Witness name: Emran Mian
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Exhibits: 51
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UK COVID-19 INQUIRY
WITNESS STATEMENT OF EMRAN MIAN

I, Emran Mian, will say as follows:

1. I make this statement to assist the Inquiry on matters of relevance to Module 7. I have been assisted in making this statement by the Government Legal Department. The statement focuses on my work as Senior Responsible Officer (SRO) for Disproportionately Impacted Groups (DIGs) during the pandemic.

Role, function and responsibilities

2. I am currently Director General for Digital Technologies and Telecoms at the Department for Science, Innovation and Technology.

3. At the beginning of the pandemic and until July 2023, I was Director General for Decentralisation and Local Growth at the Department of Levelling Up, Housing and Communities (DLUHC, formerly and subsequently known as MHCLG). In the early stages of the pandemic, I led the Department's work on the Business Closure Regulations and was responsible for the Department's work on tiering, shielding and local authority engagement. It was this background together with my interest in disproportionately impacted groups which led to my being asked to act as SRO alongside my existing role. I did not have a dedicated team for this work but was instead drawing on people in the Covid-19 Taskforce, all of whom also had other responsibilities. I agreed in principle to taking on the role in the run up to a CabSec(O) meeting on 28 August 2020 [EM/1 - INQ000083902].

Appointment as SRO and commission to departments

4. On 24 August 2020, I attended a CabSec(O) meeting on the disproportionate impact of Covid-19 on specific groups. A slide pack prepared by CTF was circulated in advance containing the following by way of an overview **[EM/2 - INQ000053736].**

"**Most COVID-19 transmission occurs in three settings: hospitals, care homes, and specific, often disadvantaged, communities.** Preventing transmission of COVID-19 to and within disadvantaged groups is critical to preventing the spread of the virus both within communities at increased risk, and in the general population.
We will do a deep-dive into the data on Black and Minority Ethnic (BAME) groups in this session. It shows that ethnic minorities are at greater risk of dying from COVID-19. The data also shows that the combination of socio-economic factors, the effectiveness of Government communications, common occupations, household composition and area deprivation put ethnic minorities at greater risk from COVID-19.
Other groups are also at heightened risk from COVID-19. PHE have found that 59.2% of people who died from COVID-19 have been disabled; working age men are twice as likely to die as working age females; and people over 80 are 70 times more likely to die than those under 40. Low-skilled workers and those with comorbidities (including obesity and diabetes) are also at significantly increased risk. […]
We want to use this meeting to go through the data and recommendations, and cover: Do you agree with the recommendations? What do these recommendations miss? What will be the key implementation challenges?"

5. In relation to the effectiveness of Government communications, page 12 of the slides read as follows, "[…] public polling [by YouGov showed] that ethnic minority groups are less likely to see or hear public health messaging from the government, especially in more recent weeks [i.e., in August 2020]."

6. The recommendations in the slide pack were set out as follows.
"**To reduce mortality**:
Devise and Roll out more specific health interventions for at risk individuals in these groups, including those at risk because of a combination of factors, for instance ethnicity and obesity). (DHSC)

To reduce transmission:

Augmenting existing communications campaigns to target at-risk groups and ensure the right behaviours are adopted to prevent transmission, by: deepening audience segmentation to target at risk groups; rebuilding trust in traditional sources, tailoring information to local audiences, especially those who are hard to reach; make Government communications and guidance on COVID-19 more accessible to those with impairments, disabilities or language barriers, and to raise awareness of symptoms, the need to seek treatment early, and messages that understand the needs of different communities about how to reduce obesity and other reversible comorbidities. (CO Comms)

Increasing asymptomatic testing among disproportionately impacted communities. (NHS Test and Trace)

Trialling different approaches to preventing transmission in these groups, designed to overcome or work within the context of barriers identified. Depending on results, the Government could decide what approaches to invest in longer-term to prevent transmission of COVID-19 among these groups.

To build the evidence base:

Mandating the NHS, NHS Test and Trace and other bodies to collect data on any protected characteristics of COVID-19 patients. Current data is poor and lacks granularity. This recommendation would ensure data collected includes details of age, ethnicity, living situation, occupation, faith and religion, any comorbidities and geographic area would enable a more targeted response. (DHSC)

To improve governance of this work, and build external relations:

Appoint a DG level SRO to drive this work across Government, supported by resource at the centre.

Develop a summary of the Government's consideration of equalities issues to date, including action taken to address them, that could be published. We are under increasing pressure to release equalities impact assessments of each major policy intervention, and such a document may help to build trust and understanding, including with community leaders. (Cabinet Office)

To test the efficacy of our interventions:

Run and evaluate a time-limited (6 week) pathfinder project focused at preventing transmission and mortality from COVID-19 within particularly at risk communities.

This pathfinder would run in parallel with the work above. However, learnt would be used to inform the delivery of those recommendations."

7. Following this meeting, I was appointed SRO to drive forward cross-Whitehall work on DIGs focusing on ethnicity, gender, sex, age, occupation, disability and socio-economic deprivation **[EM/3 - INQ000593757].**

8. As SRO, on 28 August 2020, I commissioned all government departments to provide detailed recommendations for inclusion in a Covid-O paper on DIGs together with information on what they were currently doing to address the impact of Covid-19 on DIGs [EM/4 - CAB001055948]. I circulated the slide pack from the CabSec(O) meeting to prompt responses to the commission **[EM/2 - INQ000053736].** The commission included the following request:

"So that Ministers have options to consider, **please work up detailed recommendations, across three tiers of potential response packages (low** [minimal spend, quick to action], **medium** [more resource / spend needed, bigger impact] **and high ambition** [greater level of resource/ spend needed, but substantially higher potential impact.])."

