Witness Name: Sapana Agrawal

Statement No.: Second

Exhibits: 392

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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. SECTION 1: INTRODUCTION AND EXECUTIVE SUMMARY

1.1. I am a senior civil servant and serve as the Director of the Civil Service Strategy Unit 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 the Director of Health, Social Care and Delivery in the COVID-19 Taskforce (CTF), until starting my current role (which was previously named Director of Modernisation and Reform).

1.2. This corporate witness statement is produced to address questions 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 21 October 2024 (the 'Rule 9'). The statement has been prepared with the assistance of Counsel and the Government Legal Department.

1.3. The relevant period for Module 6, 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 adult social care sector during the COVID-19 pandemic. Nor is it a detailed account of every piece of advice given or decision made by the Cabinet Office in respect of the adult social care sector. 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, and explains how those structures evolved in response to the changing nature of the pandemic at Annex A.

Executive summary

1.5. To understand the Cabinet Office's role in respect of adult social care it is important to bear the following points in mind. Where there is significant overlap with other modules, such as on vaccines, I understand that additional detail will be provided as part of those modules.

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 their respective sectors. As Simon Ridley, the Secretary to the Healthcare Ministerial Implementation Group (HMIG) from March to May 2020, put it in oral evidence: "our job in the Cabinet Office was to convene, bring people together, understand the position in the round and then use the HMIG as a means for government to make cross-government decisions where it needed to"[1].

1.5.2. **The lead department for social care was the Department of Health and Social Care (DHSC) and the Ministry of Housing, Communities and**

[1] Simon Ridley's oral evidence to Module 2, 7 November 2023 page 15 lines 18-21

Local Government (MHCLG) also had a key role. DHSC sets social care policy and is accountable to Parliament and the public for the performance of the care system as a whole.[2] DHSC is responsible for agreeing central government funding for adult social care through the Spending Review process within an overall system for local government funding overseen by MHCLG.[3]

1.5.3. **The care sector is disparate and made up of different service types, such as care homes, home care and unpaid carers**. The Care Act 2014 places the duty to plan and secure adult social care services on local authorities in England who commission services through a predominantly outsourced market of approximately 18,000 provider organisations. The Care Quality Commission (CQC) is the sector's independent regulator in England, and oversees the quality of all registered providers.[4]

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 social care services**. The Cabinet Office including No.10 is not directly involved in operational decisions made 'on the ground' in social care settings.

1.5.5. **The Cabinet Office including No.10 was, however, keen to ensure that social care had due prominence in considerations about the response to the pandemic.** We were conscious that health and social care were interconnected as a system, with a continuous flow of patients back and forth between hospitals and the care sector, and had a number of risks in common, such as winter pressures. The pandemic also shone a light on the vulnerabilities of the care worker population. As the Chief Medical Officers (CMOs) recorded in their Technical Report, "Many staff came from communities experiencing higher transmission and so were also at heightened risk of exposure in the community despite their extensive efforts to reduce risk for residents. This epidemiological trend introduced both transmission risk and a risk to staffing levels in the event of large-scale absences due to COVID-19 sickness"[5].

[2] SA/1 - INQ000564787
[3] SA/2 - INQ000564791
[4] SA/2 - INQ000564791
[5] SA/3 - INQ000203933

1.5.6. **Therefore, while the Cabinet Office including No.10 did not hold the policy levers on care homes, and there were at the beginning of the pandemic significant limitations on the data available, we wanted as full a real-time understanding as possible of what was happening to ensure the safety of those in social care, and of those working in social care**. This was so we could advise the Prime Minister and the Chancellor of the Duchy of Lancaster (CDL), and be a 'critical friend' to departments. We developed very close working relationships and flows of communication with our counterparts in departments, and paid close attention to the medical and scientific advice as it evolved, which on social care came particularly from, for example, the Scientific Advisory Group for Emergencies (SAGE), the Deputy Chief Medical Officer (DCMO) Jenny Harries and Professor Jane Cummings (DHSC).

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**. The Cabinet Office including No.10 sought to ensure that social care was well considered in the development of the overall strategy and the roll-out of testing and vaccines. Examples of specific social care issues considered by the Cabinet Office including No.10 included visiting policy, where there was a difficult balance to strike between the risk to residents from Covid transmission and the impact that isolation had on their physical and mental wellbeing, and vaccination as a condition of deployment, which I understand is also being considered in Module 4.

1.6. The statement is divided into the following sections:

1.6.1. Section 2 provides an overview of the general role of the Cabinet Office;

1.6.2. Section 3 provides a summary overview of the Cabinet Office's role in pre-pandemic preparedness in relation to adult social care, and activity in the department at the emergence of the novel coronavirus before it was declared a pandemic on 11 March 2020;

1.6.3. Section 4 sets out the role of the Cabinet Office in decisions and planning affecting the care sector during the pandemic. This section provides an overview of the role of the Prime Minister in key areas of work during the pandemic; and,

1.6.4. Section 5 covers internal reviews or lessons learned exercises relevant to the adult social care sector conducted or commissioned by the Cabinet Office.

1.7. Key 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). Local authorities also play an important role in planning for and responding to pandemic outbreaks. They have responsibility for a wide range of functions including social care and children's services and crucially exercise a community leadership role. A full description of the Cabinet Office's relationship to other bodies is set out at Annex B of this statement. I understand that the Inquiry will explore children's social care in Module 8. Where I refer to the social care sector in this statement, it will be in reference to adult social care unless stated otherwise.

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

2. SECTION 2: OVERVIEW OF CABINET OFFICE STRUCTURE, ROLE, PEOPLE AND PROCESSES

The general role of the Cabinet Office including No.10

2.1. The Cabinet Office including No.10 has a unique role at the centre of UK Government.[6]

2.2. As the Cabinet Manual 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".[7]

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".

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".[8]

2.5. The Cabinet Office including No.10 enables collective decisions and provides direct policy and implementation advice and support to the Prime Minister, 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 social care.

2.6. Not all government decisions require collective agreement. 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".[9] The Cabinet Manual also sets out that "policy proposals with public expenditure implications will not be agreed unless Treasury ministers are content. If necessary,

[6] SA/4 - INQ000092893
[7] SA/5 - INQ000182315
[8] SA/6 - INQ000086870
[9] See Cabinet Manual, page 40, SA/5 - INQ000182315

2.7. **There are no sources in the current document.**issues can be referred to the Prime Minister or, if he or she so decides, to Cabinet for a decision".[10]

2.8. As the Government's website explained, the CDL "administers the estates and rents of the Duchy of Lancaster, and is a member of the Cabinet". The individuals that held the role of CDL during the relevant period were the Rt Hon Michael Gove MP (24 July 2019 to 15 September 2021) and the Rt Hon Steve Barclay MP (16 September 2021 to 5 July 2022). The CDL's responsibilities during the relevant period included (but naturally may have been subject to change given the changing holders of the role):

2.8.1. Oversight of all Cabinet Office policy and appointments;

2.8.2. Oversight of constitutional policy and enhancement;

2.8.3. Devolution and Union issues (until the establishment of the role of the Minister for Intergovernmental Relations in September 2021);

2.8.4. Leading public services recovery from COVID-19;

2.8.5. Leading cross-government and public sector transformation and efficiency;

2.8.6. Oversight of Cabinet Office responsibilities on national security and resilience, and the CCS, including COVID-19;

2.8.7. Supporting the coordination of the cross-government and the devolution aspects of the response to COVID-19.[11]

2.9. Throughout the pandemic, including in the context of work relating to the care sector, many decisions rightly continued to be taken within individual departments. Where collective decisions were not required, the role of the Cabinet Office was, as is typical for the centre of government, focused around strategic coordination, ensuring collaboration between the relevant parts of government, assuring progress and providing challenge to help strengthen policy-making and ensure alignment with the Government's overarching strategic objectives.

2.10. The decision as to how and to what extent the Cabinet Office supports or challenges departments is always a matter of judgement. Senior officials and ministers use a range of factors - ranging from political direction and appetite to more intangible factors like confidence in the management of an issue in a department or if a neutral

[10] See Cabinet Manual, page 42, SA/5 - INQ000182315
[11] SA/7 - INQ000564781(archived 1 April 2020)

broker on a contentious matter between departments is required - to decide where it needs to step in.

2.11. The Cabinet committees which managed the COVID-19 response evolved during the relevant period, and can be summarised in three stages. From the emergence of the novel coronavirus to 15 March 2020, decisions were taken through the Cabinet Office Briefing Room (COBR) mechanism. From 16 March to 27 May 2020 four Ministerial Implementation Groups (MIGs) were stood up as bespoke committees for the whole-of-government response to COVID-19. The Health Ministerial Implementation Group (HMIG) was the MIG which considered social care the most during this period. I have set out a chronology of this group's meetings at Annex A and reference key meetings where appropriate throughout this statement. From 28 May 2020 the four MIGs were stood down and the COVID Strategy Committee (COVID-S) and the COVID Operations Committee (COVID-O) were established. Annex A sets out details of the Cabinet Office's evolving decision-making structures throughout the relevant period.

2.12. 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".[12]

2.13. 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) 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 CTF). These teams, dependent on the Prime Minister's priorities, will have engaged with adult social care 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".

[12] SA/8 - INQ000086873

3. SECTION 3: PREPAREDNESS AND RESILIENCE

3.1. This section provides an overview of the Cabinet Office's involvement in pre-pandemic planning for adult social care, and its understanding of the pressures on the adult social care sector before the pandemic. The role of the Cabinet Office in pre-pandemic planning for adult social care, and an overview of the learning from previous outbreaks and simulation exercises prior to the COVID-19 pandemic, was provided in Roger Hargreaves' corporate statements for Module 1.[13] These are not all repeated here. Instead, I refer to a number of specific examples with particular learnings for the care sector. I repeat and enlarge upon various issues specific to adult social care in this statement.

Cabinet Office Responsibilities in relation to Emergency Preparedness

3.2. A longstanding role of the Cabinet Office is to co-ordinate the security of the realm, maintain the integrity of the union, support collective government decision making, and ensure the delivery of the Prime Minister's priorities in the area of emergency preparedness and response.[14] The Cabinet Office is therefore responsible for coordinating the Government's preparations for, and response to, major civil emergencies, working closely with the relevant lead government departments, devolved governments and local responders as appropriate.

3.3. The Civil Contingencies Secretariat was the unit within the Cabinet Office responsible for preparing for, responding to and learning lessons from major emergencies during the relevant period. Between 2010 and 2022, the CCS was part of the National Security Secretariat, which was headed by the National Security Adviser and which supported the National Security Council (NSC). The NSC was the main forum for ministerial discussion of the government's objectives for national security and about how best to deliver them. NSC Threats, Hazards, Resilience and Contingencies (referred to as NSC(THRC)), a sub-committee of the NSC, was established in 2010 and disbanded in 2019. The remit of the NSC(THRC) was to consider issues relating to security threats, hazards, resilience and civil contingencies, reporting as necessary to the NSC.[15]

3.4. The role of the CCS evolved since its establishment, but primary functions since its establishment in 2001 included:

[13] SA/9 - INQ000195845, SA/10 - INQ000145912, SA/11 - INQ000182612
[14] SA/12 - INQ000099517
[15] SA/10 - INQ000145912

3.4.1. Working closely with government departments, devolved governments and local responders to ensure that plans and capabilities were in place to manage all kinds of emergencies. This generally took the form of generic capability building to address many shared risks supported by specific planning where necessary and proportionate for certain risks;

3.4.2. Horizon-scanning for immediate upcoming risks (i.e. working with government departments to determine and manage risks that were likely to occur within the next 6 months);

3.4.3. Longer-term risk assessment (i.e., working with government departments to determine and manage risks that could occur within the next five years) as set out in the National Security Risk Assessment (NSRA) and the National Risk Register (NRR) to support capability development through the development of planning assumptions and to guide planning effort;[16]

3.4.4. Working with international partners such as NATO, the UN and formerly the EU, to support disaster risk reduction and develop cross-border mutual aid arrangements;

3.4.5. Managing the Emergency Planning College in North Yorkshire, providing training and support to resilience professionals across the UK and internationally; and,

3.4.6. Coordination of central government civil crisis management arrangements, including the development and maintenance of crisis management facilities.

3.5. As the Inquiry explored in earlier modules, risk management responsibilities in the UK Government are based on the Lead Government Department (LGD) model, whereby responsibility for risk preparedness and management sits with individual departments.

3.6. The Cabinet Office is responsible for designating LGDs for risks. A LGD will usually be the department with primary policy responsibility for the risk and expertise for the area impacted by the emergency scenario. LGDs, with support from other departments and bodies, are responsible for national-level risk anticipation, assessment, prevention and mitigation, preparation, and response. DHSC is the LGD for the risk of pandemics and emerging infectious diseases. In line with the LGD principles, DHSC had and continues to have overall responsibility for putting in place arrangements to mitigate the potential impacts of these risks.

[16] SA/10 - INQ000145912

3.7. The Cabinet Office is also responsible for producing the public-facing NRR and the classified version, the NSRA (and, prior to 2019, the National Risk Assessment (NRA)). Both the NRR and NSRA identify and assess the likelihood and impact of the most serious risks facing the UK and its overseas interests, acting as a tool to support emergency planning. The risks in the NSRA are identified and assessed by LGDs, and later tested with non-risk owning stakeholders and experts including Chief Scientific Advisers (CSAs) and the devolved governments to enable challenge and identify gaps. However, neither the NSRA nor NRR provide an assessment of the Government's preparedness at any given time for employing the contingency measures identified.

3.8. The assessment of risks in the NRR and NSRA was and is based on a Reasonable Worst Case Scenario (RWCS), produced by LGDs in consultation with experts, for example their CSA, other departments and agencies, the intelligence community, industry and sector stakeholders, and external scientific, academic and policy subject experts. The RWCS is neither a prediction of what will happen, nor the most likely scenario, but instead supports risk planning by giving an illustration of the worst manifestation of a risk that can reasonably be expected to occur based on current information and data.

