ000088562; SA/148 - INQ000088561; SA/149 - INQ000088563; SA/150 - INQ000088564; SA/151 - INQ000146701; SA/152 - INQ000088556
[52] SA/153 - INQ000113573

Cabinet

4.13. Formal Cabinet meetings continued to discuss COVID-19 on a weekly or other frequent basis during this second stage. Cabinet calls (not formal Cabinet meetings, but calls to which all of the Cabinet were invited and that considered pressing issues or updates outside of the weekly Cabinet meetings) were also convened from time to time.

Developments in Official Support Structures During the Second Stage

4.14. Within the Cabinet Office around 20 Directors General and Directors moved from their 'day jobs' to the COVID-19 response.[53] These officials set up new teams to advise and support the ministerial meetings:

4.14.1. A dedicated COVID-19 team was established in No.10. Tom Shinner was appointed to lead this team as Director General for COVID-19.

4.14.2. Each MIG was supported by a dedicated team in the Cabinet Office, led by the Senior Secretary for that committee.

4.14.3. A central COVID-19 secretariat in the Cabinet Office worked to Directors General Jonathan Black and Mark Sweeney. The COVID-19 Secretariat included:

4.14.4. A central coordination team which triaged issues potentially needing ministerial agreement and discussion, and directed the engagement between the different meetings, working with No.10 staff;

4.14.5. A strategy function for the Roadmap (once lockdown had been implemented and as attention turned to 'unlocking' in phases);

4.14.6. A data and analysis function;

4.14.7. A PMO (detailed at Section E) which commissioned delivery plans and began to track the implementation of measures across government departments, working alongside Tom Shinner's team;

4.14.8. In addition, Philip Barton, Director General, led a Cabinet Office team on long-term planning and the eventual recovery from the pandemic.

[53] This entailed the temporary repurposing of the Economic and Domestic Secretariat, large parts of the National Security Secretariat, the Trade Secretariat, and the Transition Taskforce (which had been set up to prepare for the UK's departure from the EU). On 16 April 2020 the Cabinet Secretary wrote to Heads of Department, setting out governance structures and programme Senior Responsible Officers (SROs) [SA/154 - INQ000087164] and the associated list of programmes of work and the respective SROs [SA/155 - INQ000087171].

4.15. The wide-ranging coordination between the UK government and the devolved administrations was supported in the Cabinet Office by the UK Governance Group, headed by Lucy Smith (later Peter Lee as Acting Director General) which supported UK government departments and devolved administrations to ensure that the response fully considered the devolution perspective and UK-wide impacts. Throughout the pandemic, the DHSC was (and remains) the lead department for health and social care in England, and where necessary, across the devolved administrations. As previously stated, as per the Cabinet Manual, health and social care are devolved to the respective legislatures and administrations in Scotland, Wales and Northern Ireland[54].

4.16. Existing functions in the Cabinet Office focussed on COVID-19 as relevant. For example, certain functions provided support for the operational delivery of the Government's response, such as the ventilator challenge and PPE procurement (the Government Commercial Function).

[54] SA/2 - INQ000182315/64

5. SECTION D: THE THIRD GOVERNANCE STAGE (FROM 28 MAY 2020)

From MIGs to COVID-19 Taskforce (CTF)

5.1. By early May 2020, the UK had passed the initial peak of the COVID-19 pandemic. The first Roadmap out of lockdown was published on 11 May 2020.[55]

5.2. On 22 May 2020, Simon Case, then Permanent Secretary in No.10 responsible for COVID-19, and Helen MacNamara, the Deputy Cabinet Secretary, submitted advice to the Prime Minister recommending changing the approach to ministerial governance and decision-making structures.[56] In summary, they advised that streamlined governance structures with clearer lines of accountability were required given the likely length of the pandemic and government response.

5.3. These changes were agreed by the Prime Minister and communicated to Heads of Department across government on 28 May 2020[57] . I now briefly summarise each aspect of this third stage of governance.

5.4. COBR continued to meet periodically during this stage, particularly where issues required cross-UK action. An update on COVID-19 continued to be taken at each weekly meeting of Cabinet. Cabinet meetings or calls were also conducted ahead of key moments and publications. From time to time, collective decisions on COVID-19 were taken at Cabinet.

5.5. The MIGs were stood down at the beginning of this stage and two new Cabinet committees were established resembling the governance structure for managing EU Exit which had enabled discussions on both strategy and on driving delivery and assurance of implementation:

5.5.1. The COVID Strategy Committee (COVID-S) was chaired by the Prime Minister. The core membership of COVID-S comprised the Chancellor of the Exchequer, the Foreign Secretary, Secretary of State for the Home Department, the CDL, the Health Secretary and the Secretary of State for Business, Energy and Industrial Strategy. According to its Terms of Reference, COVID-S was set up "to drive government's strategic response

[55] SA/3 - INQ000089917

[56] In May 2020, an internal review by Helen MacNamara identified "a need to plan further ahead; build greater resilience in structures; reduce parallel chains of command and tasking; increase understanding of organisational roles and responsibilities; and improve openness to diversity of backgrounds, views and styles of leadership" [SA/156 - INQ000137221 and SA/157 - INQ000137222]. On 22 May 2020, Helen McNamara and the Cabinet Secretary Simon Case advised the Prime Minister that the COVID-19 governance structures should be changed [SA/158 - INQ000089916].

[57] SA/159 - INQ000087165

to COVID-19, considering the impact of both the virus and the response to it, and setting the direction for the recovery strategy."[58] The meetings ran between 4 June 2020 until 21 February 2021, to set in place the overarching COVID-19 strategy, and then consider key strategic choices in the response to the pandemic. The Cabinet Office has provided the Inquiry with a full chronology of COVID-S meetings[59]. The 'Quads' referred to in the previous section A were also used to set the government's strategic direction.

5.5.2. The COVID Operations Committee (COVID-O) was usually chaired by the CDL. On occasion, meetings were chaired by the Prime Minister or delegated to the Paymaster General or the Minister for the Cabinet Office. The core membership was the Chancellor of the Exchequer and the Health Secretary (other departments would be invited according to the agenda of a particular meeting). According to its Terms of Reference,[60] COVID-O was set up "to deliver the policy and operational response to COVID-19." Meetings often started with data and science briefings either from the Dashboard team or key experts. The devolved administrations were invited to meetings where a UK-wide approach was needed, for example on border measures and vaccination. The meetings ran between 29 May 2020 and 29 March 2022. The Cabinet Office has provided the Inquiry with a full chronology of COVID-O meetings, including those meetings which discussed healthcare matters.[61] COVID-O meetings are referenced throughout this statement as appropriate.

5.6. The Government managed different phases of the pandemic with strategic plans. COVID-O was used to oversee overall implementation of the strategic plan in force at any one time, such as the progress of the Spring Roadmap 2021, and the Autumn/Winter Plan 2021. COVID-O was also used for topic-specific discussions on the design or delivery of key aspects of the strategic plans. This dual role meant that the frequency and focus of COVID-O meetings varied according to the path of the pandemic and the shape of the Government's response to it. With its large volume of meetings, it took on some of the role that had originally been envisaged for COVID-S and became a regular forum on some ongoing issues at different times.

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[58] SA/158 - INQ000089916
[59] SA/160 - INQ000176781
[60] Prior to the first meeting, the secretariat provided two documents to the Chair in addition to the Chair's brief and papers. These set out the terms of reference for COVID-O [SA/161 - INQ000087168], and also the process for managing and running the Committee [SA/162 - INQ000087169].
[61] SA/163 - INQ000177566

5.7. A senior official from the CTF (see below) took the role of Senior Secretary for COVID-S and COVID-O meetings.

5.8. COVID-O typically agreed decisions through a meeting, but like all Cabinet committees, also took a number of smaller decisions through a written procedure in line with Cabinet committee procedure.

5.9. In addition to the collective decisions taken by COVID-O, over 1,000 actions were assigned during its meetings. These actions would either fall to the CTF to take forward or to other departments and agencies. In this regard, the PMO (see Section E) was incorporated into the CTF, and provided delivery oversight for COVID-S and COVID-O.

5.10. COVID-O met for the final time on 29 March 2022 and took its final decision via letter on 5 April 2022. On 19 May 2022, advice to the Prime Minister proposed a Cabinet committee restructure and recommended that COVID-S and COVID-O be stood down, with any decisions needed beyond that point taken at a relevant committee.[62] COVID-S and COVID-O were formally stood down in September 2022.

The COVID-19 Taskforce (CTF)

5.11. It was clear within the Cabinet Office during April 2020 that the Government needed to establish a dedicated, single unit focussed on COVID-19 and that this needed to be resourced appropriately. Some duplication had emerged between the Cabinet Office and No.10 operations, which had been built at speed. In addition, the Prime Minister and other ministers wished to ensure that both the COVID-19 response and the rest of the Government's policy agenda (which had largely been put on hold from mid-March) could be pursued in parallel.

5.12. In May 2020, the CTF was formed and the other COVID-19 teams were ended, so that many staff were able to return to their previous roles. The CTF in the Cabinet Office was the unit responsible for coordinating the Government's response to the pandemic, working closely with all government departments on particular policy areas.

5.13. The Cabinet Office's Module 2 corporate statement[63] described at a high level the subsequent evolution of the CTF to March 2022, when it was stood down:

[62] SA/164 - INQ000087162
[63] SA/4 - INQ000092893/39-41

5.13.1. "The Taskforce initially reported to Simon Case as the Permanent Secretary at No.10 responsible for COVID-19. Its first incarnation brought together the No.10 team (led by Tom Shinner) and a Cabinet Office team (led by Simon Ridley)".

5.13.2. "The Taskforce coalesced over the summer of 2020. To meet the challenges of developing the Government's ongoing response and enabling the decision making required, the Taskforce had to bring in resource from around the Government, beginning this process in May and June 2020. Its size, having begun in the tens, reached hundreds within six months".

5.13.3. "After Tom Shinner left in July 2020, Kate Josephs joined the Taskforce to replace him. At this point all the staff in the Taskforce formed a single team in the Cabinet Office, which worked closely with No.10".

5.13.4. "Simon Case was appointed the Cabinet Secretary in September 2020. Simon Ridley and Kate Josephs led the Taskforce until James Bowler was appointed Second Permanent Secretary in the Cabinet Office with responsibility for leading the Taskforce from October 2020. Kathy Hall joined the Taskforce in October 2020 ahead of Kate Josephs leaving in December 2020 for a new role. Rob Harrison joined the Taskforce in October 2020 to lead the analysis and data team and to continue building these capabilities. James Bowler, Kathy Hall, Simon Ridley and Rob Harrison remained the Taskforce senior leadership until July 2021".

5.13.5. "Around the time that delivery of the [COVID-19 Response - Spring 2021] roadmap concluded, James Bowler was appointed as Permanent Secretary to the Department for International Trade with effect from August 2021. Simon Ridley led the Taskforce from this point until March 2022, supported by Kathy Hall (who remained in post until January 2022) and Rob Harrison (who remained in post until February 2022)".

5.14. The Cabinet Office has provided a dedicated statement[64] covering the role of the CTF to Module 2 of the Inquiry, which details its structures and senior leadership. I now provide a short summary based on that.

5.15. The CTF led the cross-government response to COVID-19. It led the official advice in the centre of government to the Prime Minister, CDL and other ministers on the

[64] SA/165 - INQ000248852

development and delivery of the Government's COVID-19 strategy, across the full range of policy issues and at all key decision-making moments, informed by a single analytical picture of the pandemic (the Dashboard). The CTF also ran the Government's COVID-19 Cabinet committee meetings, which sought to ensure that: key decisions were agreed collectively in line with Cabinet Government principles; that ministers could collectively scrutinise data, strategy and implementation; and that decisions involved input from the right departments and experts, and were then communicated appropriately. While the response of the healthcare system was central to the overall strategy of the Government's response to COVID-19, the CTF did not have a role in day-to-day decisions on the delivery of healthcare services on the ground.

5.16. **Strategic leadership and coordination:** The CTF coordinated and advised on strategy for the COVID-19 response, working with HMT, medical and health experts including the CMO and GCSA and other departments to ensure the strategy reflected a wide range of inputs and considerations. This included preparing a number of strategies throughout the pandemic which steered the overarching government response, such as the November 2020 'COVID-19 Winter Plan', 'COVID-19 Response - Spring 2021 (Roadmap)' and 'COVID-19 Response: Autumn and Winter Plan 2021'[65]. These were agreed with the Prime Minister and other ministers through a series of meetings, with collective agreement sought through COVID-S or COVID-O, before publication. These strategic documents guided the Government's response as it evolved throughout the pandemic, outlining steps towards the lifting of restrictions. Section F describes in detail how aspects of some of these strategies relate to healthcare systems. These strategic plans were aimed at a wide non-expert audience and considered the whole country's response to the pandemic, rather than specific steps for the response of healthcare systems themselves.

5.17. **Data and Analysis**: From summer 2020, the CTF produced the 'Dashboard', which replaced the cross-department SitRep and CRIP initially produced by CCS. The Dashboard brought together a range of data relating to COVID-19 (including on mortality, infection, health, restrictions and mobility, the economy and the public sector) into a single analytical picture that included the health, economic and societal impacts of COVID-19. The CTF collated relevant data for the Dashboard, which was used to present regular, often daily, updates to the Prime Minister and others, and to brief Cabinet and other ministerial meetings to inform decision-making. The

[65] SA/166 - INQ000137262; SA/167 - INQ000086876; SA/168 - INQ000086877

Dashboard meetings with the Prime Minister continued until February 2022. Section E provides further detail on the development and maintenance of the Dashboard.

5.18. The CTF worked closely with the key official advisers on COVID-19, including but not limited to the GCSA and CMO (and DCMOs where appropriate), who were invited to meetings with the Prime Minister and provided input to the vast majority of CTF-drafted papers for ministerial meetings and the Prime Minister. The Head of the CTF and the Directors General met regularly with the CMO and GCSA. The Science and Projects team within the CTF provided a mechanism to ensure that commissions to SAGE and its sub-groups were aligned to ongoing policy development.

5.19. **Delivery and development of policy:** The COVID-19 response was a whole-of-government effort. A very wide range of government departments and other bodies were responsible for developing policy and delivering it on the frontline. The CTF looked across the response, bringing the range of departmental views together to consider the health, economic and social impacts and help ensure that ministerial decisions were implemented effectively.

5.20. At the end of May 2020, the PMO became part of the CTF. Through the PMO (see Section E) and a range of focused teams (see below), the CTF worked with departments to promote the effective implementation of the strategy, helping to unblock issues and assure delivery.

5.21. The CTF had a number of focused teams working with other departments on a range of areas in response to the pandemic and feeding into the wider strategy. While responsibility for delivery in these areas lay with departments and other relevant bodies, the focused teams in the CTF contributed to policy development and helped ensure that collectively agreed policies were delivered effectively. This was an important way in which the CTF helped to ensure that the different components of the COVID-19 response balanced the health, economic and social impacts.

5.22. More specifically, these teams provided advice to the Prime Minister and CDL, supported cross-government ministerial and officials meetings, and worked with lead departments and experts, bringing together a range of interests. Following the establishment of the CTF in May 2020 and during its subsequent evolution, the areas covered by these teams changed over time according to the nature of the Government's response.

5.23. Areas covered for significant periods of the response include the following (listed

alphabetically): business and the economy; compliance and enforcement; DIGs; education and wider public services; health and adult social care; local action; regulations; social contact; test, trace and isolate; travel and borders; and, vaccines and therapeutics.

5.24. For the health and adult social care team in the CTF, this included providing the Prime Minister and CDL with overall assessments of how the system as a whole was responding. This was in regard to: NHS capacity and methods to increase capacity; policy measures to limit the nosocomial infections in health and social care settings including testing and visiting protocols; and, policy measures to protect and support health and social care workers and patients (e.g. mandatory vaccine considerations). The CTF worked closely with DHSC, PHE (then UKHSA) and NHSE to seek these assessments and understand progress. Further information on the role of the CTF in assessments of NHS capacity, the assessment of methods to increase capacity, and the role of the Cabinet Office in policies to limit the spread of the virus are detailed in Section F.

5.25. Individual government departments are responsible for understanding the equality impacts of their own policies through compliance with the Public Sector Equality Duty (PSED). Section G of this statement provides further details on some key equality considerations in decision-making on healthcare during this period.

Additional relevant Cabinet committees during Module 3 period

5.26. In September 2022, COVID-S and COVID-O were formally stood down. At various times during the period relevant to the scope of Module 3, there were additional Cabinet committees with remits that included healthcare as part of broader decision-making[66]. These included:

5.26.1. The National Economic Recovery Taskforce (Public Services) (NERT (PS)), established in January 2021 to drive the development and delivery of plans to recover public service performance in light of the impacts of the COVID-19 pandemic. The NERT (PS) met for the first time in February 2021 and was chaired by CDL.

5.26.2. The Health Promotion Taskforce, established in August 2021 to drive a cross-government effort to improve the nation's health, supporting economic recovery and levelling up. The Health Promotion Taskforce was

[66] SA/169 - **INQ000089797**

chaired by the Health Secretary.