9. Further emails I sent to follow up the commission are included below:
   i. On 1 September 2020, I clarified that the commission was on DIGs more broadly and not just on ethnicity **[EM/5 - INQ000593761].**
   ii. On 1 September 2020, I asked BEIS whether there was any "*action we could take with businesses that employed a lot of BAME staff. Can* [BEIS] *help us with engagement, can they take additional preventative measures for staff with particular vulnerabilities?*" **[EM/6 - INQ000593753].**
   iii. On 7 September 2020, I chased HMT for a response to the commission **[EM/7 - INQ000593752].**
   iv. On 7 September 2020, I asked to speak with Marcus Bell at the Equality Hub on work the RDU was doing in the area **[EM/8 - INQ000593754].** On 8 October 2020, I further wrote to him to reassure him that our work was not looking at ethnicity per se.
   v. On 21 September 2020, I spoke to the Secretary of State for MHCLG on the proposed role of Community Champions **[EM/9 - INQ000593751].**

vi. On 22 September 2020, I asked to speak to the Equalities Minister, the Rt Hon Kemi Badenoch MP, on ethnicity data for use at the Covid-O meeting **[EM/10 - INQ000593755].**

COVID-O meeting on 24 September 2020

10. Drawing upon the responses to the above commission, the Covid-19 Taskforce and I produced a draft paper for Covid-O [EM/11 - INQ000090034] which was discussed at an officials meeting on 18 September 2020 [EM/12 -INQ000090025] before a final draft [EM13/ - INQ000090046] was circulated for discussion at a ministerial Covid-O on 24 September 2020. At paragraphs 5 and 6 of the paper, the following recommendations were made:

"5. Given the current rise in numbers and the need to act fast to prevent a replication of the disproportionate impacts seen in the first wave, we recommend Ministers adopt a package which combines high ambition interventions to improve health outcomes, with baseline options to improve long-term adverse indirect impacts from COVID at a total cost of £29.5m.

a. **To improve health outcomes**, the package would:

i. Fund a Community Champions scheme to plug the persisting and substantial gaps in vulnerable individuals and hard to reach communities accessing and acting upon Government COVID-19 guidance. […]. (MHCLG, £25m)

ii. Expand funding of the Reading Friends Programme, to reduce self-isolation and loneliness, and expand funding of existing mental health and wellbeing programmes in libraries, which are clinically proven to support those with mental health conditions to self-manage their conditions more effectively (DCMS, £4.5m)

iii. Support businesses with higher numbers of employees from disproportionately impacted groups. The NHS has made significant progress on this issue, 91% of known at risk staff and 96% of BAME staff have received risk assessments, with mitigating steps agreed where necessary. To ensure more employers are taking these steps BEIS will: consider opportunities to strengthen the Working Safely Guidance; use data to identify and support risky workplaces, work with local partners; and develop a toolkit for employers with high proportion of employees at higher risk, detailing mitigations that can protect at risk individuals in the workplace.

b. **Improve our understanding of disproportionate impact**, and improve our response going forward. The package would mandate NHS, NHS Test and Trace and other bodies to collect data on any protected characteristics of COVID-19 patients. (DHSC, Nil cost)

c. Reduce indirect adverse impacts from COVID-19 and associated measures. BEIS would work with energy suppliers to retain voluntary support for those affected by fuel poverty, and raise public awareness of this support. (BEIS, Nil Cost)

d. Continue to raise awareness, by improving existing communications campaigns, and exploring whether we can give more weight to developing specific guidance/comms on culturally specific practices. (CO Comms, Nil additional cost)

6. As the case count rises, the risks for disproportionately impacted groups are rising too. Members of these communities will naturally feel anxious about these and public commentary will start to focus on disproportionately impacted groups again. We recommend that HMG should be front footed in responding to these concerns. A senior Minister should make a statement to Parliament or a wider public statement that brings together measures we have already taken - such as self-isolation payments which will disproportionately benefit these impacted groups, the action plan for adult social care and the priority given to keeping schools open (disproportionately benefits children from disadvantaged backgrounds) - as well as the further measures recommended in this paper to which Ministers agree."

11. The paper identified the following as DIGs: "Ethnic minorities, disabled people, older people and men are at greater risk of contracting, and dying from, COVID-19 [...] and young people, women, ethnic minorities and single parents [who were] disproportionately likely to suffer long-term adverse impacts from the measures taken to control COVID-19, including poor mental health."

12. The paper produced for the meeting recommended that BEIS use data to identify and support risky workplaces, work with local partners and develop a toolkit for employers with a high proportion of employees at higher risk, detailing mitigations that can protect at risk individuals in the workplace.

13. I made the following points in the meeting:

"[…] that some of the underlying causes of these disproportionate impacts - such as household size - would not be rectified in a reasonable time. However, there were some actions that could be taken quickly, the first of which was managing infection rates in higher risk occupations. For example, the Government had implemented regulations that required taxi drivers to wear face coverings when operating their vehicle to better protect British Pakistani men in particular.

[…] that there was evidence to suggest that awareness of symptoms, rules, and mitigations was lower in certain communities. In order to respond to this, the Government's communication campaign was adjusting its messaging to cater to disproportionately affected groups, but there was more to do at a local level. In areas like Leicester, the role of local leaders or Community Champions had had a significant impact in improving engagement with government communication campaigns […]

[and that I] was seeking the Committee's views on how the Government would like to communicate the current disproportionate effect on certain communities. [EM/14 - INQ000090183, p.6]"

14. The minutes record that the following points were made in discussion:

"a) further work was needed to understand the extent to which death and infection rate was directly attributable to ethnicity, and what proportion was a result of socio-economic risk factors;

b) focusing on the distinction between genetic and socio-economic factors was misleading and the key challenge for the Government was to resolve the disparity on impact on certain groups;

c) the current work being completed to understand the effects of coronavirus on disproportionately affected groups was not a short-term piece of work, and was likely to continue on for at least a year;

d) it was important to understand that in many cases, there was no single reason that resulted in infection or death but a concurrence of a multitude of overlapping risk factors;

e) in order to effectively mitigate the effects of being from a disproportionately affected group, the Government would need to produce and collect very clear metrics on outcomes to review the success of any measures introduced;

f) it was crucial that any recommendation or measure implemented was not segregationist or based on stigma;

g) the Government's conceptual understanding of "disproportionately affected groups" needed to include minorities such as Eastern European communities, seasonal agricultural workers, travellers, and asylum seekers or refugees;

h) there was more work to do on communication campaigns, and further effort should be made to cater communications to specifically address the needs of particular communities including but not limited to BAME, Eastern European, and refugee communities;

i) the Government should share the information they were to gather with stakeholder networks who would be better placed to tailor and disseminate information to their members;

j) spending decisions should be submitted to HM Treasury by departments with an outline business case;

k) the Government should build upon the successes of the interventions in Leicester. Specifically, the work that had been implemented to develop greater community links was crucial. These measures included developing Community Champions, expanding the Reading Friends programme, providing resources in multiple languages and engaging with local councils,

l) in regard to Test and Trace, there was an opportunity to collect ethnicity data in order to better track the effect coronavirus was having on specific communities;

m) there was a significant risk of disinformation that was negatively impacting disproportionately affected communities. With the release of a potential vaccine, this disinformation would become more prevalent. The Government should combat and aim to remove this disinformation from the internet and other sources, as there was a risk that disproportionately affected communities would engage with this information instead of official government advice;

n) cross-government work should take into account disproportionately affected groups from the outset, through procedures such as Equality Impact Assessments;

o) key lessons could be learnt from employers and organisations with high proportions of disproportionately affected communities, such as the NHS

p) the priority for any potential measures should be those which slowed the rate of infections and could deliver immediate results; and

q) following the Public Health England report which outlined the increased infection and death rates among BAME communities, the Minister for Equalities was due to submit her report to the Prime Minister. This would look to understand the key drivers of the

disparities in infection rates identified by PHE, and the relationships between different factors."