Pandemic Flu Readiness

3.9. As the Inquiry will be aware from its investigations for Module 1, in 2007 DHSC founded the Pandemic Influenza Preparedness Programme (PIPP), which was responsible for health sector preparedness for a pandemic influenza. The PIPP board met for the first time on 1 October 2007, and was chaired by the DHSC Director with a CCS representative in attendance.[17]

3.10. DHSC's PIPP undertook continuous work to strengthen the UK's resilience to pandemics, in particular by improving access to clinical countermeasures (e.g. securing stockpiles of clinical consumables or developing policy on antivirals or antibiotics). "The CCS sat on the Board for oversight, but did not have responsibility overall for Public Health Services and Resources. This was the responsibility of DHSC, along with PHE and the NHS. The CCS instead focused on wider implications".[18]

[17] SA/10 - INQ000145912
[18] SA/10 - INQ000145912

3.11. Following the Swine Flu Pandemic, an independent review was undertaken, sponsored by the Cabinet Office, and led by Dame Deirdre Hine, which reported in July 2010 (the "Hine Review"). The Hine Review made a number of recommendations on the planning and response to future pandemics. These were reflected in the revised 2011 UK Influenza Preparedness Strategy ("2011 Preparedness Strategy")[19]. The 2011 Preparedness Strategy sought to improve generalised capabilities that could be deployed to combat a range of outbreak sizes, increasing the emphasis on scientific evidence to inform decision making and the government's understanding of pandemics and their impacts on society.

3.12. The 2011 Preparedness Strategy was based on a RWCS within which 50% of the population became ill. These plans were based on scientific, clinical and operational evidence. The approach laid out in the 2011 Preparedness Strategy led to several improvements to the UK's pandemic influenza preparedness, including in relation to surveillance and modelling systems, stockpiles of clinical countermeasures including personal protective equipment for front-line healthcare workers and surge plans to reduce pressure on services. The 2011 Preparedness Strategy ultimately provided a basis for the government in the early stages of the response to COVID-19, including surge planning to prepare the NHS and adult social care to deal with extra demand and preparations for recruitment and deployment of retired staff and volunteers.

3.13. Exercise Cygnet was a discussion-based exercise held on 2 August 2016 in the build up to Exercise Cygnus which aimed to consider the UK response to a pandemic-influenza outbreak.[20] The aim of Exercise Cygnet was to provide an opportunity for colleagues from the health and social care sectors to consider the national, strategic health and social care responses to a pandemic-influenza outbreak, ahead of the broader Exercise Cygnus Tier 1 exercise. Senior representatives from the DHSC, NHS, PHE, the social care sector and the voluntary sector were involved, as well as observers from the Cabinet Office and devolved governments. Exercise Cygnet identified issues for further development before Exercise Cygnus took place. The report from Exercise Cygnus is exhibited.[21]

3.14. In October 2016, Exercise Cygnus took place, which was a cross-government exercise to test the 2011 Preparedness Strategy and its supporting plans and arrangements. The DHSC, through PHE, led preparations for the exercise, with the Cabinet Office represented in the planning group, and in the exercise itself. Exercise

[19] SA/13 - INQ000102974
[20] SA/10 - INQ000145912
[21] SA/14 **INQ000128983**

Cygnus focused on four main areas including the management of excess deaths, mass work absences and how the NHS would cope with an increased demand for treatment.[22] I exhibit the report prepared by PHE.[23] As a result of Exercise Cygnus, and in order to galvanise departments to act on the challenges that the exercise had identified, the CCS sought and obtained a meeting of the NSC(THRC), chaired by the Prime Minister, on 21 February 2017. At this meeting Katharine Hammond, Director of the CCS, presented a set of slides which identified a number of areas of concern, including providing a graph showing the extent to which, in a RWCS, the likely level of demand might overwhelm health and social care capacity by the fifth week of a pandemic".[24]

Pandemic Flu Readiness Board

3.15. The Pandemic Flu Readiness Board (PFRB) was created in 2017 as a detailed cross-government official-level work programme which was primarily focused on delivering the recommendations of Exercise Cygnus, as agreed by NSC(THRC). The PFRB sought to deliver on a number of workstreams and then report on its progress to NSC(THRC).[25]

3.16. The PFRB was chaired jointly by the Emergency Preparedness, Resilience and Response Director in DHSC and the CCS Director in Cabinet Office, and its membership included other government departments and the devolved governments. The PFRB met on a total of fourteen occasions. The Cabinet Office has provided the Inquiry with a full chronology of the meetings and papers of the PFRB,[26] and I exhibit the papers for meetings most relevant to social care matters throughout this section.

3.17. The PFRB's programme of work, set by NSC(THRC), had five strands in respect of pandemic influenza readiness, particularly focused on implementation of the Exercise Cygnus recommendations:[27]

3.17.1. Health care - to further improve the plans of the health sector to flex systems and resources to expand beyond normal capacity levels;

3.17.2. Community care - to understand and expand social care and community healthcare capability and capacity to respond to increased demand;

[22] SA/10 - INQ000145912
[23] SA/15 - INQ000056232
[24] SA/16 - INQ000006357
[25] SA/9 - INQ000195845
[26] SA/17 - INQ000198252
[27] SA/9 - INQ000195845

3.17.3. Excess deaths - to develop a capability to ensure sufficient capacity to manage the volume of deaths in a respectful and acceptable manner;

3.17.4. Sector resilience - to ensure that critical sectors had adequate resilience to anticipated levels of employee absence; and,

3.17.5. Cross cutting enablers/coordination - to:

3.17.5.1. (a) develop a legislative vehicle for pandemic response measures (including a draft Pandemic Influenza Bill);

3.17.5.2. (b) develop a more sophisticated understanding of moral, ethical and public expectations and reactions to a pandemic; and,

3.17.5.3. (c) ensure effective communications arrangements are in place.

3.18. Roger Hargreaves' third corporate statement provided a narrative of the work of the PFRB, so I have replicated this in my statement below where necessary, and expanded where relevant on matters related to social care.[28] I exhibit the high-level workplan from August 2017, which was updated over the course of the year.[29] Exhibited are the documents that were created in the first year of the PFRB and (a) set the path for it and the workstreams under it and (b) updated the NSC(THRC) on that ongoing work:

3.18.1. A background note from 1 June 2017 describing the work set in motion, updated on 13 June 2017 and 15 September 2017;[30]

3.18.2. An updated overview of the work to be undertaken by the PFRB in light of the actions arising from the NSC(THRC) meeting on 21 February 2017;[31]

3.18.3. A note on preparedness for pandemic influenza dated 18 September 2017 describing the work set in motion, and attaching to it the work plan for each of the five workstreams.[32] The note stated that "each of the workstreams has collectively-agreed plans. The majority of the workstreams are now moving from the scoping and evidence gathering phase into implementation and delivery. There is a lot of work to do between now and the first quarter

[28] SA/9 - INQ000195845
[29] SA/18 - **INQ000107934**
[30] SA/19 - INQ000006617; SA/20 - INQ000006630; SA/21 - INQ000006810
[31] SA/22 - INQ000044970
[32] SA/23 - INQ000006815; SA/24 - INQ000045098

of 2018 when the programme is due to be completed". The work plan gave the following activities for the community care workstream (combining adult social care and community health care), and the departments responsible:

3.18.3.1. "Determine the likely supply and demand for social care provision during a pandemic" (MHCLG/DHSC);

3.18.3.2. "Review existing plans for providing community-based healthcare for patients who would ordinarily receive in-patient care" (DHSC) ;

3.18.3.3. "Undertake a capability requirement analysis for social care provision during a pandemic" (MHCLG/DHSC)

3.18.3.4. "Develop agreed policy options" (MHCLG/DHSC)

3.18.3.5. "Develop a comprehensive plan for augmenting capacity to the required level including options for alternative models for temporary social care provision, both domiciliary and residential" (MHCLG/DHSC).[33]

3.18.4. On 25 August 2017, Katharine Hammond (then Director of the CCS) wrote to Mark Sedwill (then Cabinet Secretary and National Security Adviser) and provided a six-month update on the progress of the work overseen by the PFRB.[34] This update stated that the "key risk to delivery" was the "notable resource pressures" in DHSC. This pressure was stated to have had an impact on delivery of the community care workstream. Following that update, on 21 September 2017, a six-month review letter was sent to Permanent Secretaries updating them on progress, and I exhibit the copy sent to the Permanent Secretary of the Northern Ireland Office by way of example.[35] A high-level workplan was circulated in December 2017 showing the progress that had been made in the community care workstream to date, including that the workstream had determined the likely supply and demand for social care provision from the Local Government Association (LGA) and Association of Directors of Adult Social Services (ADASS), scoped and agreed support requirements from LGA and ADASS, and carried out analysis of population impact and social care capacity.[36]

[33] SA/23 - INQ000006815; SA/24 - INQ000045098
[34] SA/25 - INQ000045034
[35] SA/26 - INQ000178916
[36] SA/27 - INQ000022857

3.19. The PFRB met on 21 February 2018 where it was noted that for the community care workstream, the following actions had been completed: MHCLG had held workshops with Local Resilience Forums (LRFs)[37] which provided information on the testing of local plans; and a draft briefing had been produced for comment by PIPP on extreme surge management in the care sector (with input from the DHSC, other government departments, NHS providers and commissioners of social care, ADASS, the Care Providers Alliance and the UK Homecare Nursing Association).[38]

3.20. On 20 March 2018, the CCS sent the CDL and the Secretary of State for Health and Social Care ("the Health Secretary") an update on progress made to enhance preparedness for an influenza pandemic, to be circulated to other members of the THRC (this letter was circulated on 8 April 2018).[39] This update noted that "within the last 12 months substantial work has been undertaken, supported by comprehensive engagement with the local responder community, to strengthen the alignment of plans and activities", which had delivered "clear plans to prioritise and augment adult social care and community health care during a pandemic response". The "next steps" set out in this update note for the community care workstream were to produce "service-facing guidance for delivering adult social care and community care during a pandemic." The DHSC was the lead department for this, supported by the CCS, NHSE, the CQC, the devolved governments, and MHCLG.

3.21. At a PFRB meeting on 5 April 2018, updates on progress of the year 1 actions of the Board took place, with discussion on how work would feed into further actions for year 2. It was recorded that significant progress had been made to develop the policy paper that set out a framework on key considerations and options to maintain and augment the community health care and adult social care sectors' response to an extreme influenza pandemic. This paper would then be shared for comment with the CMO, CSA, and the Chief Nursing Officer (CNO) with discussion taking place on 16 April 2018.[40] The policy paper[41] identified that:

3.21.1. It was necessary for LRFs to have a have a pandemic influenza framework/plan which reflected "the severity of the reasonable worse-case scenario and considers the breadth of organisations in their area including

[37] LRFs are a key part of the framework established under the Civil Contingencies Act 2004 to ensure collaborative delivery of emergency preparedness at the local level. There are 38 LRFs in England and 4 in Wales based on each Police Area (with the exception of London, where one area covers both the Metropolitan and City Police Area) - SA/10 - INQ000145912
[38] SA/28 - INQ000045741, SA/29 - INQ000007215, SA/30 - INQ000007241
[39] SA/31 - INQ000007253
[40] SA/32 - **INQ000022907** SA/33 - INQ000211943, SA/34 - INQ000021662
[41] SA/35 - INQ000138637

community health care and adult social care", and noted that "DHSC is working with MHCLG to confirm all local resilience forums have a pandemic influenza plan that is of sufficient quality. Additionally, through LRF workshops and engagement with ADASS, work is underway to ensure that adult social care and community health care providers are linked in with these plans";

3.21.2. Defining "vulnerable individuals" would be helpful, and noted that "as part of the development of the Data Protection Bill, CCS has been working with other government departments to consider the definition of vulnerable individuals";

3.21.3. Work was needed on regulation of care home providers to ensure that individuals, as well as organisations, know that they will not be sanctioned for a reduction in the level of care during a severe influenza pandemic (it was noted that DHSC were in discussions with CQC);

3.21.4. All areas should have effective contact arrangements with providers, for example a provider forum, and LRFs/local authorities should be aware of the total market provision, including private providers who only work with self-funded service users/patients. Relationships should be built with these providers to make communication in an emergency smoother. It was noted that "the Care Providers Alliance and ADASS are working together to establish a framework for this and to build on the partnerships in areas with established Provider Forums. Subject to funding DHSC should expect all areas to have effective contact arrangements in place"; and,

3.21.5. DHSC had limited data on community and social care activity at a local level. It was said that DHSC was taking action to address "key gaps" in social care data. The gaps in data included "granular real-time data on domiciliary care provision, including the number of hours being delivered. DHSC is addressing this. By September 2018 Beta data will be available through the Care Quality Commission Provider Information Collection project. Whilst this project will take time to scale up and offer a meaningful national and local planning resource it is a welcome step".

3.22. The PFRB met on 22 May 2018, confirming that the briefing paper on extreme surge management had been discussed by CMO, CSA, and the CNO. It was noted in the dashboard for the meeting that ADASS had created a short report on critical data

needed by the Directors of Adult Social Services in the event of a severe pandemic. These would be incorporated into the next briefing paper. It had been agreed that the planned service facing guidance for community health care would sit in an NHSE service facing document, thereby becoming incorporated into the healthcare workstream of the PFRB, with no adult social care guidance planned to be produced from that point. The DHSC were actioned to consider the development of adult social care guidance after the completion of year 2 of the PFRB workstream. At the meeting it was noted that the year 2 deliverables for the community care workstream were working to a February 2019 deadline. Governance of the workstream continued under the PIPP with risks and issues to be escalated to the PFRB project team and the PFRB itself as necessary[42]. Devolved governments were invited to share their own outputs and timelines for this workstream. The dashboard also notes that the CQC were to share their thoughts on how they would alter their regulatory processes in a severe influenza pandemic.[43]

3.23. On 26 July 2018, at a meeting of the PFRB, it was stated that the second version of the briefing paper on community health and adult social care was being prepared for discussion with the CMO, CSA, CNO and the Chief Social Worker. At the request of CMO and CSA it was structured "more like a 'plan'".[44]

3.24. On 14 November 2018, a paper on the PFRB work programme forward look was presented. On the community care workstream it was stated that the "Plan to augment Adult Social and Community Care during a pandemic" had been agreed by the CMO, CSA, and CNO. According to the minutes of the meeting the DHSC updated that "good progress continues to be made" on the workstream, with the continuation of extreme surge aspects of community health care to be incorporated into the NHSE service facing guidance.[45]

3.25. On 29 November 2018, a submission was made to the CDL that set out the impact of Operation Yellowhammer on the cross-cutting work of the Cabinet Office and CCS.[46] The PFRB did not meet for a year from November 2018 due to all departments needing to prioritise resources on EU Exit work, though work continued in the meantime on the Pandemic Flu Bill and the Excess Deaths Framework.[47]

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[42] SA/36 - INQ000105048
[43] SA/37 - INQ000022951; SA/38 - INQ000007327; SA/39 - INQ000068394
[44] SA/40 - {**INQ000211946**}; SA/41 - INQ000108409; SA/42 - INQ000046236
[45] SA/43 - INQ000023046; SA/44 - INQ000023045; SA/45 - INQ000101611; SA/46 - INQ000022069
[46] SA/47 - INQ000211664
[47] SA/48 - INQ000196512

3.26. The PFRB met for the penultimate time on 27 November 2019. A letter was sent to all the members of the PFRB on 11 November 2019 which set out the purpose of restarting the PFRB and an updated briefing note was created.[48] The emphasis at this meeting was to reinvigorate the PFRB and to update and progress the ongoing workstreams over the next twelve months. It was noted that work had been paused on the community care workstream paper that had been provided to the CMO, CSA, and CNO (which was shared with devolved governments and Royal Colleges for comment in February 2019). It was also noted in the meeting dashboard that "DHSC will take lessons from EU Exit work (data and operational) and, in line with prioritisation decisions for 2020/21, will look to refresh the Pandemic Flu plan accordingly".[49]

3.27. It was anticipated that a further update would be provided after April 2020 when workstreams had restarted and been completed, and when the planned cross-government pandemic exercise had been completed (as discussed in the 27 November 2019 meeting). It was anticipated that this update would be to the THRC (it was envisaged by officials at this time that the THRC would be stood up again after the General Election).