5.26.3. The (Strategy) (DES) and Domestic and Economic (Operations) (DEOps) committees, established in October 2021. The former was chaired by the Prime Minister; the latter was chaired by CDL. These committees had very broad remits and discussed matters relating to domestic and economic strategy.

5.26.4. The Government Priorities Delivery Committee, chaired by the Prime Minister, was also established in October 2021 and again had a broad remit to coordinate and drive progress and accountability on the delivery of the Prime Minister's priority missions through stock takes on: levelling-up; education; jobs and skills; health and care; crime and justice; and net zero.

6. SECTION E: THE DEVELOPMENT OF THE COVID-19 DASHBOARD AND THE ROLE OF THE PROGRAMME MANAGEMENT OFFICE

6.1. The COVID-19 Dashboard and the COVID-19 PMO were central to the way in which the Cabinet Office supported the making of decisions.

COVID-19 Dashboard

6.2. The Cabinet Office sought to ensure that decision-making meetings on COVID-19 were supported by data, analysis and expert advice. During the second stage of governance (detailed in Section C), the Dashboard was the Cabinet Office's key mechanism for bringing together and presenting a single, integrated analytical picture for decision-makers. As part of this the CTF sought to ensure that healthcare impacts were included within the single picture and considered alongside impacts on the economy and society. Data was sourced from a number of different government departments (including DHSC and HMT), public sector bodies (such as NHSE) and the private sector. The structures and processes through which the Cabinet Office carried out this role evolved during the pandemic.

6.3. As the pandemic evolved and the quality of data available improved, the Prime Minister's 9:15 strategy meeting became a daily Dashboard meeting at which the Prime Minister, Chancellor of the Exchequer, other key ministers, officials and advisers received regular updates on the virus and its impacts. The Dashboard meetings with the Prime Minister complemented the policy-making process by facilitating a shared understanding of the developing data picture and building familiarity with the key indicators and trends. The Prime Minister also used Dashboard meetings to ask questions and request follow-up briefing on key issues.

6.4. The Dashboard provided a range of data, available at the time, related to COVID-19 including on mortality, infection, health, restrictions and mobility, the economy and the public sector. The Dashboard's interactive charts were shared daily via a portable document format (PDF) from 16 to 23 March 2020 to a large cross-government and devolved administration distribution list. As requested by the Inquiry, some examples, including the first and last Dashboard presented to the Prime Minister, are exhibited.[67]

6.5. On 24 March 2020, the CCS launched an interactive version of the Dashboard on a dedicated website, which was available across government and updated at the end of

[67] SA/170 - INQ000174708 (15 March 2020); SA/171 - INQ000083360 (1 April 2020); SA/172 - INQ000283725 (11 December 2020); SA/173 - INQ000283745 (2 March 2021); SA/174 - INQ000283804 (6 September 2021); SA/175 - INQ000283870 (23 February 2022).

each day. Once updated, an email alert was sent to users along with a PDF version of the Dashboard. The interactive Dashboard was used to brief the Prime Minister and senior members of Cabinet.

6.6. The range of data sources covered by the Dashboard expanded over time. For example, a wide range of data came through the NHS, testing, vaccination, and other public health infrastructure for which DHSC was responsible. A key surveillance tool feeding into the Dashboard was the COVID-19 Infection Survey (CIS) which was carried out by the Office for National Statistics (ONS) and commissioned by PHE in April 2020, with the first results made available in May 2020.

6.7. The Dashboard also continuously evolved in response to ministerial and senior official feedback, including from No.10, and as data availability and quality improved. The same is true for data on healthcare systems which can be seen by comparing the evolution of Dashboards over time. Examples to demonstrate this evolution are below:

6.7.1. The first Dashboard[68] on 15 March 2020 included healthcare data on: a breakdown of UK cases, ICU bed capacity, total deaths, health and social care situation and outlook (e.g 111 calls, GP surgery closures, cancellation of electives, hospital major incidents).

6.7.2. By 1 April 2020[69], the Dashboard included far greater data on healthcare systems, including: global health comparisons, UK daily deaths, UK daily tests, short term ventilator supply, ONS total deaths, hospital admissions, spare critical care beds, number of critical care patients, and staff absences in hospitals in England and Scotland.

6.7.3. By 10 April 2020, No.10 commissioned the NHS and DHSC to provide hospital-level data and a 'league table' setting out in particular which hospitals were most at risk, as well as the progress and capacity of the Nightingale hospitals, availability of beds, and workforce numbers[70]. Whilst the Cabinet Office is not aware of any specific decisions made as a result of the 'league table' alone, nor any made by the Cabinet Office in regard to individual hospitals on this list, it is clear this was an effort to improve the picture of data at a local level. As further demonstrated below, the effort to improve the data captured by the Dashboard helped to achieve a fuller understanding of pressures on the healthcare system, which subsequently

[68] SA/170 - INQ000174708
[69] SA/171 - INQ000083360
[70] SA/176 - INQ000280020

informed decisions on the overall strategy of the Government's response to COVID-19.

6.7.4. By 5 July 2020[71], the Dashboard included even more granular healthcare systems data such as: daily COVID-19 deaths in all settings, weekly death registrations, positive cases by local tier authority, care homes with live outbreaks, hospital admissions per 100,000 by NHS region, testing of hospital patients and NHS frontline workers, R number estimates, deaths and cases by age and gender in hospitals, infection in healthcare workers, COVID-19 related staff absences in hospitals, deaths by local authority, cancer referrals, medicine supply issues, people in hospital by location, and emergency department attendance by age group.

6.8. The development of the Dashboard was overseen by an Editorial Board (described in Katharine Hammond's Module 2 witness statement[72]) which was responsible for making decisions on the inclusion of information, and quality assuring data. The importance of reliable data, presented in a single analytical picture of the pandemic, remained integral to the Dashboard. As the pandemic evolved, quality assured data in categories on healthcare systems from departments increased, as demonstrated by the above Dashboards throughout 2020.

The COVID-19 Programme Management Office (PMO)

6.9. In early April 2020, the PMO was established to provide a high-level structure for overseeing, monitoring, and supporting the delivery of the Government's COVID-19 policy objectives and interventions.[73]

6.10. The PMO comprised a central data team and a range of subject matter specific teams that were aligned to issues. The key functions of the PMO were:[74]

6.10.1. "Driving planning and implementation of COVID workstreams: working with MIGs to ensure that all priority workstreams have underlying plans which detail milestones, metrics and risks.

6.10.2. Scrutinising delivery: Identifying issues for escalation, either to the MIGs or PM meetings, or de-prioritisation.

[71] SA/177 - INQ000174759
[72] SA/178 - INQ000221567
[73] SA/179 - INQ000174719
[74] SA/180 - INQ000174720

6.10.3. Aggregate picture of delivery: generating an overview of all plans and the inter-dependencies between them."

6.11. The work of the PMO spanned the areas of the four MIGs and included, as relevant to the scope of Module 3, teams focused on: tracing operations; testing capacity and strategy; shielding; vaccines; NHS workforce; NHS acute capacity (beds); supply (PPE); nosocomial infections; and, supply of medicines.

6.12. The teams in the PMO consisted of civil servants, military personnel, and senior management consultants. As outlined below, through these teams the PMO worked with government departments to ensure the effective implementation of the Government's COVID-19 objectives and interventions, assisting departments to identify the work required to deliver the Government's overarching objectives and interventions, and supporting departments in the planning of the necessary project or programme of works.

6.13. The specific role played by the PMO varied between projects. Broadly, the PMO monitored the delivery of projects and programmes across government that were critical to the Government's COVID-19 response by way of weekly reports; commissioning delivery plans from departments; tracking implementation working with Senior Responsible Officers (SROs) in departments; and, reporting on the implementation and risk of key programmes.[75] The PMO reported on delivery to the CDL and relevant permanent secretaries, and provided regular updates to Cabinet Office meetings. For example, on 8 May 2020, the Director of the PMO attended the Prime Minister's 9:15 strategy meeting to update on the delivery of programmes including those where slower progress was being made and where further input from other government departments was needed to address this. Minutes of this meeting are exhibited.[76]

6.14. The PMO was not a mechanism for dealing with the delivery of acute policy decisions. Typically, short-term, immediate decisions and actions would be communicated and tracked by the relevant secretariat to each ministerial forum, in the normal way. The PMO sought to complement this work by ensuring forward-looking, high-level, delivery plans, for the various programmes of work required as part of the pandemic response, aligned with ministerial policy decisions, had been adopted by the relevant departments. The PMO's main function was to oversee the departments' medium-term planning for the various COVID-19 work programmes across government.

[75] SA/181 - INQ000421018
[76] SA/182 - INQ000088650

6.15. Delivery plans commissioned by the PMO provided the centre of government with high-level visibility of progress. They were used to help ensure that ministers had a clear, concise, broad picture of existing delivery plans, the personnel responsible for delivery and emerging implementation risks or barriers. Where no specific decision on interventions had been made, it was for the department to also develop its own intervention strategy; however, the PMO would assist on the delivery approach.

6.16. The PMO implemented a framework for weekly reporting across different programmes of work. Each programme was aligned to a specific department and intervention or scope of activity. This system required relevant departments to provide updates detailing the steps taken and to be taken, together with assurances that the departments were adequately resourcing, planning and aligning their activities to the relevant government objectives and expectations. Each programme was assigned a departmental SRO who engaged with the PMO on the plans for delivery of the programme. The PMO subject-specific teams worked directly with departments, to support development of their plans, and alignment of plans with policy.

6.17. As outlined, the role of the PMO was to provide high-level support to other government departments to ensure they established programmes of work to deliver the Government's COVID-19 policy objectives and interventions and, to provide high-level monitoring of the implementation of those programmes through the weekly reporting system. The PMO did not undertake an assessment of the substantive delivery of the programmes: the details of what was happening operationally was provided by the departments to the CTF Dashboard and relevant Cabinet Office committees. Ownership of many of the programmes was concentrated in the DHSC and its agencies. Therefore, much of the work undertaken by the PMO related to programmes to be undertaken by DHSC in relation to the healthcare system. Examples of DHSC programmes relevant to this module are exhibited.[77]

6.18. In addition to the PMO core functions outlined above, the PMO also contributed to the development of the 'COVID-19 Winter Plan' (November 2020).[78] The PMO worked with No.10, other members of the COVID-19 Secretariat, and the Cabinet Office to generate a series of Reasonable Worst-Case Scenarios (RWCS) and assumptions, to be used by departments to guide winter planning. The PMO supported each department to align their plans to the RWCS and assumptions. A cross-Whitehall workshop was held in

[77] Delivery Report 9 dated 14 May 2020 [SA/183 - INQ000421020] includes the DHSC Social Distancing Programme; Delivery Report 12 dated 28 May 2020 [SA/184 - **INQ000361599** includes the DHSC NHS Acute Capacity (beds) Programme; and, Delivery Report 14 dated 4 June 2020 [SA/185 - INQ000421023] includes the DHSC NHS Workforce Programme.
[78] SA/166 - INQ000137262

July to also support departments' application of the RWCS and assumptions to their winter planning.[79] The Ministry of Defence (MOD) was also tasked with running an exercise (Exercise Fairlight outlined in Section H) to stress test the winter planning. Progress was tracked by the PMO.

[79] SA/186 - INQ000421034

7. SECTION F: THE ROLE OF THE CABINET OFFICE IN RELATION TO THE RESPONSE OF THE HEALTHCARE SYSTEM TO COVID-19

7.1. In this section, I provide an overview of the Cabinet Office's role in healthcare decisions during the relevant period. This section addresses issues thematically and with reference to the governance structures outlined in Sections A-D above. It is structured in the following way:

7.1.1. given the Cabinet Office's role, this section starts with the overarching strategies that determined the Government's response to the pandemic, which the Cabinet Office coordinated;

7.1.2. the work that the Cabinet Office undertook with regard to NHS capacity and resilience is then outlined, given that these issues were central to the overarching strategy from the beginning;

7.1.3. the provision of funding to the healthcare system is then considered;

7.1.4. the availability of ventilators, PPE, and other medical equipment, supplies and medicine is addressed; and,

7.1.5. shielding and the policies designed to protect the clinically extremely vulnerable (CEV) are summarised.

7.2. While this module focuses on healthcare rather than social care, throughout the design and delivery of strategic plans, the Cabinet Office considered health and social care as a whole system. This involved considering the impacts of different interventions on different parts of the system and ensuring that those impacts were taken into consideration in decision-making and reflected in government plans and policies.

Overarching strategies

7.3. Throughout the relevant period the Government managed its response to the different phases of the pandemic with strategic plans. The Cabinet Office led work on the design of these strategic plans, with input from key departments such as DHSC, and provided oversight of overall implementation of the strategy in force at any one time. As previously outlined, these strategic plans were aimed at a wide non-expert audience and considered the whole country's response to the pandemic, rather than specific steps for the response of healthcare systems themselves. These overall strategic plans were complementary to separate healthcare plans which were developed by DHSC.

7.4. Following agreement at a COBR meeting on 2 March 2020[80], the 'Coronavirus Action Plan: A Guide to what you can expect across the UK', was published on 3 March 2020 (the COVID-19 Action Plan).[81] This plan was published by DHSC and the health departments in the devolved administrations; the Cabinet Office provided input and circulated it for comment across Whitehall prior to its publication.

7.5. The COVID-19 Action Plan set out a number of actions that would be taken in the four identified phases of the response: contain, delay, research and mitigate. For example as part of the 'delay' strategy the Plan outlines the daily monitoring of stockpiles of protective equipment for healthcare staff who may come into contact with patients with the virus. As part of steps to 'mitigate' the impact of the virus the Plan deals with delaying non-urgent care in order to prioritise and triage service delivery and outlines that staff rostering changes may be necessary including calling leavers and retirees back into the health service. The Plan notes: "[E]veryone will face increased pressures at work, as well as potentially their own personal illness or caring responsibilities. Supporting staff welfare will be critical to supporting an extended response".

7.6. In his address to the nation announcing a lockdown on 23 March 2020, the Prime Minister said: "I want to begin by reminding you why the UK has been taking the approach that we have. Without a huge national effort to halt the growth of this virus, there will come a moment when no health service in the world could possibly cope; because there won't be enough ventilators, enough intensive care beds, enough doctors and nurses. And as we have seen elsewhere, in other countries that also have fantastic health care systems, that is the moment of real danger. To put it simply, if too many people become seriously unwell at one time, the NHS will be unable to handle it - meaning more people are likely to die, not just from Coronavirus but from other illnesses as well. So it's vital to slow the spread of the disease". In announcing the first national lockdown, his message was, "stay at home, protect our NHS and save lives".[82]

7.7. On 11 May 2020, the Government published 'Our Plan to Rebuild: The UK Government's COVID-19 Recovery Strategy'.[83] The first of its five tests to determine the pace of reopening society and the economy was: "protect the NHS's ability to cope. We must be confident that we are able to provide sufficient critical care and specialist treatment right across the UK". This report detailed 14 programmes of work which would be delivered by the Government to assist the UK's recovery. The first of these

[80] SA/187 - INQ000056176; SA/188 - INQ000056217; SA/189 - INQ000056157
[81] SA/190 - INQ000086869; SA/191 - INQ000056154
[82] SA/192 - INQ000086759
[83] SA/3 - INQ000089917

concerned the securing of NHS care and capacity. As well as highlighting the continuing work that was required on both importing PPE and expanding domestic PPE manufacturing capability, the Strategy also noted: "The guidance on shielding and vulnerability will be kept under review as the UK moves through the phases of the Government's strategy. It is likely that the Government will continue to advise people who are clinically extremely vulnerable to shield beyond June. Whilst shielding is important to protect individuals from the risk of COVID-19 infection, the Government recognises that it is challenging for people's wider wellbeing. The Government will review carefully the effect on shielded individuals, the services they have had, and what next steps are appropriate"[84].

7.8. Subsequently, with a consistent aim to protect the NHS, and balancing the impacts of the pandemic across healthcare, the economy and society, the Government published: 'The next chapter in Our Plan to Rebuild: The UK Government's COVID-19 Recovery Strategy' (July 2020)[85]. Most notably this document refers to the provision of an additional £3 billion of funding to the NHS. This included additional funding to the NHS to allow them to continue to use additional hospital capacity from the independent sector, and to maintain the Nightingale hospitals, in their current state, until the end of March (2021). The origins of this decision will be further expanded upon in the section on funding.

7.9. 'The 'COVID-19 Winter Plan' (November 2020)[86] outlined a number of steps that the Government would take in order to protect NHS capacity. It stated that "initiatives have been put in place to make use of existing capacity across the NHS, such as NHS 111 to provide more effective triaging, and accelerated discharge to support patients to leave hospital safely and more quickly. The Government is also increasing eligibility for free influenza vaccinations to all 50 to 64 year olds from December. Vaccinating this cohort, in addition to those groups who are already eligible to receive the influenza vaccine free of charge, will reduce pressure on the NHS during the winter months as well as provide additional protection to a group of people who are vulnerable to COVID-19."