15. The Chancellor of the Duchy of Lancaster summed up the meeting as follows:

"[…] the first and immediate action was to improve the communications and data gathering in relation to disproportionately impacted groups. Although the Government must tailor its national communications, there was no substitute for working with communities and trusted interlocutors in the communities affected. Furthermore, subject to HM Treasury approval, the Committee recommended developing the Community Champions scheme. There was also an opportunity to gain key information and learnings from NHS's good practice.

[…] there was a need to improve the data gathering and analysis beyond that which had already taken place. The Government was to encourage trust with the Test and Trace programme, and it was important to note that in the future there would be a significant demand for more granular data. However, as noted by the Committee in discussion, there were a number of socio-economic factors that resulted in a disproportionate effect, and the Government must take steps to deal with wider inequality. Countering disinformation was also important, as some of these groups would not trust official government sources, so further work on countering disinformation must be undertaken.

[…] the Committee would look forward to the publication of the Minister for Equalities' paper on disproportionately affected groups which was due to be submitted to the Prime Minister."

16. The following actions and decisions were agreed at the Covid-O meeting EM/15 - **INQ000065388**

"**ACTIONS**

1. The Minister for Equalities, supported by the Race Disparity Unit, to submit a report to the Prime Minister in response to PHE's report on the disparity of outcomes.

2. The COVID-19 Taskforce to ensure that decisions on future interventions fully factor in the likely impacts on Disproportionately Impacted Groups (including due consideration of Equalities Impact Assessments).

3. DHSC to take steps to encourage the collection of more granular data wherever possible, by encouraging trust in the Test and Trace regime.

DECISIONS

The Committee agreed to the recommended options at paragraphs 5 and 6 of the paper.

1.In addition:

a. while various recommendations would have benefits in relation to wider health and societal inequalities, the priority should be those that aim to prevent the spread of infection.

b. this is a broader issue than the existing work on ethnicity, and should address a wide range of impacted groups, including traveller communities, disabled people and seasonal agricultural workers.

2. The Committee agreed on the importance of Community Champions and that Government guidance and communications packages should be proactively shared with stakeholder networks, in order that they can be tailored to different audiences and can counter disinformation.

3. The Committee agreed that final decisions about the spending package would be made by HM Treasury - but should be expedited wherever possible on issues that will have an immediate impact."

Post-Covid-O meeting of 24 September 2020

17. On 2 October 2020, I met officials from MHCLG, Cabinet Office and DHSC to consider the question of specific interventions for Pakistani groups **[EM/16 - INQ000593756].** That day the CTF commissioned departments to produce recommendations on the issue for a meeting with the PM on 7 October 2020 **[EM/17 - INQ000593750].** On 1-5 October 2020, I wrote to Imran Shafi at No.10 about measures to address the sharp spike in cases among British Pakistanis. **[EM/18 - INQ000593758].**

Covid-O meeting on 29 October 2020

18. In the wake of the Covid-O meeting on 24 September 2020, the Prime Minister gave a clear direction for Ministers to supplement the agreed measures with a more ambitious set of proposals. To that end, the Covid-19 Taskforce and I produced a draft paper for the Covid-O committee [EM/19 - INQ000090136] which was discussed at an officials' meeting on 26 October 2020 (EM/20 - INQ000090138]. The final draft (EM/21 - INQ000090146] was circulated for the ministerial Covid-O meeting on 29 October 2020. The recommendations read as follows:

"3. […] a. **To improve health outcomes swiftly in the community**, the package would:

1. **Invest in community led testing**. Volunteers to be recruited from local charities and faith groups, to work alongside public health, council or military workforce in door to door testing. People will be met with trusted figures who speak the same language, bridging the gap between the official and the general public. (NHS T&T £10m)

2. **Increase testing at places of worship**, will be encouraged to host asymptomatic testing units in tier 2-3 areas. (NHS T&T €11.1m)

3. **Roll out the announced Community Champions scheme**. As funded, the next steps are to finalise the allocation methodology and approach local authorities; agree local action plans and the terms for funding; and activate the XWH governance structure to maximise the impact for HMG, and monitor and learn from the projects. This is being undertaken at pace, with action expected this week. Subject to early reception and success, there may be potential to scale up. Funding is currently earmarked for 30-40 authorities based on need and scale, however we have an initial long list of 65 areas who could all be funded, at c. £450k-600k per new area, subject to scale (MHCLG).

a. The Office for Civil Society will continue to work closely with and support MHCLG to deliver the Community Champions scheme, which includes targeted grant funding through the voluntary and community sector. (DCMS, nil cost)

4. **Reduce transmission in higher education settings** by a communications programme targeted at students likely to be disproportionately impacted or at higher risk of transmission, reinforcing public health and risk mitigation messaging (DfE, £300k).

b. **To improve health outcomes in high-risk occupations**, the package would:

1. **Reduce transmission in the hospitality sector inside the workplace** by increasing ventilation in hospitality settings (via support grants). This has worked in other settings (aircraft) and is international best practice (approx. BEIS £700m based on £5k per hospitality business); and encouraging outdoor hospitality (via support grants and regulatory easements) (BEIS, approx. £400m based on £3k per hospitality business).

a. BEIS has also explored prioritising hospitality workers for supermarket delivery slots. However, Defra has advised it wants to avoid sending a message that going to a supermarket isn't safe; that it is not clear why such a policy should apply only to hospitality workers and not to other high-risk sectors; and that the supermarket sector

is well into its plans for Christmas demand and would find it difficult to accommodate complex new policy demands.

b. BEIS has also explored providing face coverings to hospitality workers, DHSC has advised that it has concerns about the feasibility of such a proposal.