3.28. Thereafter, the PFRB met one more time (in January 2020), after which it ceased to meet as the Government's focus turned to combatting the pandemic. Immediately before the pandemic broke, the PFRB had been focused on the workstreams on excess deaths and the draft Pandemic Flu Bill and had agreed to hold a cross-government exercise in Spring 2020 to test workstreams and reassess priorities identifying areas for further work. The proposal was that the 2020 Pandemic Flu Exercise would be a planned two-day command post exercise (albeit the structure was not finalised) and would focus on excess deaths, wider communication messaging, community and social care pressures, and sector resilience (including schools and prisons).[50] As the note recorded, the pandemic flu exercise was to be scheduled at this time because it was only at this stage that a number of the work streams had either been completed or were nearing completion, so that what had been completed could be tested so as to identify which areas were less prepared and required further work. However, due to the emerging COVID-19 crisis, the pandemic planning exercise was not carried out and no further update to NSC(THRC) was given.

[48] SA/49 - INQ000047283; SA/50 - INQ000007693
[49] SA/51 - INQ000047297; SA/52 - INQ000023091; SA/53 - INQ000023089; SA/54 - INQ000131541
[50] SA/55 - INQ000007795

3.29. Reference to adult social care was also included in the Resilience Standards, in particular standard 15 for pandemic influenza[51] (published in December 2019), which stated that LRF pandemic influenza plans should "set out the expectations for social care providers reflecting national guidance and local need", and that LRFs "should have clear and agreed multi-agency ways of working to implement the plan, including triggers and agreements between organisations (including MoUs [memorandums of understanding] where appropriate) in relation to excess deaths, communications and arrangements to manage additional burdens on health and social care services, including prioritisation of care". The purpose of this Standard was to give assistance to LRFs to assure their capabilities and readiness.[52]

3.30. The World Health Organisation declared COVID-19 a pandemic on 11 March 2020.[53]

3.31. The DHSC provided Health Sector Security and Resilience Plans (HSSRP) which set out their ability to respond to relevant risks in the NRA. The purpose of the resilience plans was to allow relevant departments to review their own resilience. The 2018/2019 HSSRP recorded that "The HSSRP demonstrates that there are generally good levels of resilience within the health sector, with good preparedness and business continuity arrangements in place. With respect to social care, the adult social care sector could effectively respond to a relatively short-lived or localised emergency situation, but it is likely to be much more challenged during a severe prolonged emergency".[54]

3.32. The DHSC did not put together a HSSRP in 2019 due to the extent of their work on Operation Yellowhammer. On 11 February 2020, the DHSC responded to questions raised by COBR, including "Are your CNI and critical sectors resilient, including their supply chains?" by stating "the NHS and wider health system are extremely well prepared for these types of outbreaks and follow tried and tested procedures of the highest standards to protect staff, patients and the public".[55] The public summaries were not published in 2019-20 as although they would normally be published by the end of the financial year (late March 2020), by that stage the government was focused on the pandemic response.

Response measures taken at the emergence of the novel coronavirus

[51] SA/56 - INQ000047332
[52] SA/57 - INQ000215620
[53] SA/58 - INQ000106182
[54] SA/59 - INQ000007482
[55] SA/60 - INQ000187718

3.33. Annex A provides detail on the changes in the decision making structures of the Cabinet Office throughout the relevant period. The Director of the CCS chaired the first cross-government ad hoc senior officials meeting on the novel coronavirus on 17 January 2020.[56] 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[57]. 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) augmented the response.

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

3.34.1. 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 governments;

3.34.2. The CCS carried out work on the Coronavirus Bill;

3.34.3. The CCS supplied a single, authoritative RWCS (based on scientific advice) to departments, devolved governments and local responders in order to guide planning; and,

3.34.4. 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.

3.35. A note titled 'COVID-19: the UK's preparedness' sent by the Director of the CCS to the Prime Minister on 28 February 2020 set out the UK's strategy as the virus progressed. The note outlined expected decisions in the coming days should SAGE "assess that we are possibly moving towards some variant of the reasonable worst case scenario".[58] These included: "how 'at risk' groups are supported (e.g. the elderly

[56] SA/61 - INQ000097687; SA/62 - INQ000097689; SA/63 - INQ000097688
[57] SA/4 - INQ000092893
[58] SA/64 - INQ000182331

in care homes) which may need to differ from the wider population"; "how to keep key staff (e.g. nurses) in work, and how to make the most of the voluntary sector"; and which economic interventions might be needed to support local and national economies.

3.36. Following agreement at a COBR meeting on 2 March 2020[59], 'Coronavirus Action Plan: A Guide to what you can expect across the UK', was published on 3 March 2020 (the COVID-19 Action Plan).[60] This plan was published by the DHSC and the health departments in the devolved governments; the Cabinet Office provided input and circulated it for comment across Whitehall prior to its publication.

3.37. 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. In regards to the adult social care sector, the Plan stated - within the steps for the 'mitigate' phase of the response: "health and social care services will work together to support early discharge from hospital, and to look after people in their own homes"; and, the implementation of a "distribution strategy for the UK's stockpiles of key medicines and equipment (e.g. protective clothing)". This was to "cover the NHS/HSCNI [Health and Social Care Northern Ireland], and extend to social care and other sectors as appropriate". The UK's Social care systems were expected to start to implement their business continuity plans. The Plan noted: "Everyone 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".[61]

3.38. The Plan also noted in regards to national responsibilities that "the tripartite partnership of DHSC, PHE and NHS England provides strategic oversight and direction for the health and adult social care response to an influenza pandemic", and that "DHSC is the lead UK government department with responsibility for responding to the risk posed by a future pandemic."

[59] SA/65 - INQ000056176; SA/66 - INQ000056217; SA/67 - INQ000056157
[60] SA/68 - INQ000564783
[61] SA/68 - INQ000564783

4. SECTION 4: ROLE OF THE CABINET OFFICE IN DECISIONS AND PLANS AFFECTING THE CARE SECTOR

4.1. This section provides a summary of policy development, cross-governmental decision making processes and information on the roles of the Prime Minister and the CTF, insofar as they relate to the adult social care sector. Bein a summary, this section does not exhaustively describe the department's consideration of every issue and its involvement in the development of every policy before it was decided (e.g. at COVID-O). We do, of course, stand ready to provide any further evidence the Inquiry may require. Annex A sets out an overview of the governance changes to the Cabinet

Office and its decision-making structures. This section addresses issues thematically, with reference to the governance structures stated at Annex A in the following way:

4.1.5. 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, as well as the Cabinet Office's involvement in social care specific plans produced by the DHSC;

4.1.6. How the Cabinet Office ensured pressures on the social care sector were understood by decision makers to consider issues in the round, via the Dashboard, the single analytical picture of the pandemic, as well as a specific rapid review conducted on the adult social care sector;

4.1.7. The provision of funding to the social care sector;

4.1.8. An overview of the development of the policy for visiting in care homes and the difficult decisions made to protect those in care homes;

4.1.9. The availability and supply of PPE; and,

4.1.10. An overview of restrictions on staff movement between care settings where the Cabinet Office was sighted, or where decisions warranted collective agreement.

4.2. While this module focuses on adult social care rather than healthcare, 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 and plans

4.3. 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 strategic plans, with input from key departments such as the DHSC, and provided oversight of overall implementation of the strategy in force at any one time. These strategic plans were aimed at a wide non-expert audience and considered the whole country's response to the pandemic. COVID-O was used to

oversee overall implementation of strategic plans, such as the Spring Roadmap 2021.

4.4. These overall strategic plans were complementary to separate health and social care plans which were developed by the DHSC, such as the Adult Social Care Winter Plan 2020/2021.

4.5. I have provided an overview of strategic plans produced by the Cabinet Office insofar as they relate to adult social care. I have then stated where the Cabinet Office commissioned, or was involved in, the production of social care-specific plans from the DHSC.

Overarching strategies produced by the Cabinet Office

4.6. The CTF coordinated and advised on strategy for the COVID-19 response, working with HM Treasury (HMT), medical and health experts including the CMO and the Government Chief Scientific Adviser (GCSA) and other departments, to ensure the strategy reflected a wide range of inputs and considerations.[62] 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'.[63] 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. I have provided examples of where these plans were relevant to the adult social care sector.

4.7. On 11 May 2020, the Government published 'Our Plan to Rebuild: The UK Government's COVID-19 Recovery Strategy'.[64] This detailed 14 programmes of work which would be delivered by the Government to assist the UK's recovery. The second of these programmes concerned protecting care homes. The strategy set out the steps the Government would take to support and work with the care sector which are summarised below:

4.7.5. The strategy stated the Government was "providing widespread, swift testing of all asymptomatic care home residents, and all patients

[62] SA/4 - INQ000092893
[63] SA/69 - INQ000137262; SA/70 - INQ000086876; SA/71 - INQ000086877
[64] SA/72 - INQ000198892

discharged from hospital before going into care homes", and committed to offering a COVID-19 test to every staff member and resident in every care home in England by 6 June 2020;

4.7.6. On infection prevention and control, the strategy stated: the Government was "stepping in to support supply and distribution of PPE"; was "supporting care homes with extensive guidance, both online and by phone, on how to prevent and control COVID-19 outbreaks"; that the NHS had committed to "providing a named contact to help 'train the trainers' for every care home that wants it by 15 May [2020]"; and that the Government expected "all care homes to restrict all routine and non-essential healthcare visits and reduce staff movement between homes, in order to limit the risk of further infection";

4.7.7. The Government was "expanding the social care workforce through a rapid recruitment campaign, centrally paying for rapid induction training, making Disclosure and Barring Services checks free for those working in social care and developing an online training and job matching platform";

4.7.8. The Government was "accelerating the introduction of a new service of enhanced health support in care homes from GPs and community health services, including making sure every care home has a named clinician… by 15 May [2020]";

4.7.9. The Government was "providing a variety of guidance, including on GOV.UK, and…signposting, through the Social Care Institute for Excellence, resources for care homes, including tailored advice for managing the COVID-19 pandemic in different social care settings and with groups with specific needs, for example adults with learning disabilities and autism"; and,

4.7.10. The role of local authorities was to ensure each care home was accessing the extra support on offer, with "any issues in accessing this support" to be escalated to regional and national levels as necessary.

4.8. The 'COVID-19 Winter Plan' published on 23 November 2020 stated the Government's "programme for suppressing the virus, protecting the NHS and the

vulnerable, keeping education and the economy going and providing a route back to normality".[65] I have summarised the parts of this plan related to adult social care:

4.8.5. The Adult Social Care Winter Plan had been published in September 2020 alongside the increase of the Infection Prevention Control fund. I have provided further detail on the Cabinet Office's involvement in this Plan in the next section of this statement;

4.8.6. **Funding** - £1.1 billion had been provided to implement infection prevention and control measures. This was in addition to the £4.6 billion that had been made available to local authorities in England to address pressures on local services caused by the pandemic, including adult social care;

4.8.7. **Visitors** - The plan stated that the Government wanted to end the "pain of separation and help care homes bring families and loved ones together in a way that recognises the risks, but enables these to be managed in the best way possible". The plan went on to state that the "launch of visitor testing is a crucial step", with a pilot beginning in 20 care homes. The plan stated that the Government was committed to providing twice weekly testing to enable all care home residents to have regular visits from up to two visitors;

4.8.8. **Staff movement** - The plan also stated that the Government was "introducing legislation, by the end of the year, that requires care home providers to restrict all but essential movement of staff between settings in order to reduce transmission";

4.8.9. **Testing** - The plan noted that to prevent the risk of infections entering care homes, the Government was working with the CQC and the NHS to ensure "everyone discharged to a care home has an up-to-date COVID-19 test result and anyone testing positive will be discharged to a setting that has been assured by the CQC specifically for the purposes of providing safe care for COVID-19 positive residents";

4.8.10. "All care home staff are now offered weekly testing and this will be increased to twice weekly by the end of December [2020]. Resident testing started in April and all care home residents have been offered monthly

[65] SA/69 - INQ000137262

testing since July. This will be increased to weekly testing in December [2020]";

4.8.11. **Vaccines** - The influenza vaccine would also be made available, free of charge, to all care staff, personal assistants and unpaid carers for further protection over the winter period;

4.8.12. **PPE** - 83% of eligible care homes (41,000 providers) were now registered with the PPE Portal, where they were able to access all PPE requirements. Personal assistants, supported living, shared lives and day care services could obtain free PPE from their local authority[66]; and,

4.8.13. **Data** - The Government had also launched the Adult Social Care COVID-19 Dashboard to help local authorities monitor outbreaks.