7.10. The 'COVID-19 Response: Spring 2021 Roadmap' (February 2021)[87] proposed the sequential re-opening of the economy against 'four tests': (1) The vaccine deployment programme continues successfully; (2) Evidence shows vaccines are sufficiently

[84] SA/3 - INQ000089917/32
[85] SA/193 - INQ000086693
[86] SA/166 - INQ000137262
[87] SA/194 - INQ000072888

effective in reducing hospitalisations and deaths in those vaccinated; (3) Infection rates do not risk a surge in hospitalisations which would put unsustainable pressure on the NHS; (4) Our assessment of the risks is not fundamentally changed by new Variants of Concern.

7.11. The 'COVID-19: Response: Autumn and Winter Plan 2021' (September 2021)[88]; and the 'COVID-19 Response: Living with COVID-19' (February 2022)[89] both contained details on NHS contingency planning and how the NHS had developed a range of interventions to respond to Covid-19 demand, while protecting urgent and elective care including implementing a range of workforce interventions such as increasing staffing numbers, temporary local adjustments to staffing ratios, with flexible redeployment of staff including training for roles in critical or enhanced care.

NHS Capacity

7.12. As is set out above, from the start of the pandemic, one of the Government's strategic aims was to protect the NHS. Therefore, monitoring NHS capacity, understanding how it could be maintained and seeking to understand what more could be done across the healthcare system to increase capacity was an important part of data collection and decision-making.

7.13. The capacity and resilience of the NHS was a key item of discussion at many ministerial committees and officials meetings, both in the early period of the pandemic response, and in more targeted ways as the response to the pandemic evolved. It was a key consideration which permeated almost all aspects of pandemic-related decision making both at times when prevalence of COVID-19 was high and as part of contingency planning, particularly for winter pressures.

COBR and NHS Capacity

7.14. In the early stage of the Government's response to the pandemic, COBR commissioned a COVID-19 RWCS - compiled with input from the CMO and the GCSA - and agreed to increase preparedness in line with such a scenario. A RWCS was commissioned regularly throughout the relevant period and was based on scientific advice. The initial RWCS was discussed at a ministerial COBR meeting chaired by the Health Secretary on 29 January 2020.[90] Based on advice from SAGE, ministers agreed to use the RWCS planning assumptions which were already in place for pandemic

[88] SA/195 - INQ000065168
[89] SA/196 - INQ000086652
[90] SA/197 - INQ000056226

influenza.[91] The initial planning priority for the RWCS identified as a key planning area 'support measures for primary care workers and patient triage planning, including NHS surge activity'. The RWCS was revised in the early part of the pandemic. On 30 March 2020 revised RWCS assumptions[92] were circulated, based on a variety of scenarios for compliance with the lockdown. These updated assumptions included data on hospitalisations, ICU admissions and ICU occupancy based on both poor compliance with behavioural and social interventions ('BSIs') and good compliance with BSIs. Throughout the pandemic, departments were required to develop plans against the scenario and specifically, to consider impacts of COVID-19 on NHS capacity and the healthcare system and to help inform government policy and plan for the impact of COVID-19.

7.15. In addition, from early March 2020, COBR was the forum through which collective agreement was provided for the Coronavirus Bill, with the CCS and subsequently the Economic and Domestic Secretariat (EDS) supporting DHSC (as lead department for the legislation) in preparation for the Bill to ensure it captured the powers needed. The Coronavirus Bill received Royal Assent to become an Act on 25 March 2020.[93] It included provisions around healthcare, particularly 'Enhanced capacity and flexible deployment of staff' which included provisions for the emergency registration of health and social care workers, relaxation of some of the measures in the Mental Health Act 1983 relating to safeguards, and flexibility for Local Authorities around the Care Act 2014.

HMIG and NHS Capacity

7.16. Through the HMIG and 9.15 strategy meetings, there was a continued focus on NHS capacity. For example:

7.16.1. At the first HMIG, held on 18 March 2020, NHS Capacity and Resilience were discussed[94] and DHSC were assigned an action to continue at pace with work on options for increasing the NHS workforce. A draft copy of the minutes[95] and actions from this meeting are exhibited.[96]

7.16.2. The Prime Minister's 9:15 strategy meeting on 23 March 2020 considered Operation Nightingale, tasking DHSC and NHSE to 'drive forward…

[91] SA/198 - INQ000056149
[92] SA/58 - INQ000083639
[93] SA/199 - INQ000058335
[94] **SA/93 - INQ000056051**
[95] SA/94 - INQ000056261
[96] SA/95 - INQ000056123

contingency plans at pace, expanding hospitals, procuring further capacity for beds, operation Nightingale, and expediting staffing plans'.[97] This was part of DHSC's 3-month 'battleplan' for health and social care[98] focused on tackling the virus and protecting life. At this meeting, it was also agreed that the HMIG should examine how equivalent work was being done by the devolved administrations to ensure awareness of wider UK plans.

7.16.3. On 22 March 2020 HMIG was informed by the DHSC of the NHS decision, in order to support capacity, to stop elective operations on 15 April 2020, with "individual Trusts tapering to that date at the rate they see fit"[99].

7.16.4. Nightingale hospitals were also considered at the Prime Minister's 9:15 strategy meeting on 24 March 2020, with DHSC and NHSE tasked to work with the MOD to accelerate existing work to ensure that the planned 10 new hospitals were operational as soon as possible. DHSC was asked to return to the meeting the following day with a clear timetable and plan for the construction of the new hospitals, including details on when they would become operational, the number of beds and ventilation facilities required, and staffing and volunteer levels required at each stage.[100]

7.16.5. NHS capacity data was a regular feature of the often daily Dashboard meetings. The Cabinet Office regularly corresponded with the NHS to try and obtain as accurate and timely data as possible.

7.16.6. In April 2020, there were a number of meetings to discuss NHS Capacity including an NHS Officials meeting on 14 April 2020.[101] On 15 May 2020 there was a COVID-19 NHS Capacity meeting looking ahead to try and anticipate future risks. A copy of the slides[102] produced by NHSE on capacity planning for 2020/2021 for this meeting have been exhibited, alongside the meeting readout and actions.[103]

7.17. A significant factor in the management of NHS Capacity for DHSC and NHSE was understanding nosocomial spread of COVID-19. Data on infections within hospital and other healthcare settings became a feature of the Dashboard meetings and the

[97] SA/102 - INQ000056096
[98] SA/98 - INQ000056110
[99] SA/32 - INQ000055942
[100] SA/104 - INQ000056105
[101] SA/201 - INQ000198047
[102] SA/202 - INQ000198094
[103] SA/203 - INQ000198093

Cabinet Office played a convening role in seeking to ensure that there was a clear and common understanding of the data among DHSC, NHS and others and that all practicalities were being considered when addressing nosocomial spread. In practice this involved bringing PHE (subsequently UKHSA) and NHSE together to seek assurances that they understood the risks with regards to nosocomial spread, and could outline what steps were being taken to manage it on the ground.[104]

The COVID-19 Taskforce and NHS Capacity

7.18. Monitoring and tracking NHS capacity and the factors that could support it was also a strong focus for the CTF, working closely with DHSC, PHE (subsequently UKHSA) and NHSE. The CTF worked to ensure that ministers were provided with reliable and up-to-date information and that decision-making balanced the challenges of managing NHS capacity. The Cabinet Office did not make decisions on the day-to-day capacity of the NHS as outlined in the introduction of this statement; rather, their decisions on the overarching strategy of the Government's response to COVID-19 were influenced by the monitoring and tracking of NHS capacity. For example, each lockdown decision (e.g March 2020, October 2020 and January 2021) was made in part due to concern for NHS capacity.

7.19. Throughout the summer of 2020, as prevalence of COVID-19 decreased, the concern surrounding NHS capacity was not so pronounced. However, in the autumn of 2020, the R rate increased to above 1 and SPI-M (Scientific Pandemic Influenza Group on Modelling) forecasts indicated that the NHS would come under increasing pressure.[105]

7.20. On 30 September 2020, the Cabinet Secretary met with NHSE Chief Executive, Simon Stevens, DHSC Permanent Secretary, Chris Wormald, and others to take stock of the challenges facing the NHS going into winter. A readout and actions from the meeting were circulated on 1 October 2020.[106] Following this meeting, DHSC, NHSE and the CTF were asked to develop a framework setting out a current assessment of NHS performance (broken down on a regional and local basis), the data flows required to track NHS performance, the criteria for action at a local, regional and national level, and at what level decisions needed to be taken when criteria were reached. This work would inform future ministerial discussions.

7.21. Following the Cabinet Secretary's stocktake, an NHS Decision Framework table, which crucially addressed capacity, was produced. The Decision Framework table was

[104] SA/204 - INQ000421040
[105] SA/205 - **INQ000062738**
[106] SA/206 - INQ000280021

included in a slide pack[107] prepared for a stocktake with the Prime Minister to discuss the NHS and winter preparedness on 23 October 2020.

7.22. The Decision Framework table sought to identify the key decisions that may need to be taken to manage NHS capacity over the winter period, and at what level (e.g. local, regional or national) those decisions needed to be taken. This supported ministers, including the Prime Minister, Health Secretary and Chancellor, to understand which decisions may need to be taken by central government. The framework set out the ways in which the NHS's operational independence would be exercised in order to preserve capacity at a time of rising cases and hospitalisations. The framework also recognised where decisions should be taken at an operational level within the NHS, and set out the data and critical dependencies that would inform decision-making.

7.23. The majority of decisions outlined in the table were identified as decisions to be taken by NHSE, and that central government would be sighted on this work. Decisions requiring more substantial input from central government included standing up Nightingale sites, extending hospital discharge arrangements beyond March 2021, and postponing non-urgent elective operations. In these instances, central government would work with the NHSE and others to inform any decision-making.

7.24. The Decision Framework table noted that central government ought to be given sight of some critical local decisions (such as any A&E closures or local public communications not to attend A&E unless absolutely necessary). It was important for central government to maintain sight of such decisions to understand pressures in different parts of the country and to ensure alignment with wider government activity.

7.25. During September and October of 2020, as prevalence rose, work was undertaken on the introduction of Local Alert Levels. The tiering of local areas was influenced by the latest understanding of NHS capacity concerns. As an example, in October 2020, there were concerns about increased incidence in Merseyside and Burnley and the pressure that this could place on the NHS locally unless action was taken.[108] On 8 October 2020 a meeting with the Prime Minister[109] took place, attended by senior leaders of the NHS (Simon Stevens, Amanda Pritchard and Stephen Powis), as well as CDL, the Chief Secretary to the Treasury, the CMO and GCSA, to discuss NHS capacity[110]. A paper provided by the NHS gave an analysis of capacity concerns in the north west of

[107] SA/207 - **INQ000062796**
[108] SA/208 - INQ000198156
[109] SA/209 - INQ000421010
[110] SA/210 - **INQ000087459** SA/211 - **INQ000146615** SA/212 - **INQ000146613**

England including Merseyside, Greater Manchester, Lancashire and Tyneside, and Leeds.

7.26. Subsequently, on 10 October 2020, there was a meeting between the Chancellor, the Prime Minister, the Health Secretary and the Secretary of State for Housing, Communities and Local Government at which DHSC was actioned to prepare a public presentation to be delivered on 12 October 2020 on NHS capacity projections in Merseyside.[111]

7.27. On 11 October 2020, the introduction of tiering was discussed at both a COVID-O meeting[112] and Cabinet meeting,[113] ahead of a public announcement[114] on new local COVID Alert Levels in England on 12 October 2020. The Health Secretary set out concerns with ventilated bed capacity in East Lancashire, where 93% of beds were already in use, explaining that intervention was needed at a local level.[115] Actions[116] from the meeting were for HMT and MHCLG to agree financial packages for local authorities "if they were to move into Tier 3" (Tier 3 being the highest alert level[117]), and MHCLG was asked to "engage" with local leaders in the North East to "continue discussions around local restrictions and mapping across to the new alert levels". A package of measures was also discussed, developed with Liverpool City region leaders to come into effect on 14 October 2020, in response to the NHS capacity concerns local authorities "if they were to move into Tier 3"[118].

7.28. The need to protect the NHS from becoming overwhelmed was a key factor in the decision to place the country into a national lockdown on 5 November 2020. In the 31 October 2020 press conference to the country announcing the second national lockdown, the Prime Minister had said "that current projections mean [the NHS] will run out of hospital capacity in a matter of weeks unless we act".[119]

7.29. Subsequently, at a COVID-O meeting on 14 December 2020, as part of winter planning, there was a discussion of hospital capacity data including Nightingale hospitals and NHS workforce capacity challenges over the winter months. The minutes[120] of the meeting record the discussion in which senior leaders from NHSE

[111] SA/213 - INQ000252869
[112] SA/214 - INQ000090163
[113] SA/215 - INQ000088990
[114] SA/216 - INQ000137280
[115] SA/214 - INQ000090163
[116] SA/217 - INQ000090205/1
[117] SA/218 - **INQ000062728**
[118] SA/219 - INQ000090093
[119] SA/220 - INQ000086830
[120] SA/221 - INQ000091135

updated on the efforts underway to increase capacity for winter, the availability of NHS workforce data (e.g figures on staff recruitment), and critical care surge capacity should hospitalisations increase. A list of actions[121] and decisions was circulated shortly after, the actions agreed being: NHSE and DHSC to share further data with the CTF on a variety of matters e.g international recruitment of nurses, numbers of patients being discharged from hospital with a positive COVID-19 test, and progress plans to boost NHS workforce numbers; NHSE and DHSC to share data with HMT on timings of contracts with the independent sector and bed capacity of the independent sector; and, NHSE and DHSC to provide data to the CTF to "show points at which the NHS becomes under increasing pressure" and the extent to which capacity has been increased. COVID-O noted the contents of the briefing material (a slide pack titled 'NHS Capacity, December 2020)[122] and requested a progress update at a later date.

7.30. At a COVID-O meeting on 12 January 2021, in the context of the third national lockdown and the ongoing response to the Alpha variant, DHSC provided an NHS capacity paper that updated on funding to healthcare or healthcare providers; staffing levels; and Nightingale hospitals.[123] These discussions sought to ensure the right data was being collected and shared with all relevant actors across the sector and to ensure that DHSC was providing reassurance to the Cabinet Office that capacity could meet demand and whether there were any ways in which capacity could go further.

Modelling capacity

7.31. Modelling on NHS capacity, which was primarily driven by data provided by SPI-M forecasts, SAGE, as well as hospital level data provided by the NHS, informed discussions on the potential introduction of NPIs from the early stages of the response to the pandemic.

7.32. On 15 March 2020, a slide deck produced by SAGE was considered at the 9.15 Strategy meeting. These slides concluded that "tuning behavioural and social interventions (BSI) to minimise the epidemic without giving a second peak can halve deaths [and] reduce [the] peak by two-thirds. But [the] remaining peak still overwhelms UK surge critical care bed capacity by 8-fold. Remaining within the surge capacity of the NHS will require more intensive social distancing. Measures will need to be introduced in the next 2 weeks, 3 maximum. These measures will need to be in force (perhaps intermittently) into 2021 to avoid a resurgence of transmission".[124]

[121] SA/222 - INQ000091260
[122] SA/223 - **INQ000087478**
[123] SA/224 - INQ000092217; SA/225 - INQ000091643
[124] SA/226 - INQ000146583

7.33. The NHS was frequently commissioned to provide the Cabinet Office with healthcare data, which was considered in Dashboard and other meetings, to help ensure there was a shared understanding on whether the NHS was building sufficient capacity to meet the demand that was expected, and also on the appropriate response.

7.34. On 18 April 2020, there was a 9:15 Strategy meeting which considered the need to ensure that any discussions about the use of free NHS Capacity were to be closely linked with discussions on the overall social distancing easement strategy which was to be based on data from SAGE and SPI-M. The actions from this meeting are exhibited.[125]

7.35. NHS capacity continued to be monitored throughout 2020 and 2021 and was a regular feature of the Dashboard.

7.36. Towards the end of 2021, as incidence of COVID-19 began to increase with the emergence of the Omicron variant, there was an increased focus on NHS preparedness and capacity for the winter of 2021. On 19 December 2021, No.10 commissioned[126] the NHS to provide plans on, among other things, hospital discharge, how Nightingales would be utilised throughout the winter of 2021, workforce and staffing models and use of the Independent Sector. The NHS's response to this commission is exhibited.[127] It can be noted from this response that, in the winter of 2021, the NHS took action to free up as many beds as possible by upgrading to incident level 4, diverting support to the vaccine programme and maximising use of the independent sector with an aim of using all 2,000-3,000 staffed beds that were available in the independent sector. A list of the actions taken by the NHS to increase capacity during the Omicron response is exhibited.[128]

NHS funding

General funding

7.37. The overall funding allocation for the healthcare system is determined by HMT through a well-established spending review and budget setting process that entails bilateral discussions between HMT and DHSC. The Cabinet Office and in particular No.10 works to ensure there is agreement between No.10 and HMT on the overall government spending package and on particular governmental spending priorities.