2. Increase workforce safety and reduce the risk of transmission amongst taxi drivers and private hire vehicle (PHV) drivers, through:

a. Distributing face coverings, cleaning supplies and sanitiser to drivers to help promote compliance. (DfT £5-10m)

b. Setting up a grant scheme to fund the installation of permanent adjustments to vehicles (e.g. air ventilation units, screens and sanitiser dispensers) alongside a cross sector In Vehicle Safety Taskforce. (DfT £40m)

c. Promoting the Safer Transport Campaign, providing sector specific guidance and commissioning new research on emerging technologies to reduce the risk of transmission to drivers and passengers (DfT £100k-250k)

3. Continue to offer training and guidance for social care workers, and writing to Directors of Adult Social Services asking them to reassure themselves that their social care departments and providers are making use of a Risk Reduction Framework to support those who may be at greater risk (DHSC, nil).

c. To Improve wider health outcomes for disproportionately impacted groups and reduce the risk of COVID-19, the package would:

1. Improve uptake of flu vaccination in at risk communities and high COVID risk areas. Boosting flu vaccination amongst groups disproportionately impacted by COVID, including those with severe mental illness, will reduce infection rates and release pressure on the NHS during the winter. To be delivered through tailored communications at local level via community health champions or health bodies. (DHSC £3-5m)

2. Tackle obesity to reduce risk of COVID 19. 63% of adults in England are overweight or obese, with those living in deprived areas and certain BAME groups are more severely affected, which increases their vulnerability to experiencing severe cases of COVID-19. Targeted weight management interventions will reduce this risk for these groups. It will also bring significant savings to the NHS and social care. Scaling up weight management services fully aligns with the government's strategy: Tackling Obesity, published in July 2020, that committed to saying more soon about how the

government will support people who want to lose weight. No 10 focus groups have shown the idea to be popular. [...]

3. Expand the Better Health Campaign to target BAME groups to reduce obesity and other comorbidities associated with COVID-19. (DHSC £2m)

d. Improve our understanding of disproportionate impact, and improve our response going forward, the package would:

1. Convene a roundtable discussion with the security industry to understand what further measures are required to reduce the risk of transmission amongst security guards and develop recommendations for COVID-O to tackle disproportionate impacts (HO)

e. Reduce indirect adverse impacts from COVID-19 and associated measures, the package would:

i. Develop a heating voucher scheme for low-income, vulnerable households to be supported in heating their homes over the winter (BEIS £15m-35m).

ii. Scale up social enterprises and voluntary organisations in disproportionately impacted communities (DCMS £3m).

iii. Incentivise the Take-up of Fixed Broadband Connections. Working with telecoms companies to create a new low-cost internet package, funded for 2-3 months by the government, for consumers who are low income or vulnerable and without an existing fixed connection (and who do not qualify for existing social tariffs), in order to help people who are digitally excluded to conduct activity online and to mitigate social isolation. Following the 2-3 month period, consumers would pay a low monthly rate to the service provider. (DCMS to be costed)

Communications recommendations to meet the Prime Minister's ambition

4. In order to deliver the ambition directed by the Prime Minister, we recommend an enhanced and targeted communications and engagement programme to engage these impacted communities - helping to land key messages and drive the behaviour change needed to reduce transmission.

5. The communication and engagement activities outlined in the above package of measures will come together with an augmented package of wider communications to deliver a coherent cross-government approach to tackling disproportionate impacts.

6. Synergies will be used to maximise effectiveness: For example, the community champions scheme (MHCLG) will provide a route to increase community-led testing in affected communities (NHS T&T), support delivery of the flu vaccination scheme in high risk communities (DHSC), and provide guidance to those in high risk occupations to reduce the risk of transmission (BEIS, HO).

7. An example of new communications helping to deliver the measures outlined above would be targeting those in professions and roles which are particularly impacted (such as taxi drivers or hospitality workers) both as recipients and messengers for their networks.

8. In addition to supporting the specific measures in this package, the existing communications and engagement campaign would be further boosted through additional funding being made available for:

b. [sic] targeted focus groups to provide a nuanced understanding of what motivates these audiences and to ensure HMG communications have increased impact;

c. translations to meet targeted audience needs;

d. enhanced influencer activity, partnerships, co-creation of assets and messaging to reach audiences through the channels and engagement routes they trust most;

e. free, low-cost and paid-for marketing and direct (on-the-ground) support in order to better engage these audiences in existing communications campaigns. (£16-20m)

9. This package would include audience-focused, insight-driven communications, such as promoting guidance on avoiding in-home transmission as winter approaches, and going further to tackle misinformation.

10. Where appropriate, the COVID-19 Taskforce is working with HMT and relevant departments to devise funding plans to agree the funding for the additional measures. We expect departments to fund bids from their own budget, with any exceptions to be made on the basis of demonstrated need. Most recommendations would not require legislation or the creation of additional infrastructure, and would be driven forwards by implementing departments."

19. The following actions and decisions were agreed at the Covid-O meeting [EM/22 - INQ000090299].

"**ACTIONS**

MHCLG and Cabinet Office Communications to work with other departments to better align communication and engagement efforts across government.

Cabinet Office Communications to engage with DCMS to consider the best media outlets that will reach furthest into disproportionately impacted groups, giving particular consideration to using local radio stations.

DHSC to explore the need for NHS support for new parents (e.g. health visitors) to remain in place during resourcing constraints for the second wave.

Departments to feed reporting measures data into the Race Disparity Unit ahead of the quarterly report on progress by the Equalities Minister to the Prime Minister and Health Secretary, on addressing COVID-19 health inequalities.

HMT and MHCLG to engage bilaterally on the need to align funding for the new package of measures, with existing funding commitments, bringing in other departments as needed for example: i. HO on funding further enforcement measures for example use of body cams. ii. DfT on funding work to engage with taxi/private hire drivers

No.10 to consider appointing the Equalities Minister to lead a targeted communications campaign alongside a high profile science or medical professional.

DECISIONS

The Committee agreed with the proposed supplementary package of measures to prevent disproportionate outcomes for groups or people with particular backgrounds or characteristics with assurances needed that these measures will be monitored for effectiveness.

The Committee agreed that the Government needs to urgently address clarity of communication with the focus targeted on occupations that require regular personal contact (e.g. in health care settings, security industry) and therefore carry greater exposure risks.

The Committee agreed that funding proposals are subject to HMT approval."