4.9. The 'COVID-19 Response: Spring 2021 Roadmap' (February 2021)[67] laid out the stepped lifting of lockdown measures on the basis of 'four tests': (1) "The vaccine deployment programme continues successfully"; (2) "Evidence shows vaccines are sufficiently 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". I have summarised the parts of the 2021 roadmap relevant to the adult social care sector:

4.9.5. The Government had achieved its goal of offering a first vaccine dose by 15 February 2021 to "all those in the four most vulnerable cohorts identified by the Joint Committee on Vaccination and Immunisation (JCVI). This includes elderly care home residents, those aged 70 and over, those with conditions that would leave them clinically extremely vulnerable to serious illness and death as a consequence of COVID-19, and frontline health and social care staff";

4.9.6. From 8 March 2021, every care home resident in England would be able to nominate a single named visitor for regular visits, requiring that they take a rapid lateral flow test for each visit, wear PPE and keep physical contact to minimum. At Step 2, the Government would take a decision on extending the number of visitors to two per resident;

[66] SA/69 - INQ000137262
[67] SA/73 - INQ000072888

4.9.7. "Over the winter the Government provided £120 million additional funding to help local authorities boost staffing levels and £149 million to support rapid testing of staff and facilitate visits from family and friends (prior to the current restrictions coming into force)";

4.9.8. There was recognition that some care home residents might need more support (for example those with advanced dementia, learning difficulties or autism), from a particular trusted person to perform personal care tasks. The Government would provide "extra support to those visitors, whose visit is essential to the resident's immediate health". This support would be published in future guidance.

4.9.9. "Additional testing will also be provided to facilitate safer visits for residents in high risk supported living and extra care settings".

4.10. The 'COVID-19 Response: Autumn and Winter Plan 2021' was published in September 2021.[68] This plan stated that work continued to support the adult social care sector, with the removal of caps to the number of visitors individual residents could receive in care homes. The plan set out that "On 27 June 2021 the Government announced a further £251 million of adult social care COVID-19 support through an extension of the Infection Control and Testing Fund.[69] This means that throughout the pandemic, the Government has made available over £2 billion in specific funding for adult social care.[70]" The plan stated that from 11 November 2021, it would be a condition of deployment for anyone working or volunteering in CQC-regulated care homes to be fully vaccinated against COVID-19. The Cabinet Office has provided evidence on vaccination as a condition of deployment in its corporate statement for Module 4.[71]

4.11. 'COVID-19 Response: Living with COVID-19' was published in February 2022.[72] The document summarised the Government's prior actions to protect the care sector with additional measures, as had been set out in the previous plans. The document stated the Government would provide continued support to the sector with the following protections:

[68] SA/74 - INQ000137270
[69] SA/75 - INQ000564778
[70] SA/76 - INQ000564779
[71] SA/77 - INQ000474418
[72] SA/78 - INQ000055798

- "Supporting and encouraging the take-up of vaccines amongst care recipients and staff, including any further doses that may be recommended by JCVI for COVID-19 and other infections;
- Guidance on precautions for visitors and workers in adult social care; and
- Providing access to free PPE to the end of March 2023 or until the UK IPC [infection prevention and control] guidance on PPE usage for COVID-19 is amended or superseded (whichever is sooner)."

Hospital discharges and the development of the April 2020 Adult Social Care Strategy

4.12. As previously stated, at the onset of the pandemic, following agreement at a COBR meeting on 2 March 2020[73], the 'Coronavirus Action Plan: A Guide to what you can expect across the UK' (the COVID-19 Action Plan), was published on 3 March 2020.[74]

4.13. At a meeting of Cabinet on 17 March 2020, it was discussed that "to free up hospital beds, over 30,000 patients were expected to leave hospital into social care, imminently."[75] The NHS Chief Executive and Chief Operating Officer wrote to chief executives of all NHS trusts and foundation trusts that day, confirming the need to "free-up the maximum possible inpatient and critical care capacity".[76]

4.14. On 18 March 2020, the first HMIG meeting discussed the processing of discharges from hospital to social care. Given the pressures on the NHS, it was NHSE's and the DHSC's view at that time that this should be done as soon as possible, as summarised in the Chair's Brief.[77] The DHSC's focus at this stage was on ensuring that the NHS were able to free up as many acute care beds as possible in an effort to maintain NHS capacity as the numbers of people suffering severe illness as a result of COVID-19 began to grow. It was noted that social care providers and local authorities would require additional support to cope, given likely workforce absences and additional reliance on unpaid carers. Further, at the first HMIG meeting, MHCLG and the DHSC had outlined proposals and additional funding to build resilience and efficiency on these fronts.[78] The actions state that, "due pace would be given to discharging patients from hospital" supported by an "injection of new funding" to

[73] SA/79 - INQ000086869; SA/80 - INQ000056154; SA/66 - INQ000056217
[74] SA/79 - INQ000086869; SA/80 - INQ000056154
[75] SA/81 - INQ000056135/5
[76] SA/82 - INQ000087317
[77] SA/83 - INQ000055939; SA/84 - INQ000055933
[78] SA/83 - INQ000055939. This paragraph is based on the Module 2 witness statement of Simon Ridley.

clinical commissioning groups (CCGs) and local authorities.[79] This was announced by the DHSC and MHCLG on 19 March 2020.[80]

4.15. On 19 March 2020, the DHSC published 'Coronavirus: Hospital Discharge Service Requirements', which set out requirements of discharge from hospital beds.[81]

4.16. In the HMIG meeting on 22 March 2020, the following point was made: "to support capacity in community care advice to care homes should be updated - current guidance suggests they should accept patients who are asymptomatic even if they have not received a COVID test".[82] There was an action for the "CMO to consider whether definitive guidance can be given to care homes that they must accept patients on discharge without COVID-19 testing if they are asymptomatic" (the risk posed by asymptomatic patients was picked up by SAGE on 31 March 2020 and ultimately SAGE made a recommendation in relation to testing of asymptomatic patients at their meeting on 14 April 2020, see paragraphs 4.46-7 below). There was also an action for "DHSC & NHSX to consider further metrics on ASC bed and care package capacity to support discharges through to the care sector".[83]

4.17. On 3 April 2020, officials in No.10 and the Cabinet Office raised and considered whether there was a "coherent overall strategy for care homes" in place within the DHSC or MHCLG, and whether (in the way that there was one in place for the NHS) one was required. It was queried whether this should be brought to the HMIG, and the HMIG secretariat responded that they had been working with departments and were writing to the DHSC that day suggesting that there should be an HMIG meeting on social care early the next week.[84] That same day, the HMIG secretariat wrote to the DHSC recommending "turning to focus on [adult social care] given the large scale discharge from NHS that has been required, the risks in this sector and the need for a strategy to manage COVID in care homes".[85]

4.18. On 4 April 2020, a report was commissioned from the DHSC for the HMIG meeting to be held on 7 April 2020, which sought to explore what was happening in care homes, including whether admissions should be stopped, or isolation practices changed.[86] A report was produced by the DHSC for the HMIG.[87] At the HMIG meeting, the Health

[79] SA/85 - INQ000055912
[80] SA/86 - INQ000564800
[81] SA/87 - INQ000087450
[82] SA/88 - INQ000055942
[83] SA/89 - INQ000055937
[84] SA/90 - INQ000198032
[85] SA/91 - INQ000564807; SA/92 - INQ000564808
[86] SA/93 - INQ000198033; SA/94 - INQ000564806
[87] SA/95 - INQ000083637

Secretary stated that the Group would review the situation in adult social care, noting that it was a "mission critical" element of preserving NHS capacity. The minutes went on to record that the Minister of State for Care said "discharges from hospital into the community to increase NHS capacity had been hugely successful. Non-COVID bed occupancy had reduced by nearly 40,000 patients since 2nd March, against the target of 30,000. Clear guidance on discharge processes and care home acceptances had been published. The DHSC were aware of some concerns in the sector and guidance on infection control was under review. Further work was ongoing to model future discharge volumes and likely acuity of patients to ensure Adult Social Care capacity was sufficient in the coming weeks and months".[88] There followed a wider discussion in relation to adult social care covering matters such as metrics, return to work for recent leavers from the sector, data reporting, the current rate of deaths, and financial resilience.[89]

4.19. The day after the meeting, on 8 April 2020, officials in No.10 and the Cabinet Office again noted the importance of social care resilience as a key area upon which focus was required at a deep dive meeting to be held with the First Secretary of State (FSS).[90]

4.20. On 9 April 2020, it was agreed at a 9:15 C-19 Strategy meeting with the FSS that the secretariat were to "schedule a deep dive on social care on Monday [13 April 2020], with a view to publishing a broader strategy on Tuesday [14 April 2020]".[91] The Cabinet Office commissioned the Strategy from the DHSC.[92]

4.21. On 9 April 2020 and again on 11 April 2020, the DHSC provided the Cabinet Office with a draft social care strategy. The Cabinet Office had concerns which were set out internally.[93] The Cabinet Office returned comments on a draft of the strategy to the Health Secretary's office on 11 April 2020.[94] There was a strategy meeting led by the FSS on 13 April 2020 and the Cabinet Office's concerns were fed into the annotated agenda.[95]

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[88] SA/96 - INQ000083702
[89] SA/97 - INQ000083693 (agenda); SA/95- INQ000083637 (DHSC slide-deck); SA/98 - INQ000083640 (MHCLG slide-deck); SA/99 - INQ000083638; SA/100 - INQ000083633 (Healthcare Ministerial Implementation Group Paper); SA/101 - INQ000083639 (SAGE Reasonable Worst-Case Planning Scenarios); SA/96 - INQ000083702; SA/102 - INQ000083694; SA/103 - INQ000564805
[90] SA/104 - INQ000564804. 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 C-19 Strategy meetings and the Quads.
[91] SA/105 - INQ000564731
[92] SA/106 - INQ000564730
[93] SA/107 - INQ000198042
[94] SA/108 - INQ000564728; SA/109 - INQ000564727
[95] SA/110- INQ000198043

4.22. On 13 April 2020, the FSS held a 9:45 C-19 Strategy meeting to consider the draft strategy.[96] It was decided at this meeting that the strategy needed agreement from the CDL before sending it to the FSS with further comments provided from No.10 officials.[97] The note on the strategy was approved by the CDL that evening, with his substantive comments sent on to FSS.[98]

4.23. On 14 April 2020, the strategy was brought back to a 9:45 meeting with the FSS, and I have exhibited the note provided to him by No.10 officials alongside the strategy.[99] It was decided at this meeting that the strategy be published, subject to final cross government agreement.[100] I have exhibited a further update on the outstanding policy questions: it sets out that "Testing will be done on discharge for admissions to care homes due to new CMO guidance (to be fully confirmed). Testing will also be extended to all symptomatic patients in care homes (5 residents per care home cap lifted)"[101]. The FSS then agreed to publication of the strategy the next day, 15 April 2020.[102] It provided advice on how to minimise the risks and transmission of COVID-19 in care settings along with the support that central and local government could give to care providers. It also stated that "We can now confirm we will move to institute a policy of testing all residents prior to admission to care homes. This will begin with all those being discharged from hospital".[103]

Adult Social Care Winter Plans

4.24. During the pandemic the Government published winter plans for the adult social care sector. I have provided a summary overview of the development of the Adult Social Care Winter Plans 2020/21 and 2021/22 where the Cabinet Office was involved.

4.25. The Adult Social Care Winter Plan 2020/21 was published by the DHSC on 18 September 2020 and set out "the key elements of national support available for the social care sector for winter 2020 to 2021, as well as the main actions to take for local authorities, NHS organisations, and social care providers, including in the voluntary and community sector".[104]

4.26. The Adult Social Care Winter Plan accepted the majority of recommendations of the

[96] SA/111 - INQ000564726; SA/112 - INQ000088387(agenda); SA/113 - INQ000088388 (draft strategy)
[97] SA/114 - INQ000564811; SA/115 - INQ000564810
[98] SA/116 - INQ000564737
[99] SA/117 - INQ000564748
[100] SA/118 - INQ000564724
[101] SA/119 - INQ000198045
[102] SA/120 - INQ000564749, SA/113 - INQ000088388
[103] SA/121 - INQ000233794
[104] SA/122 - INQ000058216

review by Sir David Pearson, the Chair of the Social Care Sector COVID-19 Support Taskforce in the DHSC. The review was commissioned in June 2020 by the DHSC to advise the Government on what was needed to prepare the sector for winter, and was published in September 2020.[105]

4.27. The Cabinet Office worked with the DHSC on the Adult Social Care Winter Plan 2020/21, including on the creation of a plan in October 2020 to ensure care homes paid full wages to staff in isolation. To be clear, the Adult Social Care Winter Plan 2020/2021 was not the first time that the matter of having care homes pay staff full wages to isolate had been raised (see, for example, a note provided to the Prime Minister titled 'Care Homes Covid Update' on 14 May 2020[106], and discussion over care home staff pay and conditions in earlier emails of 11 April 2020[107] and 23 April 2020[108] between officials in No.10 and the Cabinet Office). Many care homes were already paying isolating staff full wages. The review by Sir David Pearson stated that it was important that the Infection Control Fund money (introduced in May 2020), be used, in part, to "ensure that staff who are isolating, in line with Government guidance, receive their normal wages while doing so", which in turn meant the fund "acted both as a tool and lever, to reduce the risk of outbreaks". The review recommended that "the Infection Control Fund should be in place for the rest of the financial year".[109] The Adult Social Care Winter Plan stated that "over £500 million" of additional funding would be provided "to extend the Infection Control Fund to March 2021".[110]

4.28. The DHSC updated COVID-O regularly on the progress to deliver and enforce the measures published in the Adult Social Care Winter Plan. The CDL would then regularly update the Prime Minister on the delivery of the Plan. I now summarise the updates to COVID-O and from CDL.

4.29. On 14 September 2020, the CTF provided advice to the Prime Minister on the Adult Social Care Winter Plan. The advice recommended that in response to "rising cases in care homes", the Health Secretary announce the Plan and the extension of the Infection Control Fund "with stringent conditions to effectively refuse staff movement".[111]

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[105] SA/123 - INQ000279934
[106] SA/124 - INQ000564754
[107] SA/106 - INQ000564730
[108] SA/125 - INQ000198061
[109] SA/123 - INQ000279934
[110] SA/122 - INQ000058216
[111] SA/126 - INQ000564761

4.30. The first update to COVID-O on the Plan took place on 15 September 2020, where the Minister for Care[112] said that cases were rising in care homes and the Government would act on the recommendations from the Pearson review.[113] The minutes stated that "the majority of these, such as the expansion of the Infection Control Fund, were incorporated into the DHSC's Adult Social Care Winter Plan", which was provided to the COVID-O committee. COVID-O agreed to publish the Plan that week. The CDL sent a note to the Prime Minister on 15 September 2020 to update on the Plan.[114] This note stated that a "decision needs to be made on care home visits" due to the issue of rising cases. I have provided further detail later in this section on the decisions made on care home visitors throughout the relevant period in which the Cabinet Office was involved.