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[125] SA/227 - INQ000088430; SA/228 - INQ000088615
[126] SA/229 - INQ000280030
[127] SA/230 - INQ000280031
[128] SA/231 - **INQ000270042**

7.38. The decisions on funding for healthcare during the relevant period followed this pattern. Throughout the course of the pandemic, the NHS required additional resources and a number of funding decisions were taken so as to ensure that the NHS had the resources needed and so as to mitigate the impact that the pandemic would inevitably have on NHS capacity.

7.39. Throughout the relevant period, there were decisions in relation to the provision of a funding framework to address spending pressures arising from the pandemic, in order to ensure that the NHS and all government departments had the resources they needed with the use of different mechanisms for different purposes.

7.40. For example, on 11 March 2020, HMT announced[129] a Budget setting out a £12 billion package of temporary measures to support public services, people and businesses through the period of disruption caused by COVID-19. This package of temporary support measures included a £5 billion emergency response fund to support the NHS and other public services.

7.41. There will be occasions when No.10 will express views on funding allocation within the NHS. The Inquiry has asked about decisions in July 2020 on NHS funding, ahead of the Spending Review which was planned for later that year. I understand that the Prime Minister will take advice from HMT for such decisions. I was not involved in this at the time, but I will set out my understanding based on the documents that have been identified.

7.42. In June 2020, officials in DHSC and HMT exchanged proposals on capacity planning for the winter. The NHS sent[130] an updated proposition[131] for capacity planning to No.10 on 3 June 2020, and again on 10 June 2023.[132] On this issue of NHS capacity, HMT stated that the proposition was not suitable in its current form[133] on 14 June 2020, with an accompanying analysis.[134]

7.43. The Prime Minister was updated on the NHS proposal on 25 June 2020[135], with an accompanying paper[136], informed by HMT's analysis. This paper contained two options for the Prime Minister. On the decision for bed numbers, option one was to "retain the Nightingales (cost: £160 million) and the independent sector beds (£1.8 billion)", and

[129] SA/232 - INQ000236913
[130] SA/233 - INQ000421024
[131] SA/234 - INQ000421025
[132] SA/235 - INQ000421026
[133] SA/236 - INQ000421027
[134] SA/237 - INQ000421028/1
[135] SA/238 - INQ000421029
[136] SA/239 - INQ000421030/1-2

option two "includes everything above plus 8,000 new, permanent beds at an additional cost of £4.9 billion". The paper sets out that "both options provide enough capacity to accommodate covid and emergency patients, even in a RWCS/second peak - though this still does depend on the NHS implementing an effective winter plan. The main difference between the two options is how much capacity is left for electives". The paper recommends that the Prime Minister agree to option one "given that option two costs an additional £5 billion and appears to make a moderate, rather than large difference to the overall waiting list".

7.44. A letter on 29 June 2020[137] from No.10 to DHSC and HMT sets out the Prime Minister's decision from this meeting, summarised into three actions which were recommended in the above paper:

7.44.1. "The Prime Minister would like to see a clear plan setting out the actions that will be taken forward in the NHS this winter to manage COVID-19 safely and appropriately, including minimising nosocomial infections and embedding important COVID-related changes (such as workforce flexibility and digitisation); and to manage demand for urgent and emergency care. He has asked that the Chancellor and Health Secretary agree the necessary capacity and investments to support this goal by no later than Friday 3 July. This should include the continuation of Nightingale and independent sector capacity; and of appropriate arrangements to ensure that medically fit patients are discharged swiftly – so long as the data from the COVID-19 response to date indicates they have been effective."

7.44.2. "He has also asked that the Chancellor and the Health Secretary consider by 3 July specific measures and associated investment needed to help prevent overcrowding and queues outside emergency departments, which would both threaten patient safety and provide a visible symbol of winter pressures. He is sympathetic to the need to expand some A&E departments where physical space would otherwise inhibit patient flow and infection control, but wishes to emphasise that the NHS must prioritise demand reduction initiatives, including implementing a phone or digital triage stage before attendance at A&E and an expanded flu vaccination programme."

7.44.3. "In respect of elective care, the Prime Minister has requested that the Health Secretary develop a recovery plan in two parts. The first should be an urgent

[137] SA/240 - INQ000269958

plan for this winter, ready by Friday 10 July, which sets out the performance objectives and how they will be measured, together with the key actions being taken forward. In particular, this should include ensuring patient attendance returns to normal levels; mitigating reduced productivity for diagnostic and surgical procedures; and ensuring that available bed capacity is fully utilised, including in the independent sector."

7.45. DHSC responded with a letter on the winter plan to No.10 on 13 July 2020.[138] The letter asked for formal agreement on a number of points:

7.45.1. point 1) "Nightingales as surge capacity through winter";

7.45.2. point 2) "Independent sector capacity use until March";

7.45.3. point 3) "Discharge funding";

7.45.4. point 4) "Operation of A&E over winter" - asking for the agreed £450 million with HMT announced by the Prime Minister to be allocated;

7.45.5. point 5) "The flu vaccine programme" - asking for agreement on funding; and,

7.45.6. "The NHS system financial plans for the rest of the year need urgent agreement".

7.46. A response to the DHSC's letter from the Prime Minister's Private Office to HMT and DHSC on 14 July 2020[139] states his overall decision was that he "would like to announce the remaining elements of the winter capacity package on Friday – i.e. funding for the extension of the Nightingales and independent sector capacity; discharge; and flu vaccinations (points 1, 2, 3 and 5 in your letter)." This is also set out in an email between Simon Ridley and officials.[140] The Prime Minister's decision to agree to further capacity in Nightingales and independent sector capacity followed advice from HMT, whilst agreeing to the conditions DHSC argued were needed for the NHS "to accommodate covid and emergency patients, even in a RWCS/second peak".[141]

7.47. This was announced on 17 July 2020, in the Prime Minister's speech[142] on 'The next chapter in Our Plan to Rebuild: The UK Government's COVID-19 Recovery Strategy'

[138] SA/241 - INQ000269957
[139] SA/242 - INQ000421033
[140] SA/243 - INQ000298959
[141] SA/239 - INQ000421030/1
[142] SA/244 - INQ000234406

(July 2020).[143] This was followed by work on addressing the backlog, which will be covered in the next section of this statement.

Elective Recovery Funding

7.48. COVID-19 presented intense resourcing challenges for the NHS and, in the early period of the pandemic, NHS staff were redeployed to deal with increasing hospitalisations. As the pandemic progressed, many NHS workers found themselves unable to attend work as they had become infected with COVID-19. As the NHS is operationally independent, all staffing decisions, including the decision to redeploy staff, were taken by the NHS. The impact on elective and non-emergency procedures from the resourcing challenges faced by the NHS was profound. For example, the DHSC briefed COVID-O and NERT (PS) in March 2021 that the elective waiting list had grown from 4.4 million in March 2020 to 4.7 million in January 2021. Non emergency procedures ('52+ week waits') had increased from 1,600 in January 2020 to 304,000 in January 2021[144]. In early 2021, work commenced on addressing the backlog of elective and non-emergency procedures.

7.49. This work was a focus for NERT (PS), established in January 2021 and chaired by the CDL. Advice[145] to the Prime Minister ahead of the establishment of NERT (PS), noted that the NERT would "focus on those services worst affected by Covid where the impact of service provision had a major impact on peoples' lives (particularly education, criminal justice and health)". As above, the proposed Terms of Reference were "to drive the development and delivery of plans to recover public service performance after the COVID-19 pandemic, supporting economic recovery and levelling up".

7.50. On 18 March 2021, NERT (PS) considered a proposal from the DHSC on the Elective Recovery Fund which would, subject to funding that would be agreed at Cabinet, set out to achieve the highest possible levels of recovery activity in a manner which was fair, equitable, transformative and realistic[146]. The outcome of this proposal[147] was that DHSC were tasked to work with the NHS to revert to NERT (PS) with a plan for elective recovery. The plan[148] was provided to NERT (PS) on 29 March 2021 via email, where DHSC set out how the £1 billion agreed at the last year's Spending Review would enable the department to fund activity to increase the rate of clearing the backlog (alongside other winter pressures), with the caveat that recovering to

[143] SA/193 - INQ000086693
[144] SA/245 - INQ000421036
[145] SA/246 - INQ000421035
[146] SA/247 - INQ000280025
[147] SA/248 - INQ000421039
[148] SA/249 - INQ000280026

"acceptable levels would require substantial multi-year funding during this Parliament".[149]

7.51. NERT (PS) on 30 March 2021 noted that waiting list projections were likely to increase considerably, placing a higher demand on NHS services, and that while "£1bn agreed at last year's SR [Spending Review] will enable us to fund activity to make inroads to this increase…recovering to acceptable levels will require substantial multi-year funding during this Parliament, including additional capacity to increase the rate of backlog clearance alongside other winter pressures".[150]

7.52. On 20 September 2021, a slide deck was produced which noted that the approach to the Elective Recovery Fund would change in order to be "more focused on our key objectives"[151] and on 26 October 2021, there was an elective recovery stocktake which also considered the Elective Recovery Fund.[152]

7.53. The Elective Recovery Fund was discussed at Cabinet on 30 November 2021. The Chair's brief for the Prime Minister noted that "[t]o support elective recovery the Government has committed more than £8 billion from 2022-23 to 2024-25, supported by a £5.9 billion investment in capital. This is in addition to the existing £2 billion Elective Recovery Fund and £700 million Targeted Investment Fund."[153]

Ventilators, PPE, and other Medical Equipment, Supplies and Medicine

7.54. The Cabinet Office understands that Module 5 of the Inquiry will focus on procurement, which is not, therefore, a major focus of this Module 3 statement. It is worth noting that the Government Commercial Function (GCF) - based in the Cabinet Office - was significantly involved in areas of the pandemic response including, in broadly chronological order: death management, ventilator design and manufacture, PPE procurement, the scale up of Test and Trace capacity, and then its expansion, the acquisition and commissioning of mask making machines, the procurement of Lateral Flow Device (LFD) tests, and then the identification and scale up of UK LFD manufacturers.

7.55. In relation to ventilator procurement, the Government's strategy was two pronged, led by DHSC and Cabinet Office respectively. First, to buy as many ventilators as possible from both UK and global suppliers as part of a wider 'oxygen, ventilation, medical

[149] SA/250 - INQ000421037/1
[150] SA/249 - INQ000280026
[151] SA/251 - INQ000280028
[152] SA/252 - INQ000280029
[153] SA/253 - INQ000089097/9

devices and clinical consumables' programme, with contracts let by DHSC as part of this wider joint programme with NHS England and NHS Improvement. Second, to run in parallel a program with UK manufacturers to develop, test and, having gained appropriate approvals from Medicines and Healthcare products Regulatory Agency (MHRA), scale up production of mechanical ventilators; 'the Ventilator Challenge', led by the Cabinet Office.

7.56. In relation to PPE procurement, staff in Central Commercial Teams (CCT) of the GCF - based in the Cabinet Office - provided support to DHSC and NHSE&I, mainly through the provision of skilled procurement resources, including experienced team leaders that were deployed into relevant teams. Further, the Cabinet Office was involved in the procurement of face covering manufacturing machinery and its scale-up at selected UK manufacturers.

7.57. In relation to Test and Trace procurement, the Cabinet Office's contribution was to supply the initial leadership for the commercial team that Test and Trace required, and then to supplement that with additional resources from across the GCF and, with interim resources, from outside the Civil Service.

7.58. The Government Chief Commercial Officer, Gareth Rhys Williams and his deputy, Chris Hall, supplemented by some of the external team who had supported the Ventilator Challenge, worked on the scale up of testing capacity, including the Mega Labs, and the initial sourcing of LFDs and the subsequent development of a UK supply chain for LFDs.

7.59. I understand this will be covered in more detail as appropriate in the Cabinet Office's response to Module 5 and other modules covering, for example, Test and Trace, where required.

7.60. All of the MIGs had an interest in health and care supplies in addition to the C-19 procurement group chaired by Lord Agnew, then Minister of State for Efficiency and Transformation. The exhibited paper[154] set out the remit of each MIG in relation to health and care supplies, in order to ensure clarity between the MIGs and the C-19 procurement group. The paper explained that the HMIG would cover the demand and supply of these supplies for health and social care services, and related coordination with the devolved administrations. The GPSMIG would cover demand and supply of health and care supplies for public services outside health and social care (e.g. police and military), including related coordination with the devolved administrations. The

[154] SA/39 - INQ000055943

IMIG would cover gaps in UK domestic supplies through international engagement and would deal with international requests for support and international interventions in UK healthcare supply chains (e.g. export restrictions). The EBRMIG's remit would include the wider domestic supply chains, priority distribution of healthcare products in the private sector and engagement with businesses. It also proposed that Lord Agnew, as lead minister for government procurement, would coordinate across the MIGs on health and care supply issues.

7.61. By mid-March 2020, procuring ventilators was a crucial workstream as the number of patients needing beds with ventilators during the first wave rose quickly. This was discussed at the first HMIG on 18 March 2020.[155]

7.62. Further examples of key meetings, and actions arising included:

7.62.1. tasking NHSE with procuring 20,000 ventilators[156];

7.62.2. actioning the provision of data on the trajectory for acquiring additional ventilators, tasking SAGE and the NHS with updating the RWCS modelling[157];

7.62.3. tasking DHSC to work with the MOD and the FCO to expedite the export of ventilators from China[158];

7.62.4. tasking the DHSC and NHS to provide full data for the ventilators[159]; and,

7.62.5. liaising with the devolved administrations on the supply of ventilators.[160] It also included the Prime Minister setting a challenge of obtaining 8,000 ventilators by 13 April 2020.

7.63. In the early stages of the pandemic response, the CCS convened the first of the cross-government meetings on PPE. A list of decisions and actions were produced after each meeting and circulated to the attendees. These meetings took place until the end of March when they were replaced by the DHSC PPE Governance Board. CCS requested that the PPE Board include other government departments and the devolved administrations.[161] The three meetings led by CCS are summarised below:

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[155] **SA/93 - INQ000056051**
[156] SA/255 - INQ000197995
[157] SA/256 - **INQ000061816**
[158] SA/257 - INQ000198005, SA/258 - INQ000198014
[159] SA/259 - INQ000198007, SA/260 - INQ000198024
[160] SA/261 - INQ000198030
[161] SA/262 - INQ000174699

7.63.1. On 18 February 2020, departments were actioned to share details of the PPE supplies used by their departments and sectors, and DHSC were actioned to complete stocktakes of stock levels and model requirements. They agreed to reconvene to discuss 'pinch-points' and options for resolving them, including how to facilitate mutual aid and other levers to influence supply chains or mitigate risks.[162]

7.63.2. On 27 February 2020, 'pinch points' and mitigations were discussed, and all departments were actioned to identify departmental asks for PPE supplies and in what specific situations PPE may be needed during the Reasonable Worst Case Scenario, and to share them with Public Health England by 6 March 2020. Departments were also asked to consider the PPE purchasing needed for recovery stages and be ready to present initial thoughts at the next PPE supply chains meeting.[163]

7.63.3. On 10 March 2020, PPE and department sector needs and prioritisation of PPE were discussed; actions from this meeting included for the CCS to share DHSC PPE stockpile levels with the group.[164]

7.64. These cross-government meetings held by CCS were not the first time departments were asked to share details of PPE supplies. Multiple meetings were held on an ad-hoc basis at the initial outbreak of COVID-19, and multiple departments updated on their PPE supplies before the CCS coordinated cross-government meetings from 18 February 2020. Some examples are provided below but are not intended to be an exhaustive list of the cross-government work on PPE supplies in the early stages of outbreak:

7.64.1. On 5 February 2020 the second SitRep circulated by CCS includes an update from DFID on procurement of PPE[165];

7.64.2. On 7 February 2020 an ad-hoc officials meeting on the outbreak of the novel coronavirus was held with DHSC asked to update on PPE supplies;[166] and

7.64.3. On 14 February 2020 an ad-hoc officials meeting was held where FCO and DFID were actioned to include devolved administrations in work regarding PPE requests from foreign states.[167]

[162] SA/263 - INQ000421014
[163] SA/264 - INQ000421015
[164] SA/265 - INQ000421016
[165] SA/266 - INQ000279711/10
[166] SA/267 - INQ000421011/6; SA/268 - INQ000421012/3
[167] SA/269 - **INQ000287892**

7.65. Discussions on PPE also took place at the HMIG and Prime Minister's 9:15 strategy meetings. The Cabinet Office role here was primarily to work with departments and the devolved administrations to support them to develop PPE capacity, supply chains manufacturing capabilities, modelling demand and supply of PPE data. This included working with DHSC and the NHS modelling teams. Modelling for demand for PPE was carried out by consultants under the direction of DHSC, with the patient data used to provide modelling drawn from estimates under the RWCS.

Shielding and the Clinically Extremely Vulnerable

7.66. The Government sought to protect the clinically extremely vulnerable (CEV) from the start of the pandemic.

7.67. One of the key strands of this response strategy was shielding, the objective of which was to reduce deaths among those at greatest risk of serious COVID-19. This was seen as a necessary healthcare intervention to protect the elderly and CEV from contracting COVID-19 and consequently, necessary for reducing pressure on the NHS.