Covid-O meeting on 30 November 2020

20. On 5 November 2020, the Covid Taskforce and I were asked to produce a paper on the disproportionate impact of Covid-19 on disabled people for the Covid-O committee [EM/23 - INQ000083917]. Later that day I sent out a commission to all departments with a table listing some of the issues and measures for departments to consider [EM/24 - INQ000187633]. The Covid-19 Taskforce and I drafted a paper [EM/25 -

INQ000090976] which was discussed at an officials' Covid-O meeting on 30 November 2020 [EM/26 - INQ000090979]. The final draft [EM/27 - **INQ000325294** was discussed at the ministerial Covid-O meeting on 8 December 2020. The paper contained the following recommendations:

"10. Given the need for urgency, we recommend Ministers endorse the following package of measures to improve health outcomes for disabled people in response to COVID-19, some of which are already public and in train (denoted by **) Further measures relating to adult social care are being presented to COVID (O) at a meeting scheduled for 8 December 2020.

a. **To improve the data** and our understanding of disproportionate impacts on disabled people, and improve our response, the package would:

i. **Improve the data collected on disability by commissioning research to understand factors driving increased mortality risk**. Disability Unit working in conjunction with the ONS, DWP and health partners to improve the data collected to better understand factors driving increased mortality risk, improve linkage of existing datasets, break down types of impairment and, where relevant, intersectionality associated with an increased risk of infection or severe outcomes from COVID-19, in order to develop effective interventions and policies. (DU, DWP, ONS, £120k - funded)

ii. **Conduct a data audit of disabled people's travel patterns and preferences** to inform policies that help improve disabled passengers' safety, confidence and experiences using public transport during the pandemic. (DfT, £100k, funded)

b. **To reduce mortality and morbidity** and improve health outcomes for disabled people, the package would:

i. **Support more regular testing for disabled people and their contacts, including in the following settings, which are part of the published winter plan**:

a. In care homes by providing at least two weekly tests for staff and at least weekly tests for residents, with lateral flow testing for visitors likely to be required before entry. (DHSC, funded **)

b. In domiciliary care settings by providing regular testing for CQC-registered domiciliary care workers, with the ambition to extend this to non-CQC-registered care workers. (DHSC, funded **)

c. In high-risk Extra Care/Supported Living settings by providing regular testing for staff and residents. (DHSC, funded **)

ii. **Support measures to improve infection control by reducing movement and the associated potential for transmission**:

a. Explore introducing support payments for the clinically extremely vulnerable in Tier 3 areas who cannot work from home, are not furloughed, and are expected to return to work in environments where social distancing is difficult, in order to prevent them from being exposed to a higher level of risk than those not in this position. (MHCLG, TBC - unfunded)

b. Support residential care providers in preventing staff movement between care settings, minimising the risk of infection by providing the necessary financial support through the Infection Control Fund. (DHSC, funded)

c. Improve guidance to help employers better support their clinically extremely vulnerable (CEV) employees. Guidance will be updated to help employers have appropriate conversations with CEV staff, and to consider furloughing those who cannot reasonably work from home. It will also make clear how appropriate COVID-Secure adaptations can be made to help support CEV staff who are in work. (MHCLG and BEIS, nil cost)

d. Reduce the risk of transmission for passengers who require close-contact assistance, many of whom are disabled, by encouraging transport workers in these scenarios to use face coverings, and assessing the case for mandating the use of face coverings in close-contact passenger assistance. (DfT, nil cost).

c. **To mitigate indirect impacts of COVID-19**, the package would:

i. **Support measures to address the negative effects on the wellbeing of disabled people from COVID-19 restrictions**:

a. Provide immediate, targeted support to redress the known indirect impacts of COVID-19 on disabled people, and improve the physical and mental wellbeing of disabled people and carers, by funding voluntary and community organisations providing direct support. (DHSC, £2.4m, unfunded)

b. Reduce the mental health risks of isolation by providing clear guidance on care home visits, setting out precautions that mitigate the risk of transmission. (DHSC, nil cost **)

c. Promote the new exemptions in access to respite provision for families of disabled children and support bubbles for those with disabled children under 5 who require

continuous care, in order to prevent isolation and burnout and improve mental health for parent carers over winter. (DfE, nil cost **)

ii. **Help disabled people access and use digital technology to stay well and connected**:

a. Reduce the digital exclusion of people with disabilities by providing basic devices, data and digital support to people with learning difficulties or severe impairments. (DCMS, £5m-10m, unfunded)

b. Ensure more disabled young people have the technology that they need to fully participate in work by expanding specialist hardware needs assessments, and promoting them more effectively through targeted marketing and partnering with the voluntary sector. (DCMS, included in above £5m-10m, unfunded).

c. Create a National Centre for Digital Access to use the 'forced digitisation' of services and social life during COVID-19 as a catalyst to make this the most accessible place in the world to live and work with digital technology (CO, £2.5m - unfunded).

iii. **Improve educational provision and support for disabled children**:

a. Increase the schools budget for high needs with a £730m increase for 2021-22 meaning a cumulative increase of nearly a quarter in two years. (DfE, funded)

b. Creating new high needs school places and improving existing provision by investing £300m in 2021-22 in mainstream and special schools. (DfE, funded)

c. Invest in improving education provision for children with disabilities by investing in a training provider to provide Special Educational Needs and Disability training for all 24,000 schools and colleges in England on how to best support disabled pupils, including digital education provision. They could be in place by April 2021. (DfE, funded).

d. Continue to train Educational Psychologists in England. From September 2020 there will be a further three training rounds and an increase in the number of trainees from 160 to at least 203, to help keep up with demand for this specialist advice. (DfE, funded)

iv. Provide support for parents of disabled children:

a. Continue to support low-income families with disabled children who have been hard hit by the pandemic, by investing further in the Family Fund to provide goods, grants and services on top of statutory entitlements, with increased funding to respond to COVID pressures. (DfE, £5m, funded)

b. Improve advice for families with increased grant funding to the 151 parent-carer fora in England and a new national advice helpline. (DfE, £8.7m, funded)

v. Improve employment access and provision for disabled people:

a. Improve access to employment advisers for those receiving psychological therapies by investing in a temporary increase in the number of employment advisers (EAs) working in high-performing NHS Improving Access to Psychological Therapies (IAPT) sites which will support approximately 520 additional clients in this financial year. (DWP, £336k, funded for 2020/21)

b. Improve the successful Access to Work scheme by creating an app and digital payments system, increasing awareness and allowing support to be provided more rapidly by replacing a slower paper-based system. (DWP, £2m, funded).