4.31. COVID-O reviewed progress of the delivery of the Plan in a meeting on 6 October 2020.[115] A note from the CDL to the Prime Minister sent on 12 October 2020 observed that "providing pay for isolating staff in care homes reduces outbreaks by 13%. We have provided funding for this (£600 million in June, £546 million one week ago), and driven up the proportion of care homes paying staff their full wages to isolate from 30% to 70%...I have asked DHSC to resolve this issue urgently".[116]

4.32. On 23 October 2020, the DHSC updated COVID-O on the progress of the delivery of the Plan.[117] The Minister for Care said "there had been progress on care homes paying staff to self-isolate. The second tranche of the Infection Control Fund was available, with more onerous conditions, which supported the requirements on staff not moving between care homes and paying sick pay to those self isolating". This statement will consider the restrictions on staff movement and where the Cabinet Office was involved, later in this section. The DHSC had access to data that showed 30% of care homes were not paying staff to self-isolate, however "much of this was expected to be as staff were not showing symptoms". The paper provided by the DHSC for the meeting stated "findings from a small survey of care homes which apparently did not pay full wages suggest the actual compliance rate could be higher than reported". The DHSC were to refine the questions in the Capacity Tracker "to better understand this cohort and better identify at risk care homes".

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[112] The role of Minister of State for Care was held during the relevant period by Helen Whateley MP (13 February 2020-16 September 2021) and the Rt Hon Gillian Keegan (16 September 2021-8 September 2022).
[113] SA/127 - INQ000090190; SA/128 - INQ000090221; SA/129 - INQ000090012; SA/130 - INQ000090186
[114] SA/131 - INQ000226642
[115] SA/132 - INQ000090063; SA/133 - INQ000090250; SA/134 - INQ000090249; SA/135 - INQ000090248; SA/136 - INQ000090171; SA/137 - INQ000090247
[116] SA/138 - INQ000564762
[117] SA/139 - INQ000090292; SA/140 - INQ000090126; SA/141 - INQ000090124; SA/142 - INQ000090121; SA/143 - INQ000090291; SA/144 - INQ000090302; SA/145 - INQ000090293

4.33. On 29 October 2020, the CDL provided a note to the Prime Minister. The note stated that "DHSC data suggested that 30% of care homes were still not paying staff full wages to isolate". The note continued that the DHSC had a "plan of action to target the remainder (e.g. equipping LAs [local authorities] and the CQC with data to target homes at risk of an outbreak but who are not paying full wages to isolate). With these measures in place we expect to get close to full compliance".[118]

4.34. On 8 December 2020, the DHSC updated COVID-O on the delivery of the Plan.[119] It was stated that there was "82% compliance with the measure amongst providers who have had staff absence" to pay full wages to staff isolating.

4.35. On 22 December 2020, the DHSC again updated on the delivery of the Plan, namely that 83% of providers were stated as providing full wages to isolating staff. Of the remaining providers of social care: 13% provided Statutory Sick Pay (SSP); 3% were paying greater than SSP but less than normal wages; and 1% were not paying staff to isolate.[120]

4.36. The DHSC gave a further such update on 11 January 2021. On the issue of paying staff full wages to isolate, the accompanying slides stated that 82% of respondents reported that they had paid staff full wages, "this is a very small decrease compared to the update at last COVID-O" and reflected that significantly more providers responded to the DHSC's questions than when data had last been collected. To mitigate this the DHSC: were to work with the Regional Assurance Team to build further understanding of non-compliance, and a team was commissioned to work on this until the end of the Infection Control Fund (until March 2021); were to write to all local authorities to stress [the] importance of complying with this measure of the Plan (by 18 December 2020); and were "in the process of commissioning rapid fieldwork with providers to give a more detailed understanding of cost pressures and the flow of funding (outputs by end of February [2021])".[121]

4.37. On 18 January 2021, CDL wrote to the Prime Minister to update on the DHSC's work to deliver the Plan. The note stated that "DHSC will work up and announce a new £120 million fund to address staff shortages. The DHSC will work with NHSE/I to address issues delaying the discharge of COVID positive and non COVID positive

[118] SA/146 - INQ000564763
[119] SA/147 - INQ000091239; SA/148 - INQ000091235; SA/149 - INQ000091044; SA/150 - INQ000091234; SA/151 - INQ000091005
[120] SA/152 - INQ000091281; SA/153 - INQ000091280; SA/154 - INQ000091133; SA/155 - INQ000091096; SA/156 - INQ000564713
[121] SA/157 - INQ000092263; SA/158 - INQ000092264; SA/159 - INQ000091639; SA/160 - INQ000507806; SA/161 - INQ000092262

patients, and identify where pressures on the discharge of residents are greatest across the country…DHSC and NHSE/I will report progress to you directly".[122]

4.38. Whilst COVID-O continued to discuss adult social care issues throughout 2021 (as set out later in this statement), the next update to COVID-O on the delivery of the following year's Plan took place at its meeting on 20 October 2021. COVID-O agreed to the publication of the Adult Social Care Winter Plan 2021/22, and noted plans by the DHSC to deliver COVID-19 booster vaccines and flu vaccinations in the adult social care sector, as well as the DHSC's plans to mitigate the risk of workforce shortages in the sector.[123]

4.39. The Adult Social Care Winter Plan 2021/2022 was published on 3 November 2021 by the DHSC.[124] The Plan stated that in order to meet the challenges of the coming winter the following measures would be in place:

4.39.5. £388.3 million in further funding to support IPC, testing and vaccination in adult social care settings, in addition to a further £478 million to continue enhanced hospital discharge support until March 2022;

4.39.6. Free flu vaccination for frontline social care workers and carers, and frontline social care workers could continue booking their first and second dose of the COVID-19 vaccine through the National Booking Service;

4.39.7. Continued provision of free PPE to the adult social care sector until the end of March 2022 for COVID-19 infection prevention, with sufficient stock to cope throughout winter;

4.39.8. Continuation of regular asymptomatic testing with availability of "more intense testing regimes for higher-risk settings"; and,

4.39.9. Continuation of support to care providers "to make best use of technology to support remote monitoring, enable secure online communications, and enable people within care homes to remain connected with friends and families".

4.40. The Cabinet Office worked with the DHSC on the Adult Social Care Winter Plan 2021/2022. This included oversight from the Domestic and Economic (Operations) (DE(Ops)) committee, established in October 2021, on some adult social care

[122] SA/162 - INQ000226655
[123] SA/163 - INQ000092132; SA/164 - INQ000092587; SA/165 - INQ000092133; SA/166 - INQ000092588; SA/167 - INQ000092128; SA/168 - INQ000092237; SA/169 - INQ000092134
[124] SA/170 - INQ000086797

matters. The DE(Ops) committee was chaired by the CDL. This committee had a very broad remit and discussed matters relating to domestic and economic strategy.[125] The DE(Ops) committee commissioned the DHSC on 25 October 2021 to "prepare a short, precise, evidence-based paper on the DHSC's plan for monitoring and mitigating workforce shortages in Adult Social Care (ASC) over Winter".[126] The DHSC produced a slide pack titled 'Monitoring and mitigating workforce shortages in ASC – Autumn/Winter 2021/22' which is exhibited. The draft of this paper was reviewed by a DE(Ops) officials committee on 4 November 2021.[127] The CDL preferred to discuss it with the Health Secretary in a bilateral meeting.[128] This meeting took place on 11 November 2021 and the actions are exhibited.[129] There was a further note to the Prime Minister on 26 November 2021 on labour market shortages[130].

Understanding of pressures on the social care sector

The Dashboard

4.41. The Cabinet Office sought to ensure that decision-making meetings on COVID-19 were supported by data, analysis and expert advice. The Dashboard became the Cabinet Office's key mechanism for bringing together and presenting a single, integrated analytical picture for decision-makers. The CTF sought to ensure that health and social care impacts were reflected in the Dashboard 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.

4.42. 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 government distribution list.

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[125] SA/171 - INQ000089797
[126] SA/172 - INQ000564715
[127] SA/173 - INQ000564714. The Cabinet Manual (SA/5 - INQ000182315) explains that "official committees may be convened for a variety of purposes, but would normally meet in advance of a Cabinet committee. This would enable them to consider the issues that would need to be covered in Cabinet committee papers and to help the Cabinet Secretariat identify points that are likely to be raised so that it can brief the chair of the Cabinet committee effectively".
[128] SA/174 – INQ000565852
[129] SA/175 - INQ000564718
[130] SA/176 - INQ000564734

4.43. 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 each day. Once updated, an email alert was sent to users along with a PDF version of the Dashboard. The range of data sources covered by the Dashboard expanded over time. A key surveillance tool feeding into the Dashboard was the COVID-19 Infection Survey (CIS) which was commissioned by PHE in April 2020 and led by the Office for National Statistics (ONS), with the first results made available in May 2020.

4.44. The development of the Dashboard was overseen by an Editorial Board which was responsible for making decisions on the inclusion of information, and quality-assuring data.[131] 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 from the social care sector increased. The Cabinet Office has provided the Inquiry with all of the Dashboards from the relevant period. The number of care homes (in England and Wales) with COVID-19 cases were included from 2 April 2020.[132] Information on staffing levels and PPE in care homes were included from 16 April 2020.[133]

4.45. As the pandemic evolved and the quality of data available improved, the Prime Minister's 9:15 C-19 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.

Concerns about nosocomial transmission and the Adult Social Care Rapid Review

4.46. A SAGE meeting on 31 March 2020 actioned the "NHS to urgently create and chair a nosocomial infection sub-group, with DCMO support, involving modelling, genomics, clinical expertise and engineering: the sub-group needs to consider the role of healthcare workers in nosocomial spread, the risk to care homes and solutions for reducing nosocomial spread".[134]

[131] SA/177 - INQ000221567
[132] SA/178 - INQ000174717
[133] SA/179 - INQ000083660
[134] SA/180 - INQ000119727

4.47. Dr Ben Warner in No.10 became increasingly concerned about nosocomial infection rates in hospitals and raised this concern with the DHSC on 13 April 2020.[135] A SAGE meeting the following day noted that "There is significant transmission in hospitals…Nosocomial cases are therefore making up an increasing proportion of cases. Care homes also remain a concern. There are less data available from these. SAGE advises that increased testing in these settings, supported by modelling, is important". The nosocomial working group was actioned "to widen viral sampling in hospitals and care homes - including a rapid review of infection, prevention and control - to test for infection. Note that asymptomatic individuals should be tested in certain circumstances".[136]

4.48. On 20 April 2020, there was a meeting between the Cabinet Office, the DHSC and the NHS on nosocomial transmission. The NHS reported that they were re-doing the infection control guidance as it was too complex.[137] There were also discussions about testing asymptomatic staff in hospitals and care homes.[138]

4.49. I understand that following the Prime Minister's discharge from hospital and return to work, he became personally concerned about the position in care homes.[139] Around this time concerns were being raised in No.10 and with the DHSC.[140] On 24 April 2020, the Prime Minister chaired a call with the Health Secretary, the Cabinet Secretary and wider members of the No.10 team to discuss PPE, care homes and testing. The Health Secretary commented that it was too early to evaluate the impact of the measures in the Adult Social Care Action Plan published on 15 April 2020. According to the readout, the Health Secretary was planning to implement a further batch of measures in the next few days, aimed at preventing and containing outbreaks, including better segregation within care homes, reducing movement of agency staff between settings, assigning GPs to care homes and survey testing".[141] The Care Home Support Package was announced on 15 May 2020 by the DHSC which encompassed these measures, and which I later refer to at paragraphs 4.118 and 4.128.[142]

4.50. On 28 April 2020, the Prime Minister led a deep dive meeting on care homes. The readout notes that "The Prime Minister opened the discussion by highlighting that the

[135] SA/181 - INQ000198046
[136] SA/182 - INQ000061533
[137] SA/183 - INQ000564809
[138] SA/184 - INQ000061944
[139] SA/185 - INQ000252914
[140] SA/125 - INQ000198061
[141] SA/186 - INQ000564742
[142] SA/187 - INQ000564782

rate of infections and deaths in care homes was a major concern… Attendees agreed that, alongside testing and quarantine, the key solutions were to restrict movements of the social care workforce between care homes and to increase infection prevention and control measures".[143]

4.51. Following this deep dive, the CCS supported the Adult Social Care Rapid Review, conducted between 30 April 2020 and 4 May 2020. It was completed by a joint team, consisting of the Prime Minister's Implementation Unit (PMIU),[144] the HMIG secretariat, the CCS Dashboard team and CCS Health and Science team. These reviews involved interviews with front line individuals, including LRFs, NHS staff, and adult social care providers, as well as analytical work. I have summarised the development and outcome of the review.

4.52. The scoping document for the Rapid Review outlined that the aim of the review was to: "...identify the barriers and solutions for the effective implementation of the policies agreed on 28 April [at the deep dive]" with specific focus on proposals to:

1. Restrict workforce movement - limit movement of staff between care homes; further limit travel and social interaction of staff; and,

2. Improve infection prevention and control through isolation of care home residents.[145]

4.53. The scoping document also set out the "key research questions" for the review, and where possible the review would "aim to understand how answers to the following vary by care home type… including size, and region / Local Authority".[146]

4.54. Interviews were conducted with the following stakeholders: care staff agencies; local authority Directors of Adult Social Care or Commissioners; CCG commissioners; care provider associations and representative bodies (e.g. the Social Care Institute for Excellence, the Local Government Association and the Association of Directors of Adult Social Services (ADASS)). Analysis was conducted of baseline staffing and PPE, and a sampling framework of a random selection of 10 care homes were interviewed.[147]

[143] Chair's Brief: SA/188 - INQ000198069; Readout: SA/189 - INQ000564723
[144] The PMIU was a unit based in the Cabinet Office and the predecessor team to the No.10 Delivery Unit.
[145] SA/190 - INQ000564741
[146] SA/190 - INQ000564741
[147] SA/190 - INQ000564741

4.55. The product of the review provided qualitative feedback from providers on the feasibility of restricting workforce movement and isolating residents in care homes.[148] The main findings of the review were that "care homes acted early to limit visits and restrict the movements of staff, visitors and residents. Other policy proposals have significant trade-offs, with large costs and impacts on the welfare of residents and staff".