7.68. At a meeting of SAGE on 13 March 2020, the CMO presented a briefing paper on shielding which set out the objective of the intervention and the two separate groups of 'general vulnerable' and 'high risk vulnerable'.[168] I set out the summary of this paper as requested by the Inquiry, which was presented by the CMO, and not the Cabinet Office.

7.68.1. The objective was to reduce deaths among those at greatest risk of serious COVID-19 disease who were vulnerable due to age, underlying health conditions or pregnancy.

7.68.2. The general vulnerable group, estimated at 18 million, included those aged 70 or older (regardless of medical conditions), those under 70 with defined long-term medical conditions (based on flu risk) and pregnant women at any stage of pregnancy. These individuals would be expected to self-identify as a result of national information campaigns and the use of an online tool. Pregnant women would also receive direct notification through maternity services.

7.68.3. The high-risk vulnerable group, estimated at 1.4 million, included those with immediate heightened infection risks. The advice to this group would be to self-isolate at home and minimise all contacts. These individuals were to be

[168] SA/270 - INQ000106205

contacted proactively by personal letter from the NHS with advice, as well as a document to share with their employer if needed. GPs would also be able to designate a patient as high risk.

7.69. At a COBR meeting on 16 March 2020, the decision was taken that 'within the next week, they would move to shield the most vulnerable (c. 1.4 million individuals). A full support package would be announced later in the week for England. Individuals in this category would be contacted by their GP practice'.[169]

7.70. The shielding policy would include a package of measures to support vulnerable people, including central government support with food, medicine and social care, provided through local authorities. On 19 March 2020, at the 9:15 strategy meeting chaired by the Prime Minister, it was agreed that: "[T]he policy on shielding should be announced in the PM's press conference the following day (20 March), publicising: a. [T]he categories of people who were defined as 'clinically high risk' and to whom the shielding intervention applied [DHSC/CMO lead]; b. [C]lear guidance on how volunteers and care workers supporting those subject to shielding should interact with them [MHCLG lead]; and c. [T]hat urgent work was underway to contact relevant individuals to confirm that the shielding policy applies to them [DHSC / NHS lead]".[170]

7.71. The shielding policy and the implementation of the cross-government programme was a central focus of the HMIG meetings from its establishment in mid-March 2020. In addition to the discussions in HMIG meetings and certain decisions taken within COVID-O (such as the decision to pause shielding measures from 6 July 2020,[171] the decision to pause shielding from 1 August 2020,[172] and the decision not to re-introduce shielding in October 2020[173]), the Cabinet Office's role was one of coordinating and convening officials from across Whitehall to help establish cross-departmental input to the shielding programme and the provision of food parcels for those shielding. Cabinet Office officials also liaised with officials in the devolved administrations in relation to shielding.[174] The policy to advise the most clinically vulnerable to stay at home was UK-wide, though the delivery mechanism was determined locally.

7.72. The Cabinet Office role extended to the Government Digital Service (GDS) which was tasked to develop a website, an automated telephone helpline and other services required to collect, store and share information on the support needs of CEV people. At

[169] SA/271 - INQ000056210/4
[170] SA/272 - INQ000056056/2
[171] SA/273 - INQ000088758/1
[172] SA/274 - INQ000088833/2
[173] SA/275 - INQ000090241/2
[174] SA/276 - INQ000197988

a meeting of the first HMIG on 18 March 2020 (chaired by the Health Secretary), the Secretariat was actioned "to commission GDS to work with MHCLG and NHSX to explore the feasibility of a website (or other technologies) to sift clinically vulnerable individuals and capture their data to reduce the burden of the national call centre".[175] The GDS service was operational by 23 March 2020.

7.73. Shielding remained a focus for the HMIG during this early period of the pandemic response. DHSC worked with the Cabinet Office, NHSE, and PHE to develop an analysis of the effectiveness of the Shielding Programme in reducing the spread of COVID-19 among the shielded population and reducing the number of Covid-related deaths. From the middle of March 2020, cross-Whitehall shielding calls were held, chaired by Simon Ridley.[176] On 7 May 2020, HMIG discussed a paper by DHSC on the effectiveness of shielding as a public health intervention.[177] While the Cabinet Office did not play a direct role in developing analysis of the effectiveness of the shielding programme, No.10 commissioned the International Comparators Joint Unit (ICJU) to investigate how effective the shielding programme had been in protecting the vulnerable in comparator countries. The ICJU's report,[178] published on 18 June 2020, was unable to conclude on effectiveness of shielding measures in comparator countries, noting that "the best comparative evidence… for the impact of the UK's shielding programme is from within the UK itself."

7.74. A full equality analysis of social distancing measures, including restrictions on movement and restrictions on gatherings was conducted[179], dated 27 May 2020. The document records the analysis undertaken by departments to enable ministers to fulfil requirements placed on them by the Public Sector Equality Duty (PSED). This analysis set out the ongoing impact of the social distancing measures on each protected characteristic and included an assessment of the positive and negative impacts of the shielding policy.

7.75. The analysis highlighted that the goal of all interventions, including shielding, was "the protection of life, in particular for people who are vulnerable because of their age, health, pregnancy, or other factors".[180] The assessment of positive and negative impacts of measures on protected characteristic groups includes the impact of shielding and measures in place to mitigate those impacts.

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[175] SA/16 - INQ000055912
[176] SA/277 - INQ000198002
[177] SA/278 - INQ000083674
[178] SA/279 - **INQ000196549**
[179] SA/280 - INQ000183938
[180] SA/280 - INQ000183938/13

7.76. For example, the analysis noted that "inevitably some shielders will not be able to work from home and it is not feasible for some types of work to be undertaken at home; this could lead to some shielders being furloughed, having reduced hours and/or pay, redundancies etc. Young people, women, disabled people, and ethnic minorities include people who are likely to be vulnerable to income loss and people with lower financial resilience who are likely to be particularly affected. This has been mitigated by the government advising that shielders can be furloughed (as well as those who need to stay home with them); shielders are additionally eligible for SSP [Statutory Sick Pay] (provided they meet the other SSP criteria)."[181]

7.77. By way of further example, the analysis also highlighted that people aged 70 and over were considered clinically vulnerable, and were advised to shield themselves in order to mitigate risk. The negative impacts of this outlined in the analysis are summarised below:

7.77.1. Individuals over 70 were at "a heightened level of social distancing".[182] The Government took further steps to support those shielding, including encouraging them to register for support packages

7.77.2. Some individuals shielding may not be able to work at home, which may therefore "lead to some shielders being furloughed, having reduced hours and/or pay, redundancies".[183]

7.77.3. Young people, women, disabled people and ethnic minorities "who are likely to be vulnerable" were particularly affected by loss of income and lower financial resilience. The government mitigated these risks by advising that shielders could be furloughed, and were eligible for Statutory Sick Pay.

7.77.4. Negative impacts were also found in regard to "physical and mental wellbeing as a result of being limited to the home". The shielding cohort were found to have an "increased risk of mental illness compared to the general population".[184]

7.78. The analysis outlined that overall the health impact on the above groups, compared with not issuing the shielding guidance was "positive because of the higher fatality rates associated with those categorised as vulnerable".[185]

[181] SA/280 - INQ000183938/86
[182] SA/280 - INQ000183938/86
[183] SA/280 - INQ000183938/86
[184] SA/280 - INQ000183938/87
[185] SA/280 - INQ000183938/86

7.79. Overall, the assessment identified many equalities impacts of the policy, including those resulting from the shielding measures. However, it also highlighted that "the health imperative continues to justify the Government's approach and there is good evidence that the Government is adapting its policy and taking measures to mitigate the impacts on groups with protected characteristics where possible and appropriate."[186]

7.80. By the summer of 2020 incidence of COVID-19 began to fall. Discussions were then directed to measures that could be taken to continue to protect the CEV but in a way that would also ease the restrictions which had been imposed.

7.81. COVID-O was established after the creation of the shielding policy. On 3 June 2020, COVID-O convened to discuss shielding. A Chair's brief[187] was prepared for the CDL prior to the meeting, and a paper[188] titled 'Shielding' by the Cabinet Office was provided. These documents outlined the need to review and determine what advice would be given to the CEV at the end of June 2020, when the current shielding guidance was due to expire. Highlighting that those being shielded were one of the groups most adversely affected by COVID-19, being at the gravest health risk and currently having to comply with the most stringent social restrictions, the documents acknowledged that as the Government adjusted social restrictions for the non-shielded population, the gap between the experience of the shielded and non-shielded was likely to widen. At the end of June 2020, there would be a range of options for how far the guidance could be relaxed or tightened, and the objective would be to relax shielding guidance where possible, whilst recognising that uncertainties around rate of infection when the country moved out of lockdown would likely mean that the shielding cohort would continue to be in a unique circumstance amongst wider society, with the greater restrictions on their lives. The paper included an annex setting out a range of these potential relaxed options and additional precautions that should accompany any relaxations in guidance.[189]

7.82. The recommendation to COVID-O was that decisions on whether and how to relax shielding guidance should be taken in parallel with the review process for the broader population every 4 weeks, and on the basis of clinical advice. The early clinical steer was to plan for scenarios that include maintaining the current approach or further easing shielding measures, but to also include the potential need for measures to be

[186] SA/280 - INQ000183938/88
[187] SA/281 - INQ000088836
[188] SA/282 - INQ000088716
[189] SA/282 - INQ000088716/7

tightened. The need to review the current basis for inclusion in the CEV categories was also highlighted.[190]

7.83. Following discussion by the COVID-O committee,[191] DHSC, working with the Cabinet Office, was actioned to provide advice[192] which included: a recommendation on who should remain in the CEV cohort of shielded and who should no longer part of that group; a recommendation on what restrictions should remain in place upon the CEV cohort from the end of June 2020; a recommendation on what restrictions could be relaxed for that group; and further information on the make-up of the CEV cohort and the effectiveness of measures for this group. The actions also included MHCLG and Cabinet Office to coordinate across all departments, and specifically DHSC on the clinical guidance, and to provide a proposed announcement for publication on the next steps for the shielding cohort beyond June 2020 to the committee.

7.84. Due to the declining prevalence of COVID-19, a change in guidance for the CEV was announced on 22 June 2020 which led to the relaxation of shielding in two stages on 6 July 2020[193] and 1 August 2020.[194]

7.85. At COVID-O on 6 August 2020, it was decided that there should be a move to a more targeted local delivery model of shielding services but to ensure that this local model could be scaled up in the event of a larger wave in the pandemic. The COVID-O committee agreed in principle that there should be a support package for those who are shielding, made available on a UK-wide basis.[195]

7.86. Towards the end of summer 2020, discussions commenced around the need to ensure that a rise in incidence of COVID-19 was tackled at a local level with targeted regional interventions. This would ensure that the virus could be suppressed where incidence first increased but that the rest of the county could remain 'open' thereby protecting the economy in those parts of the country where COVID-19 incidence was not increasing. These discussions ultimately led to the development of the 'tiering' system. On 18 September 2020, a COVID-O was held at which the interaction between shielding and tiering was discussed. DHSC were tasked with developing an updated iteration of shielding guidance which would align with the new tiering system.[196]

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[190] SA/282 - INQ000088716/2
[191] SA/283 - INQ000088783
[192] SA/284 - INQ000088719
[193] SA/273 - INQ000088758
[194] SA/285 - INQ000088782
[195] SA/286 - INQ000089951
[196] SA/287 - INQ000090196

7.87. On 1 October 2020, a COVID-O was held at which it was decided that full shielding would not be re-introduced. This view was shared by all four UK nations.[197]

7.88. Throughout October 2020, there were discussions about the maintenance of the Shielded Patient List (SPL) and the manner in which an individual would be designated as being CEV. On 9 October 2020, COVID-O discussed[198] the agreed contingency funding model and local council support available to CEVs in the event of a change in local tiering, including the provision of a contingency call centre for existing and new SPL registrants. The papers[199][200] and chair's brief[201] for this meeting are exhibited. On 15 October 2020, COVID-O discussed the application of the risk stratification tool to the SPL including: "the timelines for the process, interaction with GPs and the NHS and the mechanism to remove those viewed as lower risk from the SPL."[202] At a COVID-O chaired by the CDL on 20 October 2020, the committee agreed a new threshold for identifying the CEV and that clinical judgement should remain a factor in identifying the CEV and that the list should be maintained through a "new highest risk list".[203]

7.89. By October 2020, the Vaccine Taskforce (which had been established in May 2020 and was headed by Kate Bingham) had been making good progress on the procurement of a vaccine with the expectation that a vaccine would be ready for regulatory approval towards the end of 2020. The issue of how the vaccine would be deployed, including to the CEV, was a focus of Vaccine Deployment meetings, chaired by the Prime Minister, as well as at COVID-O meetings. Following a COVID-O meeting on 13 November 2020, for example, the Deputy Chief Medical Officer (DCMO) was asked to discuss prioritisation of vaccines to the CEV with the Joint Committee on Vaccines and Immunisation (JCVI).[204]

7.90. At COVID-O on 3 February 2021, during the third national lockdown, MHCLG, the Department of Work and Pensions (DWP) and HMT were commissioned to agree the cost implications of an extension to shielding until 31 March 2021.[205]

7.91. On 11 March 2021, the Health Secretary presented a paper to COVID-O which set out a proposed future policy on shielding and the CEV.[206] The recommendation

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[197] SA/275 - INQ000090241
[198] SA/288 - INQ000090178/4
[199] SA/289 - INQ000090256
[200] SA/290 - INQ000090072
[201] SA/291 - INQ000090253
[202] SA/292 - INQ000090275
[203] SA/293 - INQ000090277
[204] SA/294 - INQ000090919
[205] SA/295 - INQ000092320
[206] SA/296 - INQ000092395

(summarised in this statement at the Inquiry's request) was that owing to the improved epidemiological picture, the current national shielding advice and associated support should be paused from 31 March 2021. From 1 April 2021, precautionary advice on managing the risk of exposure should instead be issued for those on the SPL. In support of this proposal the paper outlined that 70% of the 3.8 million CEV people currently on the SPL had received their first vaccine dose. It also highlighted that reducing infection rates, and the phased relaxation of wider NPIs in the Roadmap, would continue to protect those on the SPL as lockdown ended. COVID-O considered that the Government should remain operationally ready to reimplement shielding advice in response to any significant outbreak or dangerous new variant.

7.92. The paper also acknowledged that for a small group of the CEV cohort, the vaccine might be less effective at providing protection. Therefore, a task group chaired by the DCMO had been established to undertake work to identify this potential group, and to review and refine the SPL. The PHE vaccine surveillance programme would feed into this group, which was already monitoring vaccine effectiveness across various cohorts. The decision on any future support for this smaller CEV group would depend on the findings of the foregoing task group. DHSC was actioned to report to COVID-O in due course, with any further recommendations on any unprotected groups and support required for the CEV during autumn and winter.

7.93. This paper[207] also emphasised how the ending of shielding took account of the Public Sector Equality Duty noting that: "As shielding ends, individuals in these (CEV) groups may face or perceive greater risks without support and therefore face a disproportionate impact from ending support, particularly on their mental health. Councils will have funding through COMF (the Contain Outbreak Management Fund) to provide transition support to those who require it and continue to have access to supermarket priority slots if they have registered previously, helping reduce the risks of unequal impacts. Ministers will wish to consider this risk in line with the Public Sector Equality Duty".

7.94. On 11 March 2021, ministers agreed at a COVID-O meeting that current national shielding advice and associated support would end on 31 March 2021.[208] In line with this decision, on 18 May 2021, ministers agreed[209] at a COVID-O meeting that shielding guidance would be retained as a contingency option until the end of March 2022 subject to further review if necessary.

[207] SA/296 - INQ000092395/7
[208] SA/297 - INQ000091799
[209] SA/298 - INQ000091926

7.95. On 6 September 2021, a COVID-O meeting was convened to discuss the long-term approach for the CEV.[210] A paper on 'Long Term Support for the Clinically Extremely Vulnerable' was produced by MHCLG and DHSC.[211] A Chair's brief[212] was prepared, and a minute of the meeting was taken.[213] Following the meeting, actions and decisions were circulated on 7 September 2021.[214] The purpose of the meeting was for ministers to review the shielding contingency measures and take a decision on whether shielding advice, the SPL and associated support should move from being paused, to ending. COVID-O accepted the recommendations set out in the paper to end shielding and the SPL. It decided that the support measures for any individual categorised as being CEV or who was listed on a Shielding Patient List would be stood down and, while contingency plans would be developed by DHSC covering advice to people with clinical vulnerabilities in the event of a 'vaccine-escaping' variant of concern, all policies in respect of shielding would end.