c. Establish an advice centre on employment rights for disabled people to advise on discrimination, flexible working, rights and obligations around reasonable adjustments, and fairness in redundancy situations, and to help employers to meet their obligations. (BEIS, funded)

d. Support disabled people to work flexibly through working with employers, and explore including measures in the Employment Bill to make flexible working the default and to introduce a new employment right to one week's unpaid Carer's Leave. (BEIS, nil cost)

e. Continuing employment support provision, including targeted schemes. Many disabled people will be supported through the £3.6bn Plan for Jobs. Targeted support, including the Work and Health Programme and Intensive Personalised Employment Support, is available for those with more complex needs. (DWP, funded **)

f. Support more young people with SEND to prepare for and successfully transition to paid work, by strengthening the Supported Internship programme through updates to the guidance to ensure young people receive a high-quality internship. (DfE, nil cost).

d. **All Government departments are required to provide information in accessible formats** under the Equalities Act (2010). To improve communications and guidance for disabled people, the package would enact this by:

i. **Ensuring that those with disabilities receive COVID-19 guidance and communications in a timely and accessible way** by creating a 'rapid accessibility content team' to produce

content in alternative formats. This provision of British Sign Language (BSL) interpreters, voiceover artists and graphic designers will allow any critical content to be rapidly developed into suitable formats at speed and scale. It will help address stakeholder criticism [and legal actions] that the government is not getting the basics right. (CO, £150k funded).

ii. **Better utilise and coordinate guidance and updates to stakeholder forums** and disability charities in order that they receive the most up to date and accurate government information to share with their communities. (TBC but minimal, DU/CO)

iii. **Make health and social care guidance and materials more accessible** by accelerating procurement of alternative formats within DHSC, and making resource available to make accessibility checks a prerequisite for publication. (DHSC, £500k, - funded, subject to approval)

iv. **Work with operators and disabled people's organisations to make transport information more accessible and user-friendly** across the public transport industry, to better support disabled customers. This will include improving the visibility of available passenger assistance services. (DfT, funded)"

21. The following actions and decisions were agreed at the Covid-O meeting [EM/28 - INQ000091234].

"**ACTIONS**

MHCLG, DWP and CTF (COVID Taskforce) to work with BEIS on clear advice and guidance for Clinically Extremely Vulnerable (CEV) employees and their employers.

BEIS to work with ACAS (Advisory, Conciliation and Arbitration Service) to establish an advice centre on employment rights for disabled people, due to launch in Spring 2021.

DCMS, CTF and Disability Unit to engage with HMT on technology schemes (currently unfunded) to reduce digital exclusion among people living with disabilities, providing the business cases as needed.

DHSC to provide more granular analysis on the effectiveness of testing in care homes, and vaccine prioritisation and visits policy across different residential settings.

DHSC to provide information on prioritisation of those with a terminal prognosis for vaccination.

DfE to share analysis and data with HMT on the success of improving digital access and ensuring children with special educational needs receive the support they require for remote learning.

DWP and the Disability Unit to work with departments and the Office of National Statistics (ONS) to address the gaps in data and research on the impact of disability on Covid-19 outcomes.

DECISIONS

COVID-O agreed with some of the recommendations set out at paragraph 10 of the SRO's paper *Disproportionately Impacted Groups - Disability* that:

-departments should move at speed to roll out the measures agreed, and they should engage swiftly with HMT where additional funding is required.

-departments should work together to use improved data to better understand the disproportionate impacts of COVID-19 on people living with disabilities, including conducting a data audit of disabled people's travel patterns and preferences (paragraph 10ii).

-departments should support measures to address the negative effects of COVID-19 restrictions on the wellbeing of disabled people.

COVID-O did **not** agree to explore the introduction of specific financial support payments for Clinically Extremely Vulnerable (CEV) people in Tier 3 areas who cannot work from home and are not furloughed - noting the possible detrimental impacts isolation can have on their wellbeing. Instead departments will work together to ensure guidance is available for employers and employees.

COVID-O noted the Minister for Disabled People's offer for departments to contact him in order to share messaging with relevant stakeholder networks and groups such as the Disabilities Charities Consortium (DCC). This will help with better comms, provide early insight into key issues and reduce anxiety among network members.

COVID-O agreed this item should return to COVID-O with an update on progress, and as new data and analysis emerges."

DIGs cross-Whitehall Steering Group

22. By email dated 14 January 2021 **[EM/29 - INQ000593770],** I invited a range of officials from across Whitehall to join a new steering group on DIGs and scheduled an inaugural meeting for **28 January 2021** **[EM/30 - INQ000593771], [EM/31 - INQ000593769]** to

discuss progress against the measures approved by the COVID-O committee as set out in slides prepared for that meeting **[EM/32 - INQ000531434].** The steering group's terms of reference were agreed at the meeting as follows **[EM/33 - INQ000593767]:**

"The DIGs SG members are responsible for:

- ensuring existing and new C-19 policy / interventions / programmes for the short and long term (including but not limited to vaccine roll-out and testing) take account of and address the clinical and non-clinical impacts on DIGs, where appropriate, including adults, children and young people;
- ensuring effective join-up of DIGs work and planned activity across Whitehall is aligned, including on related issues on health inequalities, C-19 recovery, and developing priorities for areas of focus for the Autumn Budget and upcoming Spending Review;
- driving accountability and responsibility for DIGs work within respective Departments and consider what further work is needed at Department/national/local level;
- monitoring implementation and evaluation of agreed COVID-O measures to address the direct and indirect impacts of C-19.

The DIGs SG members will do this by:

- ensuring their teams and Departments are giving this agenda due regard and using relationships across Whitehall to strengthen and influence impact;
- integrating work on intersecting elements of DIGs to generate policy that is greater than the sum of its parts;
- encouraging strong working level relationships to help deliver agreed measures, drive forward outcomes from Board and help support delivery of next phase of DIGs work.
- identifying issues to take to Covid-O for Ministerial discussion and decision;
- considering whether available data is sufficient and identifying where/how our evidence base can be strengthened."