4.56. The review recommended that clearer guidance with a focus on practical isolation measures was needed, along with assessing the case for further financial support. The overall policy and delivery of these matters remained the responsibility of the DHSC, in line with their remit as set out in paragraph 1.5.2. I have summarised the recommendations below:[149]

4.56.5. DHSC/PHE were to work with representative bodies (e.g. Care England, National Care Forum) to provide clear guidance on practicalities of implementing cohorting and segregation of residents and staff;

4.56.6. DHSC were to accelerate delivery of PPE to care homes. Greater support for meeting the cost of PPE was to be explored with HMT;

4.56.7. DHSC/PHE were to prioritise mobile testing and/or home testing approach to all care home staff and residents;

4.56.8. DHSC/HMT/MHCLG were to consider the case for funding providers to maintain lower levels of occupancy (i.e. block purchasing beds);

4.56.9. DHSC/HMT/MHCLG were to assess the extent to which additional funding provided to local government was reaching and providing sufficient support to social care providers; and,

4.56.10. DHSC/PHE were to undertake qualitative analysis of the impact of policy proposals on infection and death rates.

4.57. The findings of the rapid review were provided to the DHSC on 6 May 2020 to inform the department's policy making and delivery.[150] The findings were also reviewed at a wider deep dive meeting on adult social care with FSS on 6 May 2020, for which I have exhibited the relevant papers and minutes.[151] The actions from that meeting included that the DHSC were to provide the Cabinet Office with proposals for a

[148] SA/191 - INQ000564732
[149] SA/191 - INQ000564732
[150] SA/192 - INQ000564740
[151] SA/193 - INQ000088561; SA/194 - INQ000146701

number of decisions including on visitor restrictions in care homes.[152] I have provided further detail on these decisions later in this statement. Following the meeting, the FSS wrote to the Prime Minister.[153]

4.58. The Prime Minister chaired a meeting on care homes on 22 May 2020. The readout notes that he asked whether those in attendance thought the measures being implemented "would be enough to prevent and contain care home outbreaks. The CSA and the CMO confirmed that the strategy…was right to be enacting multiple different measures in tandem, backed by public health principles and evidence — and the key would be making it operational…The meeting concluded with agreement that DHSC should develop a clear framework for assessing both progress and delivery".[154] The Prime Minister also reiterated his desire for a leadership figure to drive delivery: Sir David Pearson was appointed in June 2020 to lead the Social Care Sector COVID-19 Support Taskforce, reporting to the Minister of State for Care, as described above in paragraph 4.26. After the meeting, the Cabinet Office commissioned the DHSC for an update for the Prime Minister on the delivery of the measures, which the DHSC provided on 27 May 2020.[155]

Funding of the social care sector

4.59. The overall funding allocation for the social care system was (and still is) determined by HMT through a well-established spending review and budget-setting process that entails bilateral discussions between HMT and the DHSC. MHCLG is responsible for the financial framework within which local authorities operate, and distributes funding to local authorities who fund care and support in their local areas, in line with their statutory duties under the Care Act 2014.[156] No.10 and HMT agree the overall government spending package and particular governmental spending priorities.

4.60. The decisions on funding for social care during the relevant period followed this approach. Throughout the course of the pandemic, the social care sector required additional resources and a number of funding decisions were taken so as to mitigate the impact that the pandemic would inevitably have on social care sector resilience.

[152] SA/195 - INQ000088556
[153] SA/196 - INQ000198081; SA/197 - INQ000088563; SA/198 - INQ000088564; SA/199 - INQ000327877
[154] SA/200 - INQ000198098
[155] SA/201 - INQ000564722; SA/202 - INQ000564801
[156] SA/2 - INQ000564791

There were occasions when No.10 expressed views on funding allocation within the social care sector. I understand that the Prime Minister also took advice from HMT for such decisions. I was not involved in this at the time, but I have set out my understanding of key events based on the documents that have been identified. It is not, however, the intention, nor within the scope of this corporate witness statement, to comment on the adequacy of funding of adult social care during the relevant period.

4.61. In January 2020, the Prime Minister stated that the Government would bring forward a long-term plan for social care that year.[157]

4.62. On 11 March 2020, HMT announced 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.[158] On 19 March 2020, it was announced that £1.6 billion of this funding was to be provided to local authorities to relieve pressures on all services they delivered including social care. £1.3 billion was allocated "to enhance the NHS discharge process so patients who no longer need urgent treatment can return home safely and quickly".[159]

4.63. On 29 June 2020, HMT provided advice to the Prime Minister on social care funding reform, which recommended that "we should consider means test reform only once we have fully evaluated the economic impacts of COVID…Following the SR [Spending Review], we could then consider means test reform further with the view to agreeing a long-term solution within this Parliament when the system has had time to recover".[160]

4.64. In the Spending Review published on 25 November 2020, the Government stated that it was "committed to sustainable improvement of the adult social care system and will bring forward proposals next year".[161]

4.65. The Prime Minister received advice on 9 July 2021 to assist his consideration of the introduction of the Health and Social Care Levy, in which it was noted that it was to be raised to support "the NHS and fixing social care as we come out of the pandemic".[162]

4.66. On 7 September 2021, the Government set out its plan for adult social care reform in

[157] SA/203 - INQ000564792
[158] SA/204 - INQ000236913
[159] SA/86 - INQ000564800
[160] SA/205 - INQ000564758
[161] SA/206 - INQ000564795
[162] SA/207 - INQ000564771

England. This included a lifetime cap on the amount anyone in England would need to spend on their personal care, alongside a more generous means-test for local authority financial support. This was published in the Command Paper 'Build Back Better: Our Plan for Health and Social Care' authored jointly by the DHSC and the Cabinet Office.[163] The stated intention was to introduce the cap in October 2023.

4.67. With the publishing of this Command Paper, the introduction of the Health and Social Care Levy was also announced on 7 September 2021. The levy was a UK-wide 1.25% levy, based on National Insurance contributions. The 'Build Back Better' paper stated that the levy would make "available investment of around £12 billion per year on average for health and social care across the UK over the next three years".[164]

4.68. On 27 October 2021, the Chancellor presented the Budget and Spending Review to Parliament. The Budget and Spending Review focused on investing in public services, including investment in health and the NHS, part-funded by the Health and Social Care Levy.[165] As remains the convention with all fiscal events and as set out in the Cabinet Manual, the Autumn 2021 Budget was developed in consultation with the Prime Minister, before being presented to Cabinet shortly before the event.[166]

4.69. There has been significant activity in social care policy since the end of the Inquiry's relevant period. There has also been a change of administration. It is not within the scope of this statement to articulate or comment upon the current government's position on adult social care.

Visitors to care homes

4.70. I have set out below the evolution of policy on care home visiting, including advice received by the Prime Minister, and of the decisions taken at the centre of government during the relevant period, in order to control the number and spread of cases in UK care homes. The CTF coordinated and advised on strategy for the COVID-19 response, working with medical and health experts including the CMO, DCMOs and GCSA, and the DHSC and UKHSA, to ensure the advice to the Prime Minister reflected a wide range of inputs and considerations. This included ensuring visiting policy was aligned to the broader strategy, such as for easing national restrictions. Restrictions on visitors into care homes were implemented and decided upon in the centre of government where it warranted collective agreement. It was

[163] SA/208 - INQ000564780
[164] SA/208 - INQ000564780
[165] SA/209 - INQ000253812
[166] SA/5 - INQ000182315

recognised that visiting was crucially important for maintaining health and wellbeing and quality of life for residents in care homes. I have provided a summary overview of the decisions made during the relevant period in which the Cabinet Office was involved.

4.71. Testing was essential for enabling visiting in care homes during the relevant period. As the LGD for testing, the DHSC was responsible for setting targets in relation to testing. The Prime Minister remained close to work on testing throughout the pandemic, including through bilateral meetings with Baroness Harding, the Chair of NHS Test and Trace (T&T), and through regular (initially weekly) testing meetings which focused on a range of issues from the ambition to roll out a mass population testing programme, to surge testing in specific settings and geographical areas. A corporate statement on matters related to testing will be provided from the Cabinet Office for Module 7.

4.72. Following the announcement of the national lockdown on 23 March 2020, on 2 April 2020 the DHSC published guidance for the admission and care of people in care homes. A deep dive meeting on adult social care with the FSS took place on 6 May 2020 (which also reviewed the findings of the Adult Social Care Rapid Review as set out earlier in my statement).[167] The readout stated: "Published guidance stated visits should be allowed by exception only at the end of life, with some providers stopping all visits entirely. The Minister for Care said that the DHSC had received complaints about this. The FSS said that we should recommend to the PM that we mandate this policy to ensure all care homes were clear about the approach they should take. The SRO[168] said that the DHSC would need to consider the Government's legal basis for mandating this".[169]

4.73. The introduction of further levers to ensure compliance from care homes with infection control measures (such as restricting workforce movement) was further discussed by ministers. For example, a COVID-O meeting on high risk settings took place on 12 June 2020.[170] The legislative powers discussed at the COVID-O included powers to restrict workforce movement. The CDL provided a note to the Prime Minister on 14 June 2020, which stated: "With respect to care homes, the discussion exposed again that Ministers lack the levers required to require compliance. We have responsibility without power, and this must change, so we agreed that: legislating to

[167] SA/193 - INQ000088561; SA/194 - INQ000146701
[168] The Senior Responsible Owner (SRO) listed in the readout was Ros Roughton, Director of Adult Social Care in DHSC according to SA/210 - INQ000564773 which lists attendees of the meeting
[169] SA/211 - INQ000088555
[170] SA/212 - INQ000088733; SA/213 - INQ000088789; SA/214 - INQ000088736

give Ministers the appropriate powers to direct compliance is a priority, and we should be clear with the sector that these powers are coming to incentivise compliance now".[171] Subsequently, on 19 June 2020 advice was provided to the Prime Minister that recommended not to proceed with introducing legislative powers to direct social care providers. The advice stated "DHSC's view is that these existing powers [legal and regulatory] are sufficient and did not have an example of something they were unable to achieve under existing powers. Existing powers do not give coverage to direct individual providers, though with over 25,000 different providers we do not think such a power would be useful or practicable".[172] Given DHSC's recommendation in the advice, further levers such as legislation were not introduced during the relevant period to ensure compliance with restriction of workforce movement between care homes, or mandating visiting policy as suggested by FSS in May 2020.

4.74. On 22 July 2020 the DHSC announced visits to care homes could resume subject to guidance.[173]

4.75. Throughout September and early October 2020 in response to rising incidence the CTF worked with scientific experts to explore potential trajectories for the virus. Through this period, alongside the Dashboard meetings, the CTF developed a number of policy options, including drawing on lessons from other countries, and discussed them extensively with the Prime Minister and other senior ministers. This included discussion on care home visits policy.

4.76. The actions from a Dashboard meeting held on 11 September 2020 stated that a "rapid response" was needed to an increase of COVID-19 cases in social care.[174] Advice to the Prime Minister on 14 September 2020 stated that the Health Secretary proposed a number of actions. These included "reviewing visitor policy: currently local directors of public health take a risk assessment of whether to allow visits in their patch. Some have chosen not to open up visiting given high community prevalence. Given your steer, COVID-O will discuss whether national action should be taken to ban all visitors, balancing the clinical risks of transmission against the benefits of providing residents with family care and return to you with a recommendation tomorrow".[175]

[171] SA/215 - INQ000226631
[172] SA/216 - INQ000562378
[173] SA/217 - INQ000562380
[174] SA/218 - INQ000562379
[175] SA/126 - INQ000564761

4.77. COVID-O met on 15 September 2020 to discuss measures to combat rising cases in care homes. I exhibit the Chair's Brief, minutes and actions.[176] The committee acknowledged "the question of visiting was particularly difficult. If measures were in place until March it would be very hard for families and residents. There was an argument for being firm now, in order to relax restrictions later, but given the human impact of care home deaths in the intervening months this was not as applicable as to other decisions regarding the pandemic. Any approach should be proportionate to the evidence on the transmission risk". The minutes concluded that the decision on visiting would be referred to COVID-S.[177] It was at this meeting that the publication of the Adult Social Care Winter Plan 2020/2021 was agreed to, as outlined earlier in this statement at paragraph 4.30.

4.78. On 16 September 2020 advice was provided to the Prime Minister by the CTF summarising the issue that "having more people in care homes must increase risk".[178] Officials at the time were concerned particularly about the impact of prolonged isolation.[179] As previously stated, advice on the broader COVID-19 strategy from the CTF, including where it related to visiting policy, incorporated medical advice from medical experts and the DHSC. The advice to the Prime Minister noted that "CMO and DCMO have flagged that visits are critical in maintaining the mental, emotional and physical wellbeing of residents. In the first wave, it was noted that the lack of contact had severe detrimental health impacts, especially on those suffering with dementia".[180] The advice summarised the CDL's note to the Prime Minister sent on 15 September 2020, including three policy options for the Prime Minister's decision:

> "i. Continue with current policy: Directors of Public Health (DPHs) determine visitor permissions based on local risk;
>
> ii. Tighten rules on all visits and stop visits outright in high prevalence areas;
>
> iii. Stop all care home visits except at the end of life".

4.79. Subsequently on 18 September 2020, the Minister for Care wrote to local authority Chief Executives, Directors of adult social services, DPHs, care home providers and CCG accountable officers announcing the Adult Social Care Winter Plan 2020/2021. The letter stated that "visits are important for the wellbeing of residents and loved

[176] SA/127 - INQ000090190; SA/128 - INQ000090221; SA/219 - INQ000090180; SA/129 - INQ000090012
[177] SA/219 - INQ000090180
[178] SA/220 - INQ000564760
[179] SA/221 - INQ000564777
[180] SA/220 - INQ000564760

ones, but with higher rates of Covid-19 in the community, extra precautions will be needed including supervision of visitors to make sure social distancing and infection prevention and control measures are adhered to. Meanwhile, designated 'areas of intervention' must not allow visiting except in exceptional circumstances, such as end-of-life".[181]

4.80. The Adult Social Care Winter Plan 2020/21 stated care home providers should: limit visitors to a single constant visitor wherever possible, with an absolute maximum of two to reduce infection risk; supervise visitors at all times to ensure social distancing and infection prevention measures were adhered to; ensure visits take place wherever possible outside or in a well-ventilated room; and immediately cease visits if advised by their respective DPH that they were unsafe.[182] I have set out how the Cabinet Office was involved in the implementation of this Plan earlier in my statement.