7.96. The Inquiry has asked why COVID-O reached this decision. The minutes show that COVID-O considered the factors set out in the MHCLG and DHSC paper including, that shielding was extremely restrictive and had a significant impact on mental and physical wellbeing, that there was now greater understanding of vaccine efficacy and the vaccine programme had changed the parameters of what constitutes CEV and therefore, the current SPL was no longer appropriate. Other factors included that, following the vaccine rollout, there remained only a small number of individuals who would not receive substantial protection from vaccination (as of 20 August 2021, 88.2% of the 3.7 million on the SPL list had received both vaccine doses, 91.5% had received one dose), but that the overall risk for this cohort had lowered to be more in line with how the Government would approach other infectious diseases. As such, it was anticipated that this cohort would revert to the normal practice seeking individual advice from health professionals, and be prioritised if antiviral treatments became available[215]. In reaching its decision, COVID-O also recognised the potential for the need to change this approach, should a vaccine-escaping variant of concern or change in clinical risk arise[216].

7.97. This brought to a conclusion the Government's shielding policy, a programme that was developed at pace very early in the pandemic and with the objective of both reducing

[210] SA/299 - INQ000092575
[211] SA/300 - **INQ000066820**
[212] SA/301 - INQ000092574
[213] SA/302 - INQ000092115
[214] SA/303 - INQ000092106
[215] SA/302 - INQ000092115
[216] SA/303 - INQ000092106

incidence of COVID-19 as well as offering an extra layer of reassurance to the most vulnerable.

8. SECTION G: EQUALITY CONSIDERATIONS

8.1. The Public Sector Equality Duty (PSED) requires public bodies to consider how they can contribute to the elimination of discrimination, the advancement of equality of opportunity between people who have a protected characteristic under the Equality Act 2010 and those who do not, fostering good relations between different groups. As part of the policymaking process, equality related evidence and analysis should be sought during the development, consultation and testing of policies. Public bodies are encouraged to gather data that will help with their equality analyses.

8.2. This overarching duty applied to the work of the Cabinet Office on the COVID-19 response and equality considerations arose in relation to all aspects of the COVID-19 response. Consistent with the Inquiry's request, this section of this statement will focus on the Cabinet Office's consideration of equalities in relation to healthcare decisions.

The Equality Hub

8.3. The work of the Equality Hub in relation to the COVID-19 pandemic has been covered in detail in Module 2 statements provided by: the Director of the Equality Hub, Marcus Bell; the Minister of State for Equalities, the Rt Hon Kemi Badenoch MP; the Minister for Women and Equalities, the Rt Hon Elizabeth Truss MP; and Justin Tomlinson MP.[217] The Equality Hub's general function is outlined in the paragraphs that follow, at the request of the Inquiry.

8.4. In September 2020, the Equality Hub brought together four existing units that were originally situated in different government departments: the Race Disparity Unit (RDU)[218], the Disability Unit (DU)[219] and the Government Equalities Office (GEO)[220], and later the Social Mobility Commission (SMC) secretariat.[221] These units have their own areas of policy responsibilities, with a Deputy Director responsible for each policy area.[222] Since being brought together under the umbrella of the Equality Hub, the units have shared operational functions. This includes data and analysis, communications, operations and parliamentary/correspondence functions. The exception to this is the SMC Secretariat which has separate operational functions to maintain independence,

[217] SA/304 - INQ000198850; SA/305 - INQ000215534; SA/306 - INQ000218370; SA/307 - INQ000233735
[218] RDU was established in the Cabinet Office in September 2016.
[219] DU staff were transferred from the Department for Work and Pensions (DWP, where they were part of the Office for Disability Issues) in November 2019
[220] GEO transferred from the Department for Education (DfE) in April 2019.
[221] The SMC secretariat transferred from DfE in April 2021 to be part of the Equality Hub.
[222] SA/308 - INQ000083932

as it reports to independent commissioners rather than ministers[223]. Deputy Directors within the Equality Hub report directly to its Director, Marcus Bell.

8.5. The Equality Hub is responsible for cross-government policy on disability, ethnic disparities, gender equality, LGBT rights and the overall framework of equality legislation for the UK (Equality Act 2006 and Equality Act 2010). It is not responsible for policies related to the protected characteristics of age and religion or belief. Responsibility for age sits across multiple departments depending on the subject area, e.g. Health with DHSC or Pensions with DWP. The DLUHC is responsible for policy related to religion or belief. The Equality Hub also sponsors two arm's-length bodies, the Equality and Human Rights Commission (EHRC) and the SMC.

8.6. The Equality Hub's work generally falls into three key areas[224]:

8.6.1. policies that are solely the responsibility of the Equality Hub;

8.6.2. policies and pilot programmes that are developed within the Equality Hub and then handed over to other government departments to lead; and

8.6.3. advising and supporting other government departments to deliver, drawing on the Equality Hub's expertise.

8.7. The Equality Hub provides annual corporate updates as part of the Cabinet Office's annual reporting. These reports set out the Equality Hub's priorities and outcome measures for the year ahead. The Cabinet Office's 2021 Outcome Delivery Plan[225] (valid from 15 July 2021) sets out that the Equality Hub will contribute to the objective of "Improving levels of equality across the UK". The delivery milestones include:

8.7.1. leading work to analyse and tackle disproportionate impacts of Covid-19 for ethnic minority and disabled people; and,

8.7.2. promoting gender equality in the Covid-19 recovery, by working to increase women's economic participation, and reduce occupational segregation[226].

8.8. Responsibility for other policies related to equalities issues (including understanding the equality impacts of all policies) usually sits with the relevant government department. The Equality Hub does not have the capacity to engage on every issue but

[223] SA/304 - INQ000198850/2-3
[224] SA/304 - INQ000198850/4
[225] SA/309 - INQ000089732
[226] SA/304 - INQ000198850/6-7

will become involved on cross-cutting issues, or where an issue is a priority for No.10 or equality ministers. Priorities are reviewed with No.10 and equality ministers[227].

8.9. Individual government departments are also responsible for understanding the equality impacts of their own policies through compliance with the PSED. The Equality Hub does not routinely review or monitor other government departments' equality impact assessments or their approach to PSED[228]. From time to time, the Equality Hub advises and gives guidance to departments about their equality duties, as outlined below under the sub-heading, 'The Equality Hub and Public Sector Equality Duty'.

8.10. The Equality Hub's key workstreams in relation to the COVID-19 response were related to ethnicity, disability and data and analysis[229]. More specifically, the Equality Hub's principal areas of involvement in COVID-19 were the production of Covid Disparities Quarterly Reports; improving disability data; vaccine certification and exemptions; advice on PSED and Equality Impact Assessments; understanding the impact on women; and providing general, ad hoc advice[230].

8.11. The COVID-19 work of the Equality Hub was initially carried out through the Cabinet Office functions that served the relevant committee structures. This included extensively working with and through the CTF - which also carried out work on equalities and Disproportionately Impacted Groups (as outlined below) - to feed equality data, research and analysis into the COVID-S and COVID-O discussions, decisions, and actions. Over time, the work of the Equality Hub broadened out to engage other departments including the DHSC and a wider set of healthcare stakeholders such as NHSE and PHE.

8.12. Data collection, research, and analysis about the way in which COVID-19 was impacting various groups, was a significant aspect of the Equality Hub's work and key to the Cabinet Office and wider government strategy setting, understanding of the virus, and understanding of the best way to respond to the pandemic. In addition to its own data work, the Equality Hub utilised published data, research, and modelling from the ONS, health departments (mainly PHE, DHSC and NHS) and research organisations[231], some of which undertook Government funded studies, such as UK-REACH[232] which investigated how and why ethnicity affects COVID-19 clinical outcomes in healthcare workers. The team also had access to some unpublished data,

[227] SA/304 - INQ000198850/8
[228] SA/304 - INQ000198850/8
[229] SA/304 - INQ000198850/1
[230] SA/304 - INQ000198850/16
[231] SA/304 - INQ000198850/38-40
[232] SA/310 - INQ000089764

such as NHS Foundry data[233] on vaccine uptake, and the number of deaths in the NHS workforce from COVID-19. The NHS Foundry platform provided a range of tools to support strategic decision making for the COVID-19 response[234].

8.13. The Equality Hub also set up a data and analysis working group to improve collection and quality of data into disparities identified by a PHE report published in June 2020 (outlined below). The working group membership consisted of health analysts from the main departments including NHS Digital, NHS England and Improvement, PHE and ONS, along with RDU policy colleagues. As part of this work, the Equality Hub directly commissioned research and provided briefings to fill evidence gaps[235].

8.14. Most of the Equality Hub's analysis and research activities were focused on the impact of COVID-19 on ethnic minorities and disabled people[236]. Race and ethnicity research was centred around the Covid Disparities Quarterly Reports. This included evaluating available data and evidence about the impact on different ethnic groups, carrying out further research and briefing, and making recommendations to improve available data. Disability analysts worked closely with ONS to improve available data, alongside commissioning ethnographic research. Findings were shared through Quarterly Reports and at COVID-O meetings, alongside informal engagement with colleagues in other government departments[237] (as described below).

The Equality Hub and Public Sector Equality Duty (PSED)

8.15. On 14 April 2020, the CTF asked GEO (which later became part of the Equality Hub, as described earlier in this section) to help conduct a PSED assessment on the social distancing policy which would be provided to ministers ahead of a review of the COVID-19 regulations that week[238].

8.16. Following on from the first review of regulations, GEO followed a similar model, working closely with the CTF, to help coordinate PSED assessments of each subsequent review of the social distancing measures until August 2020. GEO produced an outline of the PSED assessment, earmarking different departments to lead on the relevant sections, and included suggestions of issues that GEO thought should be covered. These were based on GEO research into problems that groups with protected characteristics were experiencing. GEO received the inputs from

[233] SA/311 - INQ000089761
[234] SA/304 - INQ000198850/40
[235] SA/304 - INQ000198850/42-43
[236] SA/304 - INQ000198850/39
[237] SA/304 - INQ000198850/39
[238] SA/304 - INQ000198850/39

departments and drew them together into a single assessment document. Where time allowed, GEO also quality assured returns to ensure that the analysis was robust.[239]

8.17. The key documents that were produced in 2020 with GEO's support are set out below, alongside a summary of findings relevant to the scope of Module 3, at the Inquiry's request. These reflect the active discussions that happened at the time as different options for changes in the regulations were considered[240]:

8.17.1. PSED analysis of the first regulation review of social distancing measures on groups with protected characteristics, dated 15 April 2020.[241] The analysis recognised: "older people are more likely to be part of the extremely vulnerable group who are being shielded" (p.2); "the shielding policy may impact some people with disabilities more than the general public" (p.2); "women may have heightened risk of exposure to Covid-19 as they are over-represented in many of the roles that continue to require face to face working" (p.4); "trans people may be unable to get hormones from their GP, have gender-affirming surgery delayed or increased waiting times to see mental health professionals" (p.3) and LGBT people may be less likely to seek healthcare support and therefore be "more likely to reach an acute problem with their health" (p.5).

8.17.2. Three iterative documents for the second regulation review, produced on 29 April 2020,[242] 6 May 2020,[243] and 12 May 2020[244] respectively. The assessments were largely consistent with the initial analysis dated 15 April 2020.

8.17.3. Four iterative documents for the third review on 23 May 2020,[245] 28 May 2020,[246] 30 May 2020,[247] and 8 June 2020.[248] Some of these reviews found that: older people and the shielding cohort were at greater risk of mental illness compared to the general population as quarantine measures were relaxed[249]; and some disabled people who were "more at risk of anxiety and

[239] SA/304 - INQ000198850/30
[240] SA/304 - INQ000198850/31
[241] SA/312 - INQ000083934
[242] SA/313 - INQ000083935
[243] SA/314 - INQ000083936
[244] SA/315 - INQ000083943
[245] SA/316 - INQ000083937
[246] SA/317 - INQ000083938
[247] SA/318 - INQ000083861
[248] SA/319 - INQ000083944
[249] SA/316 - INQ000083937/4; SA/318 - INQ000083861/4, SA/317 - INQ000083938/4

social isolation" could be expected to benefit from the easing of restrictions, or if a household 'bubble' policy should be implemented.[250]

8.17.4. Analysis for the early July easements[251]. The analysis noted the positive impacts of changes in social distancing policy on a range of individuals, however, anecdotal evidence suggested that continued closure of swimming pools or indoor leisure centres may disproportionately impact disabled people. The analysis noted that older people and those with health conditions would be disproportionately impacted should easing restrictions lead to increased COVID-19 transmission, therefore the policy would remain under "constant review" as was done in Leicester.[252]

8.17.5. Analysis of easements considered in late July.[253] The assessments in (d) remain the same for this analysis.

8.17.6. Analysis of easements considered in mid-August.[254] The assessments in (d) and (e) remain the same for this analysis, with the addition of concern raised on physical and mental health of young transgender people being "isolated in homes with families who are not supportive of their trans status".[255]

8.18. In December 2021, the Minister of State for Equalities wrote to government ministers giving general advice on how to approach equality impact assessments, what documentation of decision making might be appropriate, and reminding them that it is an ongoing duty to consider equality.[256]

Equalities and COVID-19

8.19. The following examples are provided to illustrate the consideration the Cabinet Office gave to equalities in relation to healthcare matters throughout the relevant period. Each example is a high-level summary only and does not provide an exhaustive list of equality considerations.

[250] SA/319 - INQ000083944/6
[251] SA/320 - INQ000083873
[252] SA/320 - INQ000083873/5
[253] SA/321 - INQ000083867
[254] SA/322 - INQ000083868
[255] SA/322 - INQ000083868/7
[256] SA/323 - INQ000089735

COVID-19 Emergency Legislation

8.20. On 2 March 2020, COBR agreed as part of RWCS planning to bring forward emergency legislation, led by the DHSC. In developing these measures, policy officials and COBR considered the PSED.[257]

8.21. Under the emergency registration provisions, the Registrars of the Nursing and Midwifery Council and the Health and Care Professions Council were provided with temporary emergency powers to register fit, proper, and suitably experienced persons in professions such as nursing. The purpose of the provision was to assist the delivery of care for vulnerable and sick people by supplementing and supporting the existing healthcare workforce.[258]

8.22. In developing these measures, policy officials considered the Family Test.[259] For example, the equalities duties assessment explained: "We do not anticipate that there will be any disproportionate negative impact on people who share protected characteristics of the proposed clauses on emergency registration. With regard to positive impacts, as these measures are intended to allow for the provision of additional staff to deal with the increase in those needing medical care, we anticipate that there may be a greater positive impact for older people, as one of the groups who are more likely to become severely ill with the virus".[260]

Shielding and the NHS Volunteer Responder Programme

8.23. As outlined above, the shielding policy was a central focus of the HMIG meetings from mid-March 2020[261]. Shielding was seen as a necessary intervention to seek to protect the elderly and vulnerable from contracting COVID-19 and, consequently, necessary for reducing pressure on the NHS, given these groups were most likely to suffer serious illness.

8.24. On 21 March 2020, the Government published guidance on the shielding of vulnerable individuals[262]. On 15 April 2020, the Government published its equality analysis of social distancing measures, which included the Government's instructions to the public to "shield the vulnerable (self-isolation for the 1.5m most vulnerable)".[263] The analysis provided a summary of the impacts on specific groups for the policy as a whole.

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[257] SA/324 - INQ000056208
[258] SA/325 - INQ000049562
[259] SA/326 - INQ000049602
[260] SA/327 - INQ000049460, SA/325 - INQ000049562
[261] SA/328 - INQ000055933, SA/24 - INQ000055934, SA/40 - INQ000055944
[262] SA/329 - INQ000106266
[263] SA/330 - INQ000236209

Negative impacts were identified and evaluated alongside the positive benefits of shielding the vulnerable, and the ultimate goal of all of the interventions, that being the protection of life, in particular for people who, due to certain characteristics, were vulnerable. Shielding measures were assessed as most likely to impact people with a disability, those over the age of 70, and pregnant women[264]. At this time, the need to protect lives by continuing with social distancing measures, including shielding, was deemed to justify the negative impacts identified[265]. It also set out the package of support measures that the Government had implemented to mitigate the negative impacts of the shielding policy and made it clear that the policies and their impact would be kept under review[266]. Accordingly, the Government published subsequent equality analysis as the measures continued and evolved.[267]

8.25. On 15 April 2020, a HMIG meeting was convened to review the NHS Volunteer Responder Programme (the volunteer programme designed to support the shielded and non-shielded vulnerable programme e.g with collecting essential supplies, transport support) and the health impacts of social distancing, in readiness for an upcoming COBR meeting. The chair's brief,[268] papers,[269] and minutes[270] for this meeting are exhibited. During this meeting, it was noted that the impact of social distancing measures went beyond the question of mortality and included impact on physical and mental health, because of factors such as loneliness and financial insecurity. It was understood to be important to develop an understanding of these impacts and the need to improve health data to inform future social distancing policy decisions, including the need to understand any impacts on health inequalities. In relation to the NHS Volunteer Responder Programme, a DHSC paper considered by the HMIG committee confirmed that the scope of the of the programme was designed to support the shielded population and to help ease pressure on NHS and social care services but had been extended to also be available to support people who are vulnerable for other reasons, including frailty, disability, pregnancy and social vulnerability[271]. Actions and decisions[272] arising from this meeting are summarised below at the Inquiry's request:

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[264] SA/330 - INQ000236209/31
[265] SA/330 - INQ000236209/9
[266] SA/330 - INQ000236209/32-33
[267] SA/331 - INQ000236214; SA/332 - INQ000236211
[268] SA/333 - INQ000083696
[269] SA/68 - INQ000083655, SA/69 - INQ000083650
[270] SA/70- INQ000083706
[271] SA/68 - INQ000083655/3
[272] SA/71 - INQ000083695

8.25.1. DHSC and NHSE were to ensure that all verified volunteers not allocated to tasks be contacted within a week to direct them towards available volunteering opportunities;

8.25.2. DHSC and NHSE were to refer any volunteers who live in the devolved administrations to the appropriate volunteering programmes;

8.25.3. DHSC were to share data on hospital COVID-19 deaths by age and comorbidity with the HMIG;

8.25.4. DHSC and HMIG secretariat were to confirm with the devolved administrations whether they were able to share equivalent data on hospital deaths by age and comorbidity;

8.25.5. DHSC and HMIG secretariat were to follow up on a previous meeting's action on ensuring reliable distribution mechanisms for PPE, to update at the next HMIG;

8.25.6. Due to the large number of verified volunteers (600,000) DHSC, NHSE, with support from Defra, MHCLG and DCMS, were to develop an approach to volunteering referrals, linking up volunteers with accredited organisations, and inclusive of opportunities to support the non-shielded vulnerable group; and,

8.25.7. DHSC were to continue to develop the analysis on non-Covid health impacts of social distancing (both mortality and morbidity) to support future discussions at HMIG.