23. In the run-up to the first SG meeting, the CTF presented me with data on Covid-19 outcomes in the second as opposed to the first wave **[EM/34 - INQ000593760].** The

slides for the meeting **[EM/32 - INQ000531434],** proposed the following "Actions to address Wave 2 impacts":

"PM C-19 Dashboard meeting held on 22 January 2021 highlighted the difference in case rates between ethnic groups, and potential challenges with vaccine uptake in some ethnic groups. **The PM stressed the need for detailed plans and strong comms fronted by community leaders to tackle this challenge**.
Immediate actions in train:
Gathering granular level data on the worst affected areas where there is an increase in case rates but low level take up on testing to support engagement with local authorities and DPHs to consider appropriate local level action on community testing.
Considering prioritisation of community and workplace testing for BAME and low-income groups.
Self isolation policy. Looking at improving financial incentives including payments to increase the support offer.
Preventing transmission in household settings - in particular in multi-generational households – through increased targeted comms and guidance.
Publishing vaccine data to include additional information on ethnicity and occupation as well as age and location, to support advocacy. Addressing vaccine hesitancy through sustained comms campaign.
Phase 2 vaccination prioritisation. Conducting modelling on labour force survey data to support delivery of a profession-based approach to phase 2, who are in high risk occupations such as taxi drivers and security guards.
What more could and should we be doing?

24. The slides listed the following "DIGs priorities":

Ensure work on Non Pharmaceutical Interventions (NPIs), policy interventions, unwinding of restrictions and other measures including lockdown exit strategy planning **takes account of the equalities impacts on DIGs.**
Ongoing focus on vaccine communications and deployment. This includes working with communications and policy teams across Government and health partners on ensuring full considerations are given to DIGs in terms of social marketing interventions alongside deployment and accessibility.

Actively contribute to the Vaccines Equalities Board, which has been established by NHSE to ensure fairness in process, alongside a Data Board to ensure that crucial information is collected and monitored in real time so that comms can pivot to specific groups in localities if take up is seen to be low.

Focus on place based inequalities which are being exacerbated by Covid 19. Emerging evidence shows deprivation levels to be a factor in hospitalisations and mortality.

Continue to **consider ongoing issues and areas for further intervention**, where further options to support DIGs may be needed."

25. After the first meeting of the SG, the Covid-19 Taskforce Delivery Board was enlisted to seek monthly updates from other departments on measures including RAG ratings and to work with policy leads to establish the process. The slides indicated that it had been agreed that the DIGs team would develop a more programmatic approach to reviewing the Covid(O) measures with the Covid-19 Taskforce asking departments for monthly updates.

26. The second meeting of the steering group was on **25 February 2021** **[EM/35 - INQ000593768, EM/36 - INQ000593766].** My concern leading up to this meeting was that DIGs were not being adequately covered in existing work on the roadmap out of lockdown [EM/37 - DLUHC010146038]. The slides for the meeting included the following under the heading "Roadmap Strategy – key points to note on DIGs & action for OGDs [other government departments]" **[EM/33 - INQ000593767]:**

"**Prominent DIGs section** with focus on supporting and protecting affected communities.

Further work and commitments made to protect DIGs - explored below- as we move through the roadmap steps and ease restrictions, including:

Reducing transmission:

- **Twice-weekly testing of secondary school and college pupils. Use of face coverings** extended for a limited period to all indoor environments - including classrooms
- **Increasing community and workplace testing** in affected communities / high risk occupations

- **Expanding testing and improving safety measures for those in high risk institutional settings** such as prisons

Vaccines:

- **Improving vaccine uptake** through better data
- **Countering mis-and disinformation** around vaccines
- **Working with voluntary sector** to support the vaccine rollout at the community level

Indirect impacts:

- **Mitigating educational impacts**: allowing return to education for most pupils, and appointing Education Recovery Commissioner to oversee recovery on lost earning
- Providing additional support for those facing **indirect impacts of COVID-19** including supporting domestic abuse and safeguarding service, **and addressing longer-term implications of COVID**
- **Publishing Action Plan** setting out further measures to mitigate the impacts on **mental health**
- **Protecting rough sleepers** and s**upporting families with disabled children**
- **Tackling obesity and other comorbidities** associated with COVID-19."

27. NHS T&T provided an update on community testing at the meeting pointing out that it was designed to be led by local authorities who were considered "best placed to identify and target DIGs in their areas" **[EM/36 - INQ000593766, pg. 3].**

28. The third meeting of the steering group was on **25 March 2021** **[EM/38 - INQ000593764],** The CTF circulated slides on place-based inequalities **[EM/39 - INQ000593765],** the overview for which read as follows.

- "These slides set out the evidence available on placed based inequality which shows that COVID-19 has exacerbated existing inequalities.
- The analysis highlights which factors of deprivation act as drivers of enduring transmission and lead to certain areas, and groups, suffering from disproportionate COVID-19 health impacts. There are policy implications for short term efforts to prevent transmission and the long term recovery and efforts to prevent a further widening of inequalities.

- Existing economic, social and health inequalities in communities and places which were already deprived have been made worse by the pandemic.
- Without focused and timely policy interventions these communities and places will continue to be more vulnerable to the direct and indirect impacts of COVID-19 and wider inequalities will continue to worsen."

29. The slides made the following policy recommendations:

"**Short-term, urgent**

Focus on preventing transmission in deprived areas, not only to protect the roadmap but protect the communities more effectively

- The coverage and accessibility of testing (community, workplaces, home)
- Income stability in self-isolation and the role of employers
- Vaccine uptake and deployment (flex to take account of the communities eg. vaccinate whole high occupancy households, continue to target appropriate health promotion messaging to tackle concerns and misinformation)

Longer-term

Address health inequalities (and the drivers to improve the resilience of communities to COVID over the longer-term.

- Improve housing quality and air quality. […]
- Campaigns and interventions to reduce co-morbidities.

Mitigate economic impacts of COVID and address underlying inequalities to ensure deprived communities are able to recover from the pandemic shocks

- Active labour market policies to address skills and unemployment
- Improve educational attainment."

30. On intersectionality, the slides **[EM/39 - INQ000593765]** read as follows on page 2. "Factors such as large household sizes, type of occupation or necessity to travel and work for financial reasons make some unable to self-isolate - a key driver of risk for them and their contacts […] rarely operate in isolation; they operate on predictable lines of deprivation, ethnicity and poverty and concentrate in urban areas. Their combined effect creates a perfect storm, putting certain communities at considerably higher risk."

31. The fourth meeting on **9 June 2021** **[EM/40- INQ000593783]** covered the role of Community Champions in increasing vaccine uptake, the UKHSA's work with local authorities to develop a preventative package of support for areas of enduring transmission and an update from the CTF on social distancing and certification.