4.81. On 12 October 2020, the Prime Minister announced that the Government would introduce a three tiered system of local COVID Alert Levels in England. These levels were medium (tier 1), high (tier 2), and very high (tier 3). This approach sought to manage the virus on a local basis, minimising economic and social harms in those parts of the country where incidence remained low. DHSC guidance at this stage for care homes was: "Our current guidance (updated on 15th October) allows supervised visiting in Tier 1 areas provided PPE use and social distancing is observed. Visiting is allowed in Tiers 2 and 3 only in exceptional circumstances such as end of life".[183]

4.82. COVID-O met on 23 October 2020 for a 'deep dive' on adult social care. According to the minutes, the Minister for Care stated "there was a need to refresh the policy on care home visiting to something more humane", that relatives of care home residents were in an "uncomfortable position of choosing which family can come visit". The Chair, CDL stated that, provided there was assurance that care homes were "Covid-secure" (by a number of means e.g. adhering to the measures for eligibility for the Infection Control Fund), a "more humane visiting policy" could be introduced.[184]

4.83. On 31 October 2020, the Prime Minister announced a national lockdown beginning on 5 November 2020 in response to rising cases of COVID-19 and impact on the healthcare system.[185]

[181] SA/222 - INQ000235311
[182] SA/122 - INQ000058216
[183] SA/223 - INQ000062849
[184] SA/144 - INQ000090302
[185] SA/224 - INQ000086830

4.84. COVID-O met on 3 November 2020 to discuss care home visiting policy. The DHSC provided a paper titled 'Visiting in care homes'.[186] The paper presented two options to COVID-O for the national lockdown period:

4.84.5. Option A - "Allow carefully managed indoor visits for a single regular visitor per resident." This was presented as the "higher risk" option, and "PPE use and social distancing would be required, with visitors asked to self-report symptoms, and visits supervised";

4.84.6. Option B - "Allow visits where visitors do not enter the building or interact with anyone other than the resident." The paper stated this was the Minister for Care's preferred option, "with the intention of pursuing option A (single visitor per resident allowed for a carefully managed indoor visit) when population rates are lower (or we return to LAL Tiers) and when mass testing for visitors is available."

4.85. COVID-O agreed to Option B, and asked the DHSC to progress towards Option A (allowing indoor visits for a single visitor per resident). CDL stated "Visiting policy should return to the COVID-19 Operations Committee in mid-December, or when testing capacity had increased sufficiently to support a more lenient policy, whichever came sooner".[187]

4.86. On 3 November 2020 advice was provided from the CTF to the Prime Minister titled 'Care home visits for the next 4 weeks'. The advice recognised the "growing evidence around the detrimental impacts of cutting off contact between residents and their families especially for those with conditions such as dementia". The advice set out the two options discussed at COVID-O, noting that the committee had agreed to Option B (with support of the DCMO) as stated in the previous paragraph, with a view to move to Option A at "the end of national restrictions from 2 December - at which point community Covid prevalence will be lower". The advice stated that the "first priority was to keep Covid out of care homes, especially in the context of rising national prevalence, but to open up visiting in a controlled, and sequential way over the coming months".[188]

4.87. The DHSC published guidance on 4 November 2020, outlining how care homes would be encouraged and supported to provide safe visiting opportunities as new

[186] SA/223 - INQ000062849
[187] SA/223 - INQ000062849; SA/225 - INQ000091236
[188] SA/226 - INQ000564764

national restrictions came into effect.[189] The CDL provided a note to the Prime Minister on 6 November 2020 which stated that new guidance had been published, and that "DHSC was asked to progress urgently towards allowing carefully managed indoor visits for a single regular visitor per resident as testing capacity increases".[190]

4.88. As set out earlier in this statement, on 23 November 2020 the Cabinet Office published the 'COVID-19 Winter Plan'.[191] This set out the launch of visitor testing, with the target to provide twice weekly testing to enable all care home residents to have regular visits from up to two visitors.

4.89. On 24 November 2020, COBR met to discuss the CTF's proposed plans for the Government's overall approach to the Christmas period. In relation to social care, the minutes stated that in the formulation of these plans: "There had been specific discussions of care homes. With agreement to communicate on them at the same time across the UK". The actions of the meeting stated that the DHSC with the devolved governments was "to finalise arrangements for care homes, recognising the unique circumstances in each Administration".[192]

4.90. On 29 November 2020, the Cabinet Office published 'Guidance for the Christmas period'. This guidance stated that in all tiers visits could continue to relatives in care homes, except where there was an outbreak. Using lateral flow tests provided to care homes, residents could have indoor visits from up to two visitors each week by Christmas. The guidance stated limited physical contact may be permitted, as long as infection control requirements of appropriate PPE and a negative test were met.[193]

4.91. On 26 November 2020, it was announced that the tiering system would be restored on 2 December 2020 after the national lockdown. On 1 December 2020, the DHSC set out guidance for visiting care homes in England. The guidance stated all care homes regardless of tier (and except in the event of an active outbreak) should seek to enable: indoor visits where the visitor has been tested and returned a negative result; outdoor visiting and 'screened' visits; and visits in exceptional circumstances including end of life should always be enabled.[194]

4.92. Advice was provided from the CTF to the Prime Minister on 2 December 2020 titled 'Testing: update & issues'. This provided an update on the rollout of rapid mass

[189] SA/227 - INQ000564789
[190] SA/228 - INQ000226647
[191] SA/69 - INQ000137262
[192] SA/229 - INQ000083820; SA/230 - INQ000083853; SA/231 - INQ000083850; SA/232 - INQ000083825
[193] SA/233 - INQ000564785
[194] SA/234 - INQ000325293

testing as set out in the 'Adult Social Care Winter Plan 2020/21'. The note stated that the CDL would chair a COVID-O deep dive on testing, to allow for "scrutiny of delivery plans for the different testing use cases (such as care home visitors)". The phased rollout of lateral flow testing for care homes was planned for that week. Visitor testing would start that day (2 December), and it was expected that "all homes would be in a position to facilitate visitor testing by the 18 December, in time for Christmas".[195]

4.93. On 8 December 2020, COVID-O met to be updated by the DHSC on the Winter Plan 2020/21 and also to discuss visiting policy.[196] The minutes stated that the number of new cases of COVID-19 and the positivity rate in care homes were falling, however caution was needed as the falling staff positivity rates had recently plateaued. The Minister for Care stated that "the new policy of allowing visitors into care homes only after they had taken a test (in all but the lowest tier)...would also increase risk of infection. The vaccine would take time to roll out so there would be no room for relaxation". The CDL stated that the topic of visiting policy should return to a future COVID-O.[197] DHSC were also actioned to provide clarity on messaging around the visiting rules in the run up to and during Christmas.[198]

4.94. On 10 December 2020, the CDL provided a note to the Prime Minister updating him on the COVID-O meeting held on 8 December 2020. In relation to care home visits it noted, "we announced on 23 November [2020] that care homes will receive enough Lateral Flow Devices this month to allow residents to have up to two visitors, who can be tested twice a week, in time for Christmas". The note stated CDL was "concerned by DHSC's estimate that 40% of homes, perhaps more, will not be able to offer visits by the 25th." The note stated some of this may be for reasons such as homes not allowing visits for up to 28 days after an outbreak, with 28% of care homes experiencing a current outbreak. The note stated DHSC were "confident" that enough testing kits and PPE would be distributed in time but CDL had "pushed them to resolve three other operational risks urgently that would help increase the number of homes who can offer visits". The actions were: DHSC had sought to expedite new funding to cover staff and training costs associated with delivering extra tests for visitors, staff and residents; DHSC were exploring providing short-term cover where insurers refused to cover Covid-related claims, including those arising from visits;

[195] SA/235 - INQ000564765
[196] SA/147 - INQ000091239; SA/148 - INQ000091235; SA/149 - INQ000091044; SA/150 - INQ000091234; SA/151 - INQ000091005;
[197] SA/149 - INQ000091044
[198] SA/150 - INQ000091234

and, the DHSC had put out evidence on the effectiveness of LFDs to counter concerns raised by DPHs.[199]

4.95. COVID-O met on 19 December 2020 and decided that areas of the country with rising incidence of the emerging 'Kent' (Alpha) variant would enter a new 'Tier 4' of restrictions. This tier had 'stay at home' restrictions similar to those imposed in national lockdown, and came into force on 20 December 2020 in London and the South East.[200] Guidance was updated by the DHSC to reflect that:

4.95.5. all care homes regardless of Tier - and except in the event of an active outbreak - should seek to enable outdoor visiting and 'screened' visits; and,

4.95.6. that care homes in Tiers 1, 2 and 3 - except in the event of an active outbreak - should seek to enable indoor visits with appropriate testing; and,

4.95.7. visits in exceptional circumstances such as end of life should always be enabled.[201]

4.96. The third national lockdown was announced on 4 January 2021, with restrictions in place from 5 January 2021 to 8 March 2021. The DHSC updated their guidance on visiting care homes so that it applied across England (rather than vary by local area).[202]

4.97. Throughout the relevant period, the Prime Minister was updated regularly by NHS T&T on the progress of the testing programme, including on the numbers of tests in social care. For example, on 7 January 2021, NHS T&T provided the following update to the Prime Minister on the progress of the programme: "in total we have now found 28,000 positive cases through Lateral Flow tests across the NHS, Social Care, Universities and Community Testing").[203] A testing update to the Prime Minister titled 'Roadmap: Test, Trace and Isolate' from the CTF in February 2021 highlighted that testing, tracing and isolation were "key to easing restrictions and will need to be retained throughout the year". The update stated that an asymptomatic testing programme which administered 16 million lateral flow tests, reported 125,000 positive cases", including in the adult social care sector.[204]

[199] SA/236 - INQ000564736
[200] SA/237 - INQ000248852
[201] SA/238 - INQ000234635
[202] SA/239 - INQ000325221
[203] SA/240 - INQ000564721
[204] SA/241 - INQ000564720

4.98. On 18 February 2021, COVID-O met to discuss resuming visits for care homes. It agreed to: the proposal of a single named visitor rule for care homes to take effect from 8 March[205]; for this policy to be published in the Government's 'Roadmap' strategy on 22 February; and to take a decision no later than mid April 2021, as part of the next Roadmap stage, on whether to enable more visiting (e.g. up to two visitors, twice a week), based on an assessment of the latest data at that point; and to set out the longer term plan for visits policy at that point.[206] As outlined earlier in this statement, the policy was announced in the publication of the 'COVID-19 Response: Spring 2021 Roadmap' on 22 February 2021.[207]

4.99. Subsequently, on 1 April 2021, in line with Step 2 of the Roadmap, a submission from the CTF sought agreement from the Prime Minister to announce on 12 April 2021 an increase in the number of indoor care home visitors from one to two.[208] On 5 April 2021, the Prime Minister chaired COVID-O, where it was agreed to move to Step 2.[209] The Prime Minister provided an update to Cabinet that same day confirming the move to Step 2.[210] On 6 April 2021, the Prime Minister wrote to all MPs to update on Step 2 of the Government's COVID-19 response.[211] These changes were brought into effect on 12 April 2021.

4.100. On 10 May 2021, COVID-O agreed to proceed to Step 3 of the Roadmap on 17 May 2021.[212] This introduced a limit of 30 people allowed to mix outdoors, with the 'rule of six' or two households allowed for indoor gatherings. The guidance for care homes remained the same as at Step 2.

4.101. On 13 June 2021, the Prime Minister chaired COVID-O where it was agreed that a four-week pause in moving to Step 4 would be announced. However, targeted relaxations were agreed for adult social care. These were: the removal of the need for residents to isolate for 14 days after visits out (with the exception of hospital overnight stays, or a visit which was deemed high-risk by the care home, or following admission from the community); to allow all residents to nominate an essential care giver for any purpose or care need (rather than only where the purpose or care need could not be easily provided by care home staff); and to permit visits from these essential care givers during periods of isolation. The committee did not agree to

[205] SA/242 - INQ000091741
[206] SA/243 - INQ000091745
[207] SA/73 - INQ000072888
[208] SA/244 - INQ000564769
[209] SA/245 - INQ000091856
[210] SA/246 - INQ000088949
[211] SA/247 - INQ000564770
[212] SA/248 - INQ000092475

remove the limit on the number of visitors each resident could have or the number of visits per day, citing increased risk if this were to change.[213]

4.102. COVID-O met on 2 July 2021 and a paper was provided by the CTF on adult social care.[214] The paper recommended that the cap for visitors in care homes (five named visitors were allowed for each resident, with a maximum of two visitors per day) be removed at Step 4. The paper stated that if the cap were removed, there would still be a maximum of two named/nominated visitors able to visit each resident each day. COVID-O agreed to remove the restriction that limited care home residents to five named visitors, and retain the cap at two visits per day from Step 4. COVID-O also agreed that the continuation of 14-day isolation periods related to high risk circumstances were in line with PHE clinical advice.[215] The CDL wrote to the Prime Minister on 2 July 2021 confirming this agreement.[216] These changes were enacted as part of Step 4 on 19 July 2021.

4.103. On 10 December 2021, COVID-O met to discuss the response to the emergence of the Omicron variant. The DHSC provided a paper outlining recommended changes to visiting guidance that, amongst other measures, each care home resident should be limited to three nominated visitors who could visit regularly, in addition to a nominated essential care giver. COVID-O agreed to: limits to the number of visitors a care home resident could receive; the reintroduction of testing and self-isolation for care home residents after they had a visit outside of the care home; the bolstering of risk assessment guidance for visits; and that these measures (amongst others not specific to visiting policy) should be announced that evening, and implemented on 15 December 2021.[217]

4.104. On 26 January 2022, COVID-O met to discuss the lifting of restrictions imposed on adult social care in response to the Omicron variant. The Minister for Care provided a paper outlining the recommendation to remove restrictions. The committee agreed to: ease restrictions that were reintroduced in response to the Omicron variant; use LFTs to reduce the self isolation period for care home residents from 14 to 10 days; and, to announce all measures that same day.[218] The DHSC updated guidance on 31 January 2022 for care home visiting reflecting those changes.[219]

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[213] SA/249 - INQ000234322; SA/250 - INQ000146807; SA/251 - INQ000146775; SA/252 - INQ000146776; SA/253 - INQ000146810
[214] SA/254 - INQ000063947
[215] SA/255 - INQ000063951; SA/256 - INQ000092087
[216] SA/257 - INQ000226693
[217] SA/258 - INQ000092203; SA/259 - INQ000092231; SA/260 - INQ000092200
[218] SA/261 - INQ000091547; SA/262 - INQ000091575
[219] SA/263 - INQ000287738

4.105. From 22 March 2022, the DHSC updated their guidance to reflect that there were no longer any national restrictions on visiting in care homes.[220] This remained the case until the end of the Inquiry's relevant period.

PPE

4.106. Strategic targets for PPE were set by the DHSC.[221] I have set out a summary of advice and updates provided to the Prime Minister during the relevant period on PPE, where relevant to the adult social care sector.