8.26. On 11 March 2021, a COVID-O meeting focused on future advice and support for the CEV, which included consideration of the future of the shielding policy. The Chair's brief[273], papers[274] and minutes[275] of this meeting are exhibited. The 'Future of Shielding Policy' paper provided for this meeting summarised the findings of DHSC's PSED assessment of the shielding policy. The summary outlined the impact of the shielding policy on certain protected characteristics, the barriers those groups might have faced in shielding effectively, and therefore the reliance those groups had on shielding support measures. The paper also highlighted the future need to support individuals in these groups as the shielding policy ended, noting councils would receive funding to do

[273] SA/334 - INQ000092392
[274] SA/335 - INQ000091781, SA/296 - INQ000092395
[275] SA/336 - INQ000091808

this[276]. As this PSED assessment was carried out by DHSC, rather than the Cabinet Office, DHSC would be best placed to provide any further detail required. At this meeting, ministers agreed that shielding would end on 31 March 2021, and from April onwards, precautionary advice was issued.

Disproportionately Impacted Groups ('DIGs')

8.27. The Cabinet Office has provided information on the processes and guidance produced by the CCS prior to the pandemic which focused on supporting those most at risk in the event of a crisis. Pre-pandemic preparedness was examined by the Inquiry in Module 1, particularly the way in which risk assessment processes consider disproportionately impacted groups. The National Security Risk Assessment (NSRA) process recognised the potential for the pandemic to have a disproportionate impact on vulnerable groups. The 2019 NSRA, for example, states that "whether the influenza virus particularly affects one subset of the population or not, it is very likely that there will be an impact on vulnerable populations due to the wider impacts of the pandemic on public services and critical national infrastructure".[277]

8.28. During the early period of the pandemic, research was conducted across government departments to assess the disproportionate impact of COVID-19, beginning in April 2020. The Cabinet Office considered much of the reporting from this in its work. Examples of consideration and research of the disproportionate impact of COVID-19 include:

8.28.1. On 13 April 2020 a 'C-19 Foresight Working Group' meeting was held by the CCS where the "gap" in COVID-19 infections, and impact on ethnic minorities was discussed. It was discussed that the PHE were "investigating all variances in gender, race/ethnic background etc. as is happening in other countries. Evidence will be used to put mitigations in place to minimise impact."[278]

8.28.2. The CCS received some reports from the COVID-19 Clinical Information Network (CO-CIN), which reported into SAGE and NERVTAG. One such report from CO-CIN titled 'Investigating associations between ethnicity and outcome from COVID-19' is exhibited, dated 25 April 2020[279]

[276] SA/296 - INQ000092395/7
[277] SA/337 - INQ000176776/5
[278] SA/338 - INQ000421017
[279] SA/339 - INQ000421019

8.28.3. The CCS and PHE presented to the Cabinet Secretary in May 2020 on the PHE's rapid review on the disproportionate impact of COVID-19, and other data from advisory groups (SAGE, CO-CIN) on how COVID-19 affected ethnic minorities disproportionately[280].

8.29. In June 2020, following the publication of the PHE report 'Covid-19: review of disparities in risks and outcomes',[281] the Prime Minister and Health Secretary asked the Minister for Equalities to lead cross-government work to address the PHE report's findings.

8.30. Under the terms of reference for this work[282], the minister was tasked with submitting quarterly progress reports to the Prime Minister and Health Secretary. The RDU in the Equality Hub in the Cabinet Office supported the minister to publish four quarterly reports on 22 October 2020,[283] 26 February 2021,[284] 25 May 2021,[285] and 3 December 2021[286]. The quarterly reports were also informed by input from other government departments and wider stakeholder meetings.

8.31. The June 2020 PHE review had indicated that a range of people, including those who are most deprived or from ethnic minority backgrounds, were disproportionately impacted by COVID-19. Given the stark findings in relation to ethnicity, this was where work of the Equality Hub and the Minister focused. The Equality Hub also carried out a separate strand of work, focusing on the impacts of COVID-19 on disabled people, as will be set out in the following section.

8.32. In direct response to the PHE report, the CTF set up a dedicated team focused on DIGs, led by the strategy directorate. This became a cross-government piece of work overseen by MHCLG (later DLUHC) Director General, Emran Mian, as Senior Responsible Owner.[287] The CTF worked closely with DHSC, the DCMO and MHCLG/DLUHC to assess and promote actions to assist combatting impacts on DIGs.

8.33. Consistent with the general role of the Cabinet Office, as described throughout this statement, the CTF and Equality Hub did not take day-to-day decisions relating to minimising inequalities within healthcare systems. Instead, the CTF and Equality Hub worked to ensure that decision-makers were equipped with relevant advice and data in

[280] SA/340 - **INQ000256853**
[281] SA/341 - INQ000089740
[282] SA/342 - INQ000089741
[283] SA/343 - INQ000089742
[284] SA/344 - INQ000089744
[285] SA/345 - INQ000089776
[286] SA/346 - INQ000089747
[287] SA/347 - INQ000252914/79

relation to DIGs. For example, officials from the CTF and Equality Hub would regularly meet with teams in other departments to ensure consideration was being given to DIGs in data, policy and strategy work.[288] Officials from the Government Office for Science which supported the secretariat function of the SAGE ethnicity subgroup, were also invited to such meetings.[289]

8.34. By October 2020, the CTF's data and analysis capability had expanded and a team of around 100 staff were focused on the provision of data and information to provide decision makers with the most up-to-date picture across the economy, society, the NHS and direct COVID-19 impacts.[290] This data on societal impacts fed into key decision-making forums, for example the Dashboard referred to in Section E. During the relevant period the CTF teams conducted a broad range of analysis on vulnerable communities and groups, which influenced policies and guidance, ministerial meetings and equalities impact assessments. This work is now being continued as appropriate by the Joint Data and Analysis Centre (JDAC) in the Cabinet Office.

8.35. The Equality Hub also provided ad hoc advice and guidance to the CTF on how to factor equalities considerations into policy and decisions.[291] Additionally, the Equality Hub attended regular meetings with the CTF and Special Advisers in No.10 who advised ministers on ethnicity issues. In these meetings the Equality Hub shared data, evidence, and rationale relating to the impact of COVID-19 on ethnic minority groups, disabled people, and other protected characteristics. The Equality Hub also attended fortnightly COVID-O 'forward looks' managed by the CTF which provided an overview of forthcoming COVID-O meetings and any live issues. This work helped to ensure that senior decision-makers were equipped with the relevant information on DIGs, including to inform collective decision making.

8.36. In September 2020, the CTF set up a senior steering group on DIGs to advance this work within the CTF.[292] The Equality Hub fed into commissions and papers for the steering group[293]and the Director of the Equality Hub, Marcus Bell, attended the steering group meetings.

8.37. Equality ministers and senior staff from the Equality Hub attended key Cabinet Office meetings including COVID-O and official-level meetings with the CTF to provide input on equalities as required. Numerous ministerial meetings were held to discuss action to

[288] SA/165 - INQ000248852/11
[289] SA/304 - INQ000198850/53-54
[290] SA/348 - INQ000399528
[291] SA/349 - INQ000083914
[292] SA/350 - INQ000083902
[293] SA/251 - INQ000083950, SA/352 - INQ000083871

minimise the impact of COVID-19 on DIGs. Examples of such meetings are set out below.

8.38. On 24 September 2020, COVID-O considered the PHE report and a paper prepared by the CTF and SRO looking at the impact of the pandemic on DIGs. The papers,[294], chair's brief,[295] and minutes[296] are exhibited. The committee agreed[297] a package of measures of £29.5 million to prevent disproportionate healthcare outcomes for ethnic minority groups. The Cabinet Office understands that the Inquiry's investigations into the development and rollout of the COVID-19 vaccine will take place in Module 4. However, in accordance with the Inquiry's request, the needs of DIGs, and preventing disproportionate healthcare outcomes, were also a key consideration in the Government's efforts to boost vaccine uptake, so bear relevance to this Module 3 statement.

8.39. Local authorities, supported by the central government, played an important role in ensuring that the vaccine programme reached marginalised and vulnerable communities, in order to minimise disproportionate health impacts. At a Cabinet meeting on 19 January 2021, for example, ministers were updated that a "senior local government official had been seconded into the vaccine rollout programme to help provide a local perspective".[298]

8.40. The Government ran two Community Champion programmes: Community Champions (launched in January 2021) and Community Vaccine Champions (launched in December 2021). Both programmes, led and funded by DLUHC, aimed to improve health outcomes among communities at greater risk of COVID-19 by building greater awareness of, and trust in, local public health messaging and the COVID-19 vaccination programme.

8.41. The Community Champion scheme was initially discussed and agreed at a COVID-O meeting on 24 September 2020[299] which considered the impact of the pandemic on disproportionately impacted groups. The scheme provided £23.75 million funding for councils and voluntary groups to expand communications with at-risk groups, with Community Champions working locally to provide advice about COVID-19 and the vaccines, identifying barriers to accessing accurate information and providing tailored

[294] SA/353 - **INQ000053842**, SA/354 - INQ000090047
[295] SA/355 - INQ000090201
[296] SA/356 - INQ000090183
[297] SA/357 - **INQ000065388**
[298] SA/358 - INQ000089041/3
[299] SA/356 - INQ000090183

support to boost uptake[300]. Ethnic minority groups were the focus of the scheme, however local authorities were also able to use it to improve communications with other at-risk groups.

8.42. Another action point arising from this COVID-O meeting was for the CTF to ensure that decisions on future interventions fully factored in the likely impacts on DIGs.[301] The re-emphasised importance of considering these vulnerabilities when looking at future policy and implications was taken forward, as evidenced by dedicated sections in future strategy documents, reviews and assessments. On 29 October 2020, a COVID-O meeting convened to discuss a package of interventions for DIGs to:

8.42.1. improve health outcomes swiftly in the community;

8.42.2. improve health outcomes in high-risk occupations;

8.42.3. improve wider health outcomes for DIGs and reduce the risk of COVID-19;

8.42.4. improve understanding of disproportionate impact and improve the response going forward;

8.42.5. reduce indirect adverse impacts from COVID-19 and associated measures; and,

8.42.6. implement a package of improved communication measures.

8.43. The committee agreed on the recommended package of measures to prevent disproportionate health outcomes for DIGs, and actioned departments to prepare implementation and monitoring plans. The chair's brief, papers[302], minutes[303] and actions[304] from this meeting are exhibited.

8.44. Consistent with COVID-O's request that decisions on future interventions fully factor in the likely impacts on DIGs, these impacts were routinely part of the assessment of NPIs such as, the review of the impact of tiers measures on 27 October 2020, and the Social Distancing Review published in July 2021, which had a section on equalities[305]

8.45. The next two subsections of the statement will summarise the Equality Hub's findings on the impact of COVID-19 on specific groups, consistent with the Inquiry's request.

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[300] SA/344 - INQ000089744/5
[301] SA/357 - INQ000090234
[302] SA/359 - INQ000083901, SA/360 - INQ000090144
[303] SA/361 - INQ000090185
[304] SA/362 - INQ000090299
[305] SA/363 - INQ000136674

Disproportionately Impacted Groups: Ethnic minorities

8.46. The Inquiry has requested the Equality Hub's findings on the impact of COVID-19 on ethnic minorities, including from the four quarterly reports, which are set out below.

8.47. The June 2020 PHE report[306] concluded that there was a higher risk of COVID-19-related death for all ethnic minority groups relative to those of white ethnicity, and had summarised the disparities in risks and outcomes. The PHE report had not, however, drawn conclusions about why the disparities had arisen, and no single dataset which enabled a full understanding existed. Accordingly, the work of the Equality Hub's RDU focused on understanding the key drivers of such disparities and the relationships between the different risk factors. To do this, the RDU engaged with other government departments, the ONS and a wide range of academics studying the links between ethnicity and COVID-19. The RDU also worked with the new SAGE ethnicity sub-group, to help make the best use of all available data.

8.48. In relation to ethnic minority groups, as requested by the Inquiry, the main findings from the Equality Hub on the impact of COVID-19 were as follows[307]:

8.48.1. the main factors behind the higher risk of COVID-19 infection for ethnic minority groups included occupation (particularly for those in frontline roles, such as NHS workers), living with children in multigenerational households, and living in densely populated urban areas with poor air quality and higher levels of deprivation;

8.48.2. once a person was infected, factors such as older age, male sex, having a disability or a pre-existing health condition (such as diabetes) were likely to increase the risk of dying from COVID-19;

8.48.3. the direct impacts of Covid-19 improved for some ethnic minority groups during the early second wave of the pandemic, although the virus continued to have a much greater impact on some South Asian groups;

8.48.4. while ethnicity itself was not thought to be a risk factor, research by Oxford University identified that the gene responsible for doubling the risk of respiratory failure from COVID-19 was carried by 61% of people with South Asian ancestry;

[306] SA/341 - INQ000089740
[307] SA/346 - INQ000089747

8.48.5. this went some way to explaining the higher death rates and hospitalisations in that group;

8.48.6. the data showed that deprivation was a major driver of the disparities in COVID-19 infection rates for all ethnic groups;

8.48.7. the data also highlighted difficulties around adapting to the challenges of COVID-19, such as through the virtual delivery of services in communities whose members did not necessarily have the technological skills and capability to adapt to the changing circumstances, or where these groups have traditionally relied upon face-to-face council and third sector engagement. The reasons for this prior reliance on face-to-face engagement are multifaceted, but some reasons cited were low levels of English language within the community, lack of access to suitable technology, and reluctance to engage with the council directly; and,

8.48.8. the data also revealed lower levels of vaccine uptake among some ethnic minority groups.

8.49. The work of the Equality Hub's RDU and some of its findings were also shared with the inquiry led by the House of Commons Women and Equalities Committee to explore the pre-existing inequalities facing ethnic minorities and how these inequalities had impacted on their vulnerability to the virus (The House of Commons Inquiry was called 'Unequal impact? Coronavirus and BAME people').

8.50. On 15 July 2020, the Minister for Equalities and Marcus Bell along with other ministers and senior civil servants, gave evidence to this inquiry[308]. The Minister for Equalities wrote to the committee to follow up on questions raised in the oral evidence session on 1 September 2020[309]and again in February 2021[310] following the publication of the second Covid Disparities Quarterly Report. The committee published their report on 15 December 2020[311]. The Equality Hub co-ordinated the government response which was published on 5 March 2021[312].

8.51. The quarterly reports also set out the steps that the government took in each quarter to explore and address the disparities, including measures to increase vaccine uptake

[308] SA/364 - INQ000089805
[309] SA/365 - INQ000089806
[310] SA/344 - INQ000089744
[311] SA/366 - **INQ000176357**
[312] SA/367 - INQ000089808

and other initiatives designed to benefit those at the greatest risk of infection and death.

8.52. In advice to the Government on the prioritisation of vaccines for COVID-19 in December 2020, the Joint Committee on Vaccination and Immunisation (JCVI) noted that certain ethnic minority groups had higher rates of infection, and higher rates of serious disease, morbidity and mortality. [313] The JCVI concluded that good vaccine coverage in ethnic minority groups would be the most important factor within a vaccine programme in reducing disparities in outcomes for these groups. It added that prioritisation of persons with underlying health conditions would also provide for greater vaccination of ethnic minority groups, who were disproportionately affected by such conditions.

8.53. The Minister for Equalities worked closely with the Minister for COVID-19 Vaccine Deployment to encourage take up within ethnic minority communities, as will be detailed further in Module 4.