32. The fifth meeting on **14 July 2021** **[EM/41- INQ000593784, EM/42 - INQ000593780]** was led by DHSC with slides circulated on health inequality and the link to Covid-19, **[EM/43- INQ000593782]** and Long Covid **[EM/44 - INQ000593781].**

33. The sixth meeting on **14 September 2021** **[EM/45- INQ000593777].** The discussion covered the Government's Levelling Up agenda **[EM/46- INQ000593778]** and Autumn/Winter planning slides from the CTF **[EM/47- INQ000593779].** The latter included the following on key pressures on and risks to DIGs associated with Covid-19 over the period September 2021 to March 2022.

"[**Pressures**]:

- areas of enduring transmission
- any further disruption to education
- the end of economic support packages such as the furlough scheme;
- persisting issues surrounding vaccine uptake including the disparity in vaccine uptake between ethnic group especially in younger age cohorts

Mitigations

- Reintroducing NPIs
- Continuing to encourage testing and vaccine uptake (or revaccination where needed) in worst impacted communities (can be through comm champs scheme) and younger age groups (using incentives)
- Extending self-isolation support payments for those who cannot afford to miss work
- Ensuring published guidance is continually translated into a range of languages and accessible formats
- Working with Directors of Public Health to monitor transmission rates and implement further interventions where needed."

Final meeting & lessons learned

34. The seventh and final meeting on **8 December 2021** **[EM/48- INQ000593773]** included a discussion led by DHSC on the Office for Health Improvement and Disparities **[EM/49 - INQ000593774],** the UKHSA on Health Equity Policy **[EM/50 - INQ000593775],** and the Covid Taskforce on lessons learned **[EM/51 - INQ000468703]** The last item on the agenda was for the SRO to lead on 'DIGs/Taskforce transition'. So far as material, the lessons learned slides read as follows:

What has gone well?

- Establishing a dedicated DIGs team, embedded in the centre/Taskforce, to own the policy and drive progress.
- Appointing SRO DIGs champion increased visibility and leveraged support for the work/agenda
- Building evidence and insights on DIGs to inform policy development, was essential in getting traction and mainstreaming impacts.
- Setting up of the xWH DIGs Steering Group to share insights/evidence and focussed discussion on DIGs impacts
- Building strong collaborative working relationships with OGDs improved outcomes for DIGs e.g. COVID-O measures/Community Champions scheme has had a real impact
- Championing and embedding equalities considerations as part of policy making and ministerial decision making e.g. through Covid-O process, developing NPIs, Roadmap Strategy
- Driving progress to improve outcomes for DIGs e.g vaccine uptake, targeted testing, specific comms, guidance
- Sharing of insights/evidence to inform strategy/policy development on the pandemic response, and influencing longer term recovery for DIGs through the levelling up and public services reform agendas

What has not gone well

- Insufficient focus on DIGs at start of the pandemic response (other than CEV group) until a central team was formed in August 2020
- Limited in the role we could play to address entrenched health and socioeconomic inequalities in DIGs - long term ingrained issues.

- The lack of available data/ evidence due to limited access to data sources and/or insufficient data on the impacts for DIGs, however, analysis picture improved over time & led to the development of excellent DIGs data packs.
- Securing funding for key policies such as taxi screens, enduring transmission package etc. was an issue from the outset, despite the strong evidence.
- Driving accountability and getting traction on DIGs issues xWH and with key departments:
    - Limited remit of the SRO and not enough ministerial or senior level interest
    - Lack of a clear and consistent ministerial / perm sec to champion DIGs policy
- Evidence shows impacts have improved over time, but not consistently and some groups continue to be affected e.g. ethnic minorities, deprived communities.
- Difficult to quantify impact of interventions on DIGs due to lack of data / no evaluation of Covid-O measures in some cases.
- Limited remit of the x-WH DIGs forum - great at raising the profile of DIGs but no 'power' to challenge depts and drive accountability internally.
- Considerable effort required to embed equalities considerations into policy / decision making, but we have turned the tide.

<u>What could be improved/key lessons for the future</u>

- Creating a 'web of responsibility', through appointing CMO/DCMO, a Permanent Secretary and a Minister to each act as a champion for DIGs.
- Establishing a governance and accountability board to drive progress and secure senior buy-in xWH.
- Leverage external/partner expertise e.g CMO, DHPs, academics, to drive the programme / bring external challenge.
- Importance of establishing good working relationships xWH at an early stage to address something so cross-cutting.
- Embedding equality consideration of disproportionate impacts in crisis response from the outset of policy making - not retrofitting equalities impacts/writing of PSEDs.
    - E.g. consistent impact reporting in all advice to Ministers xWH
- Building on links already established with communities & importance of developing localised / targeted approaches
- Strengthening accountability for DIGs agenda:

- Giving the SRO 'power' to hold depts to account & appointing 'SRO' type figures in DHSC & HMT
- Setting up a ministerial DIGs board, either once or regularly - a forum for challenge
- Ensuring early access to data sources and encouraging proactive shared of evidence xWH to influence policy thinking / strategy across depts.
- Embedding more resource into a central team given cross-cutting work/impacts and leveraging external expertise.
- Making time for forward planning, but can be difficult when operating in a crisis situation."

Remaining issues on which I can assist

35. I am asked about the following:

- **Data** - the data covered in the papers for the relevant meetings of the Covid-O committee and DIGs Steering Group was supplied by the CTF. On the issue of sufficiency of data, please refer to the points raised in the meetings above.
- **Domestic abuse** – this was touched upon in the February SG meeting (above).
- I am asked whether the Steering Group supported government departments to carry out **equality impact assessments** in relation to DIGs. We did not produce any such assessments. These remained the responsibility accountable departments or agencies. On the linked issue of **PSED**, questions about domestic and international obligations would be better addressed by the Equality Hub.
- **NHST&T engagement –** NHST&T attended the February SG meeting.
- I have been asked about the **Quarterly Reports** produced by the Equalities Minister, Kemi Badenoch, for the Prime Minister. I was not involved in the production of those reports but recall making the work my team carried out in relation to DIGs available to the Equality Hub. Questions relating to the Quarterly Reports are better addressed to Marcus Bell and Kemi Badenoch.

Statement of Truth

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

Signed:

Personal Data

Name: Emran Mian

Dated: 17 April 2025