Disproportionately Impacted Groups: Disabled People

8.54. The Equality Hub's Disability Unit's (DU's) work focused on the impacts of Covid-19 on disabled people during the relevant period. This included establishing the evidence base of data, to better understand the impact of Covid-19 on disabled people.

8.55. Disability analysts worked closely with the ONS to collect and analyse disability data which resulted in the 'opinion and lifestyle survey' data on the social impact of Covid-19 on disabled people, being published with breakdown by impairment for the first time in May 2020 data[314], and the ONS collecting data on hospitalisation, care and death rates of disabled people related to COVID-19 (first released on 19 June 2020 and subsequently updated[315]). The DU also commissioned the Policy Lab (an expert team within the Civil Service, that supports people-centred design approaches to policy-making) to conduct qualitative research into the experiences of disabled people during the Covid-19 pandemic[316]. The aim was to understand the impact of Covid-19 on the lives of disabled people, to identify problems that could be resolved through policy changes and to make the changes necessary that would lead to positive outcomes. The DU also commissioned a number of qualitative films with disabled respondents, focusing on the lived experience of disabled people[317].

[313] SA/368 - **INQ000059401**
[314] SA/369 - INQ000089755
[315] SA/370 - INQ000308703
[316] SA/371 - INQ000089757
[317] SA/372 - INQ000421041

8.56. The Inquiry has requested a summary of the Equality Hub's findings about the impact of COVID-19 on disabled people. At an official-level cross government meeting on DIGs on 30 October 2020, the Director of the Equality Hub presented the following DU data on the impact of COVID-19 on disabled people (and the briefing provided to support the Director in this meeting is exhibited)[318]:

8.56.1. Disabled people made up almost 6 in 10 (59%) of all deaths involving COVID-19 between early March to mid-July 2020.

8.56.2. Disabled peoples' reported concerns about well-being and accessing healthcare were higher than among non-disabled people.

8.56.3. Differences in behaviour included that disabled people were more likely to go out to attend medical appointments, or take care of others, than non-disabled people were, and less likely to be socialising and eating out.

8.56.4. After adjusting for region, population density, socio-demographic and household characteristics, the relative difference in mortality rates between disabled and non-disabled was 2.4 times higher for females and 2.0 times higher for males.

8.57. In England, disabled people had a markedly increased risk of mortality involving COVID-19 compared with non-disabled people. There were some explanations available for this including that: disabled people are on average older; disabled people were more likely to become infected as a result of contact in care homes or with carers; the existence of other risk factors in relation to disabled people such as diabetes; living in socio-economically disadvantaged conditions or areas and barriers in accessing care[319].

8.58. However, the ONS sample size was limited, and knowledge gaps remained about the possible impacts of both the pandemic and the Government's response (e.g. new barriers to access created by increasingly digital service delivery). Therefore, the CTF commissioned Emran Mian, SRO of the DIGs workstream, and Helen Dickinson, Director in the CTF, to work together with HMT, DWP and the Equality Hub, to produce a paper on disproportionate impacts from COVID-19 on disabled people for a COVID-O meeting[320]. The aim of this paper was to present ministers with a package of

[318] SA/373 - INQ000083956
[319] SA/346 - INQ000089747
[320] SA/374 - INQ000083917

proposals for policies and interventions to mitigate the disproportionate impact among disabled people, including those with learning disabilities.

8.59. The DU developed a range of proposals on potential interventions[321]. This was discussed at a COVID-O meeting on 8 December 2020[322], resulting in an action for the Equality Hub to work with ONS to understand factors driving increased mortality risk[323]. The DU worked with the ONS to improve the data and evidence on COVID-19 for disabled people. There were four main pieces of work:

8.59.1. Disability mortality rates: The ONS published regular Covid-19 mortality data by disability status.[324] The analysis controlled for comorbidities and other influencing variables, like geographic factors (such as region of residence and population density), and socio-economic factors (such as household composition and occupation), and socio-demographic factors (such as age, sex, ethnicity and place of residence).

8.59.2. Disability risk of infection: ONS used the Coronavirus (Covid-19) Infection Survey to identify the proportion of the disabled and non-disabled population testing positive for COVID-19[325]. The survey data was also used to assess if there were any factors, such as personal characteristics, which contributed to the rates or confounded the results (sample size allowing).

8.59.3. Disability social impacts: ONS produced regular estimates of the impact of COVID-19 on disabled people in Great Britain, including the impact on wellbeing, access to medical care, and attitudes towards plans to combat the coronavirus[326].

8.59.4. Data mapping for analysis by impairment type: DU commissioned the ONS to develop a predictive model to estimate the relationships between health conditions and impairment types[327]. The aim of this was to result in a product that links specific health problems to the Government Statistical Service harmonised impairment types, to provide a more detailed and nuanced understanding of mortality rates by impairment. The ONS trialled a range of methods to achieve this and was only able to provide experimental statistics

[321] SA/375 - INQ000083918
[322] SA/376 - INQ000091044
[323] SA/377 - INQ000091234
[324] SA/378 - INQ000089783
[325] SA/379 - INQ000089784
[326] SA/380 - INQ000089785
[327] SA/304 - INQ000198850

for hearing and vision impairments.[328] For other impairments however, the approach did not provide a workable outcome.[329]

8.60. ONS data on disability was also continuously shared within government, for example via a data deep dive on 30 March 2021, and with the Minister of State for Disabled People, and the Secretary of State for Work and Pensions.[330]

Vaccination Condition of Deployment for NHS Frontline Healthcare Workers

8.61. On 17 March 2021 a COVID-O meeting was convened to discuss DHSC proposals on legislation that would make COVID-19 vaccination a condition of deployment for existing and new social care workers and explore whether to also pursue this for frontline health care workers. The chair's brief,[331] and minute[332] from this meeting are exhibited.

8.62. The Minister for Equalities provided input on the equality issues with making vaccination a condition of deployment, including balancing the need for measures to increase vaccination rates among healthcare workers against the significant workforce, equalities, and potential legal risks. In doing so, the Minister voiced the concerns of the BAME Communities Advisory Group that making vaccines a condition of deployment would risk damaging trust with the workforce, highlighting that the policy would impact most significantly on ethnic minority workers, especially women, and could result in workforce shortages.

8.63. A DHSC paper[333] provided to the meeting outlined the potential disproportionate harm that might be caused to persons with certain protected characteristics. This included, in particular, that ethnic minority staff and adherents to certain religions and beliefs would likely be most affected, due to high levels of hesitancy and an increased representation in the care sector. It was also highlighted that, should vaccine hesitancy and a mandatory vaccine requirement prevent front line healthcare staff from working, there would be an impact on NHS staffing levels and a risk of a capacity gap in the short to medium term.

8.64. The actions from this COVID-O meeting are exhibited.[334] Actions included for the DHSC to develop a robust handling plan to address vaccine hesitancy and equality

[328] SA/381 - INQ000089786
[329] SA/382 - INQ000089787; SA/383 - INQ000089788
[330] SA/384 - INQ000083885; SA/385 - INQ000083892
[331] SA/386 - INQ000092402
[332] SA/387 - INQ000092064
[333] SA/388 - INQ000280024
[334] SA/389 - INQ000092400

issues (particularly for ethnic minorities and pregnant women or those trying to conceive), and to write to the COVID-O committee with plans to assess and mitigate the likely impact of these measures, focusing on DIGs. Further, the DHSC and NHSE were actioned to continue work to increase vaccine uptake amongst both health and social care workers through all possible non-legislative routes, ahead of the next COVID-O on vaccine uptake.

8.65. On 15 June 2021 COVID-O agreed that the Government's proposed response to the consultation on making vaccination a condition of deployment for those working in a care home should be published on 17 June 2021 and regulations laid on 21 June 2021. Ministers also agreed for DHSC to launch a future consultation, which would look at making vaccines a condition of deployment in extended social and health care settings. The agenda[335], minutes[336] and actions[337] from this meeting are exhibited. Legislation relating to vaccine condition of deployment for care homes was subsequently implemented.

8.66. By 31 January 2022, the case for vaccination as a condition of deployment had changed due to a variety of factors including, the evolution of the dominant Omicron strain of virus which was less severe, increased levels of vaccine uptake, vaccine effectiveness, and lower levels of hospitalisation and mortality. These factors, taken together with the risk of disruption to NHS capacity and the associated equality impacts, resulted in COVID-O agreeing to revoke the care home regulations and the health and wider social care policy on vaccine condition of deployment. DHSC was actioned to emphasise the continued importance of vaccination for health and social care workers, and the public. The minutes[338] and actions[339] from this meeting are exhibited.

8.67. The Cabinet Office has also given evidence on the Vaccination Condition of Deployment to Module 4 of the Inquiry.

[335] SA/390 - INQ000092510
[336] SA/391 - INQ000092238
[337] SA/392 - INQ000091970
[338] SA/393 - INQ000091577
[339] SA/394 - INQ000091599

9. SECTION H: INTERNAL REVIEWS AND LESSONS LEARNED EXERCISES

9.1. The Government sought to learn lessons and identify opportunities for improvement throughout the pandemic. As detailed in this statement, the structures and processes through which the Government operated evolved over time, as lessons were learned, and as the focus of the response evolved.

9.2. In this section I set out some of the broad and overarching COVID-19 internal review exercises which the Cabinet Office carried out, or in which it was involved. It is important to note, by way of introduction:

9.2.1. In June 2021, the Prime Minister and the Cabinet Secretary signed the Declaration on Government Reform. They said: "The COVID-19 pandemic has strained our country's resilience like nothing we have seen out of wartime…There have been successes - the speedy introduction of furlough, the delivery of universal credit, the vaccination programme - which attest to the brilliance, imagination and dedication of public servants. But as with any crisis, the pandemic has also exposed shortcomings in how government works. Some processes have been too cumbersome. Accountability for delivery of services has at points been confused. The speed with which good practice in one department or area of government has been adopted by others has not always been rapid enough. If we are to power the recovery we need, it is imperative we both learn from our successes and are honest about where improvements must come".[340] This initiated a government-wide reform programme, which included improvements on data sharing, capabilities, and in being more representative of the country. I continue to deliver this programme of work as the Director for Modernisation and Reform in the Cabinet Office.

9.2.2. The learning of lessons more specific to the COVID-19 response was an important feature of the work, for example, of the COVID-19 Taskforce, as laid out in the corporate statement provided by Simon Ridley and James Bowler for Module 2 of the Inquiry.[341] I provide some examples below.

9.2.3. It was the role of DHSC to ensure that specific lessons about the response of the healthcare system to COVID-19 were identified and learned.

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[340] SA/395 - INQ000137267/1
[341] SA/165 - INQ000248852

9.3. Some exercises were carried out during the course of the pandemic response to help ensure that lessons were learned and to promote preparedness for the next phase. Exercise Fairlight, for example, was a cross-Whitehall forward-looking exercise, commissioned by the Prime Minister to determine the robustness of the Government's COVID-19 Winter 20/21 plans. Exercise Fairlight, which took place between 1-3 September 2020, produced 90 granular and 13 high-level observations in four categories: strategy and communication; command and control; capability and capacity; and planning.[342]

9.4. A number of key themes directly relevant to healthcare were exercised as part of Exercise Fairlight including the workforce capacity which would be required to sustain response and recovery structures across the winter. The Exercise observed, for example, that "[A]lthough activation of healthcare infrastructure for surge capacity is well understood, the mobilization of the workforce to sustain this remains unclear." The Exercise outcome[343] produced by the MOD is exhibited, alongside the Cabinet Office's review[344] of Exercise Fairlight.

Innovation and Lessons Learned from the Government's response to COVID-19

9.5. In Spring 2022, the Cabinet Office carried out an Innovation and Lessons Learned project, reflecting on the Government's response to COVID-19 to identify changes in the Civil Service approach with the potential to improve productivity or service delivery outside of crises, and at scale. This work covered three strands: a review of external literature; a review of lessons learned material completed by government departments; and a review of lessons learned material from the CTF. The final report for the Innovation and Lesson Learned project is exhibited.[345] The findings from the final report were summarised in a slide pack,[346] and in a note to the Cabinet Secretary and Permanent Secretary, Alex Chisholm.[347] The findings of the Innovations and Lessons Learned project have since contributed to work on Civil Service reform led by the Cabinet Office Modernisation and Reform Unit.

9.6. The Innovations and Lessons Learned Project did not generate new lessons learned exercises, but instead reviewed and collated lessons identified by other government department lessons exercises. The Project was therefore not intended to be fully

[342] SA/396 - INQ000280023/15
[343] SA/396 - INQ000280023
[344] SA/397 - INQ000280033
[345] SA/398 - INQ000180306
[346] SA/399 - INQ000180305
[347] SA/400 - INQ000180304

comprehensive. For example, DHSC did not contribute to the Project.[348] The findings outlined below are therefore lessons learned at a high-level for the whole of government, rather than specific lessons learned on healthcare systems response. This is consistent with the Cabinet Office not having a role in day-to-day decisions on the delivery of healthcare services.

9.7. Whilst primarily conducted to identify innovations for use outside of crises, some of the evidence gathered through the Innovations and Lessons Learned Project, particularly from the CTF strand of the review, included useful lessons about effective operation of a crisis team. The findings from the CTF strand[349] were primarily drawn from a range of lessons learned exercises completed by the CTF at key points in the pandemic, and from engagement with former CTF teams and staff members.

9.8. A number of recommendations were made by the CTF strand of the project. One recommendation was to ensure equalities considerations were central to decision-making from the start, and to identify those who may be disproportionately impacted as early as possible (e.g. multi-generational households), whilst recognising that disproportionately impacted groups will not always be the same cohort of people. Another recommendation was to create and maintain an overview of all pressures on local authorities and key delivery agencies related to the policies and decisions in question to ensure effective allocation of resources. The importance of collaboration with the media to deliver key factual public health messaging was also recognised, with a recommendation to improve data sharing arrangements across government departments.

Other notable exercises and related reports

9.9. During the pandemic, the Cabinet Office contributed to a number of lessons learned reports led by other parts of government or external bodies.

9.10. The Cabinet Office contributed to DHSC's December 2022 'Technical report on the COVID-19 pandemic in the UK'[350], produced to support future UK CMOs, GCSAs, National Medical Directors, and UK public health leaders in the event of a pandemic or major epidemic. Contributions were made by the Cabinet Office, for example, to the fourth chapter titled 'Situational Awareness, Analysis and Assessment', which included a case study on the Dashboard used to brief the Prime Minister and other ministers on

[348] SA/400 - INQ000180304/1
[349] SA/401 - INQ000280034
[350] SA/402 - **INQ000177534**

daily data throughout the pandemic (see Section E). The report may be of interest to the Inquiry given the relevance to some of the issues covered in this statement.[351]

9.11. The Cabinet Office has provided evidence to support a range of Parliamentary Select Committee investigations and reports relating to lessons learned from the COVID-19 pandemic, including on vaccines and therapeutics. The Government's response to the Health and Social Care and Science and Technology Committee Joint Report on lessons from the COVID-19 pandemic is exhibited as an example.[352] A second example is the Public Accounts Committee inquiry 'Initial lessons from the government's response to the COVID-19 pandemic',[353] which examined the key themes that emerged across a series of National Audit Office work on COVID-19, including 17 reports, published during 2020 and 2021.

9.12. In 2021, the Cabinet Office also contributed to a wider UK Government response to lessons learned work led by the Independent Panel for Pandemic Preparedness and Response. The Independent Panel was established by the Director General of the WHO in 2020 to initiate an independent review of the international health response to COVID-19 and of experiences gained and lessons learned. The Government's response, along with those of other countries, was considered for incorporation into a consolidated report published by the Panel.[354] The Government's response to this questionnaire is summarised in brief below, as requested by the Inquiry:[355]

9.12.1. the "coordination of the national and sub-national response" section contains a description of plans before the pandemic, and the response nationally and of the devolved administrations, as well as detail on the Coronavirus Act 2020, coordination of scientific leadership across the UK, the strategies as described in Section F, and expert working groups e.g SAGE, JCVI;

9.12.2. the "community engagement" section details measures to build trust in local communities such as the Community Champions scheme, asymptomatic testing pilots and the Government Communication Service public information efforts. It also details local measures to support vulnerable people such as the NHS Medicine Delivery Service and other support for the shielding cohort;

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[351] SA/402 - **INQ000177534**
[352] SA/403 - INQ000075352
[353] SA/404 - INQ000075344
[354] SA/405 - INQ000183545
[355] SA/406 - INQ000421038

9.12.3. the “implementation of appropriate public health measures” section describes the use of NPIs, the NHS workforce response to the pandemic and the establishment of the Joint Biosecurity Centre;

9.12.4. the “preparation of the health system” section contains information on the NHSE-owned response to the pandemic e.g increase of hospital capacity and workforce numbers, measures to support healthcare workers and policy on visiting COVID-19 patients in hospital; and

9.12.5. the “measures for border control” section describes the Government’s inbound travel restrictions, testing measures and approach to quarantine.

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 in its truth.

Signed:

Personal Data

Dated: 8 March 2024