4.107. Before the pandemic, local health and social care providers bought PPE primarily through distributors. There was no central PPE stockpile intended for use by local health or social care providers. From February 2020, as the pandemic spread worldwide, demand for PPE surged dramatically.[222] The DHSC decided to source and distribute PPE for use in the social care sector, as the traditional wholesale network was finding it impossible to obtain many items of stock. At all times during the pandemic the central management of PPE for clinicians and social care (including the PPE stockpiles) remained in control of the DHSC. The DHSC and PHE (subsequently UKHSA) were responsible for guidance on the use of PPE for social care providers, as per their responsibility for social care policy.

4.108. On 18 March 2020, the Prime Minister held a meeting with local authority leaders to discuss their concerns about COVID-19. The Prime Minister's briefing indicated that care providers were concerned about supplies of PPE.[223] A slide pack produced by the MHCLG set out that all registered adult social care providers would be receiving masks by that week.[224] This, according to the DHSC's published guidance on 2 April 2020 (at Annex F of the guidance), was the free distribution of fluid repellent facemasks from the PIPP stockpile, where every care home and home care provider had received at least 300 facemasks, at time of publishing.[225]

4.109. The DHSC decided to establish a "Parallel Supply Chain" to take over the supply and distribution of certain key items of PPE, because of the increased demand for PPE that SCCL and established wholesalers were unable to supply.[226] The Parallel Supply Chain was responsible for sourcing PPE for all NHS Trusts and other health and

[220] SA/264 - INQ000564786
[221] SA/265 - INQ000182611
[222] SA/265 - INQ000182611
[223] SA/266 - INQ000183900
[224] SA/267 - INQ000564747
[225] SA/268 - INQ000325255
[226] SA/269 - INQ000512986; SA/270 - INQ000497031

social care bodies. The PPE procured by the Parallel Supply Chain was provided to the end users for free and was still available for free in England until the end of March 2024[227] or when stocks ran out (more than half of the different items were out of stock).[228]

4.110. Potential issues with the release of PPE to social care providers were raised at the onset of the pandemic. An email from the CCS on 20 March 2020, stated that social care "may be struggling to access" the PPE PIPP stockpile.[229] Distribution of PPE from the PIPP stockpile was a DHSC responsibility. At the HMIG on the same day, the DHSC reported that "A plan to give PPE to social care providers would be completed the following week.[230]

4.111. The Parallel Supply Chain was set up within the DHSC and was part of the 'COVID-19 PPE Plan' published by the DHSC on 10 April 2020.[231] The PPE Plan was requested by the Prime Minister's Office.[232] It was produced by the DHSC in consultation and cooperation with the devolved governments.[233] The PPE Plan was discussed at the HMIG on 9 April 2020 and presented to the COVID-19 Strategy Ministerial Group Meeting (9:15 C-19 Strategy meeting) on 10 April 2020[234] before it was published later that day. The goal of the Parallel Supply Chain was to obtain as much PPE as could be obtained to supply the entirety of the health and social care sector.

4.112. On 24 April 2020, the Prime Minister chaired a call with the Health Secretary, Cabinet Secretary and No.10 officials to discuss PPE, care homes and testing.[235] The readout from the meeting shows that the Prime Minister sought answers from the Health Secretary on a number of key issues which were: the supply of PPE to hospitals and care homes; the plan for the response to rising outbreaks in care homes including potentially implementing infection control measures, such as restricting movement of staff and rolling out regular asymptomatic testing for all staff and residents; and the ramping up of testing capacity.[236] At the meeting the Prime Minister "stressed that delivering adequate PPE to frontline staff was for him of paramount importance".

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[227] SA/271 - INQ000477955
[228] SA/272 - INQ000477954
[229] SA/273 - INQ000105492
[230] SA/274 - INQ000055934
[231] SA/275 - INQ000050008
[232] SA/276 - INQ000477921
[233] SA/277 -INQ000088660
[234] SA/278 - INQ000088663
[235] SA/279 - INQ000564750
[236] SA/280 - INQ000564751

4.113. The DHSC identified how much PPE was needed by the recipient and sent out regular deliveries of a predetermined mix of product types using a distribution partner, Clipper Logistics. These deliveries were made to hospitals, other NHS facilities and care homes. The DHSC was responsible for the distribution of PPE, which was managed on its behalf by the army (MoD).[237]

4.114. On 6 May 2020, a deep dive meeting with FSS on adult social care took place (which also reviewed the findings of the Adult Social Care Rapid Review as set out earlier in my statement).[238] The readout stated: "All providers were invited to submit a PPE capacity tracker to DHSC on a daily basis and this, alongside access to the National Supply Hotline, determined PPE supply to care homes. All providers had contact details for their LRF, allowing them to request emergency drops of PPE at 24 hours notice, including mutual support from the NHS. However, only 25% of providers had access to the Clipper Service and DHSC had not been given a timeline for when full access would be reached. The FSS said that we should confirm this urgently with Clipper".[239]

4.115. On 7 May 2020, the FSS sent the Prime Minister a note on care homes and nosocomial transmission. The note stated that on "PPE: the main issue is a shortfall of overall supply, but distribution remains an important factor. A clear target date is needed for the Clipper service to deliver PPE needs to 90-100% of care homes. DHSC undertook to provide one, but it has not yet been received".[240]

4.116. On 8 May 2020, the Health Secretary wrote to the Prime Minister outlining the DHSC's plans for an "intensive support package" for care homes to suppress infections.[241] On PPE, the letter stated that the DHSC were rolling out an e-portal for smaller care providers to access the Clipper distribution service in Cornwall and Devon. The letter stated that the Health Secretary planned to set milestones for rollout once demand was better understood.

4.117. On 14 May 2020, advice was provided to the Prime Minister titled 'Care Homes Covid Update'. The advice stated that access to PPE remained difficult for care homes. The rollout of the Clipper service was continuing but "in the absence of this service, we are asking care homes to in the first instance contact their usual supplier, and if needs be to then contact their LRF and then the National Disruption Supply Service

[237] SA/270 - INQ000497031
[238] SA/193 - INQ000088561; SA/194 - INQ000146701
[239] SA/211 - INQ000088555
[240] SA/199 - INQ000327877
[241] SA/281 - INQ000564753

in an emergency". The advice stated that the Prime Minister had already asked Lord Deighton[242] to assess "real level demand in social care and the consequences of under-provision", and in addition No.10 were to ask him "to set out a plan to simplify the distribution of PPE to care homes, and ensure access is equitable with the NHS".[243]

4.118. On 15 May 2020, the DHSC published the Care Home Support Package.[244] This announced that the DHSC was "testing and rolling out a PPE distribution portal to supplement normal supply chains to the care sector", and that over 2,300 social care providers would be invited to join the pilot by the end of that week.

4.119. On 21 May 2020, the DHSC provided an update on PPE to the Prime Minister. The slide pack and chair's brief from this meeting are exhibited.[245] The slides stated that "care homes are successfully sourcing PPE" and "several data sources confirm improving supply position" (these sources included the social care Capacity Tracker and interviews with 120 care homes). The slides stated the DHSC were to set up a Social Care PPE Intelligence Unit to "understand the state of Social Care PPE on an ongoing basis".[246]

4.120. A meeting on PPE was held with the Prime Minister on 22 May 2020 with Lord Deighton, officials from the DHSC, NHS and the Department for International Trade. The readout indicated that the Prime Minister was concerned about PPE supply in care homes. Lord Deighton "summarised that he is now confident that supply over the next 90 days meets newly modelled demand (which incorporates updated assumptions for social care usage and increased NHS non-covid activity)". The Prime Minister asked "whether care homes were using PPE correctly and purchasing sufficient quantities from private suppliers". Lord Deighton stated his team had "surveyed 120 providers and will now survey an additional 375, as well as working with the teams providing infection prevention and control guidance to care homes".[247]

4.121. A note was provided to the Prime Minister titled 'Care Homes COVID Delivery Update" on 1 June 2020 by No.10 and Cabinet Office officials. On PPE, the note stated that care providers would not be eligible for the £600 million Infection Control Fund "unless they are completing a regular online return of their key data (on cases,

[242] Lord Deighton was formally appointed on 12 May 2020 to lead the "PPE Taskforce" (having formerly been appointed as the Health Secretary's adviser on PPE in DHSC on 17 April 2020).
[243] SA/124 - INQ000564754
[244] SA/187 - INQ000564782
[245] SA/282 - INQ000564755; SA/283 - INQ000564756
[246] SA/285 - INQ000564756
[247] SA/284 - INQ000496842

staffing and PPE etc.) via the Capacity Tracker - an online reporting tool collated by NHSE". The note stated "Approximately 2% of care homes were reporting having less than two days' worth of PPE supplies. Work is ongoing to simplify and improve distribution of PPE supplies to the social care sector and care homes specifically".[248]

4.122. By the end of June 2020, the data showed that the PPE procured from March 2020 to June 2020 would meet or exceed the volume targets set by the DHSC. This was partly due to some NHS organisations and social care providers having continued to procure their own PPE directly (so called "leakage") which reduced demand for centrally purchased items.[249]

4.123. Advice was provided to the Prime Minister on 11 September 2020 by the CTF titled 'Uptick in cases in adult social care', which provided an update on the Government's plans to address increasing cases in care homes. On PPE, the advice stated as part of the actions of the Adult Social Care Winter Plan 2020/2021, "we have agreed to make PPE free for the remainder of the financial year. The mechanisms for provision are now in place, but detailed operational plans to provide this at scale and at pace need to be worked up".[250]

4.124. The Adult Social Care Winter Plan 2020/21 was published on 18 September 2020. The plan stated that the Government would: provide free PPE for COVID-19 needs in line with current guidance to care homes and domiciliary care providers, via the PPE portal, until the end of March 2021; and provide free PPE to LRFs who wish to continue PPE distribution, and to local authorities in other areas, to distribute to social care providers ineligible for supply via the PPE portal, until the end of March 2021.[251]

4.125. The DHSC published the PPE strategy on 28 September 2020.[252] Prior to publication, as part of a briefing on the Government's wider activity planned for the following week, the Prime Minister was informed that the DHSC's strategy set out "how they will move into a data-driven, mid-to-long-term structure to stabilise and build resilience in the PPE system. The DHSC will achieve this by increasing UK supply and strengthening distribution routes. The Strategy shows we have enough PPE to see us through to spring 2021 and, by November, 20% of PPE will be manufactured in the UK for the first time".[253]

[248] SA/285 - INQ000564757
[249] SA/270 - INQ000497031
[250] SA/286 - INQ000564759
[251] SA/122 - INQ000058216
[252] SA/287 - INQ000234522
[253] SA/288 - INQ000564776

4.126. In April 2021 it was announced that the provision of free PPE would be extended to March 2022, with this measure being included in the subsequent Adult Social Care Winter Plan 2021/22.[254] On 13 January 2022 the DHSC announced that free PPE would continue until 31 March 2023.[255]

Movement of staff

4.127. Movement of staff between locations was understood to be a cause of outbreaks of COVID-19 cases in care homes. Since the beginning of the pandemic, the Government was aware that most care home providers had been taking steps that minimised the movement of workforces, in order to reduce the risk of asymptomatic transmission of the virus between members of staff, and between staff and residents. In order to protect residents, restrictions were placed on the movement of staff during the relevant period as a method of infection control. The DHSC was responsible for social care policy on staff movement. I have provided an overview of development on the policy of staff movement where the Cabinet Office was sighted, or where decisions warranted collective agreement.

4.128. On 15 May 2020, the DHSC published the Care Home Support Package.[256] Amongst other measures, the package stated that providers should minimise staff movement between care homes to stop infection spreading between locations.

4.129. The Adult Social Care Winter Plan 2020/21 (published by the DHSC on 18 September 2020) set out that the extension of the Infection Control Fund would continue to support all providers to put in place measures to stop staff movement, and continue to support providers to pay staff who were self-isolating, in line with government guidance, their normal wages while doing so. Limitations on staff movement between care homes would be enforced through regulations focused on care home providers.[257] I have explained earlier in this statement how the Cabinet Office monitored delivery of this plan.

4.130. The 'COVID-19 Winter Plan' published on 23 November 2020 by the Cabinet Office stated that the Government was planning to introduce legislation that required care providers to restrict all but essential movement of staff between settings in order to reduce transmission.[258]

[254] SA/170 - INQ000086797
[255] SA/289 - INQ000564784
[256] SA/187 - INQ000564782
[257] SA/122 - INQ000058216
[258] SA/69 - INQ000137262

4.131. COVID-O met on 22 December 2020 to discuss staff movement amongst other adult social care issues. A slide pack was provided by the DHSC providing an update on cases in care homes. The pack also provided the result of a consultation with care home providers on the potential regulation of staff movement restrictions, in which 86% of respondents stated the policy would be difficult to implement.[259] The Minister for Care updated the committee that "the decision on restricting staff movement was not straightforward". The Capacity Tracker indicated that 9% of care homes still had some sort of staff movement happening. The vaccine rollout was, however, proceeding at pace in care homes. With high staff absences further restrictions would "put further pressure on providers". The DHSC was aware that the Infection Control Fund was being used to cover some elements of staffing costs (e.g. paying a premium to ensure staff worked in only one place). It was "less clear" whether it was being used to compensate staff so that they did not work with another employer.[260] COVID-O "agreed there was a clear and shared understanding of the need to stop staff movement between care homes to reduce the risk of transmission from the new strain of the virus and to meet the costs associated with it. The Committee agreed that the furlough scheme was not the right mechanism to deliver this and that the DHSC and HM Treasury should decide on an alternative approach by 30 December [2020], ready to implement in early January".[261]

4.132. On 11 January 2021 adult social care was discussed at COVID-O. It was agreed that the DHSC would prepare "a robust report on progress towards resolving the priorities identified by COVID-O, ready to report to the Prime Minister within the next week", including in respect of staff movement.[262]

4.133. In order to address staff shortages, on 17 January 2021, the DHSC announced a new £120 million fund for local authorities to boost staffing levels.[263] The CDL provided an update to the Prime Minister on 18 January 2021 confirming the announcement.[264] On 24 January 2021 the CTF provided a note to the Prime Minister which stated that staff absences were a major challenge faced by the social care sector. The note stated "To ease burdens, as you know, DHSC have decided to no longer ban staff movement between care settings". It is stated in the note that the £120 million fund was to address workforce gaps.[265]

[259] SA/290 - INQ000091085
[260] SA/154 - INQ000091133
[261] SA/155 - INQ000091096
[262] SA/157 - INQ000092263; SA/158 - INQ000092264; SA/291 - INQ000091793; SA/292 - INQ000091795; SA/161 - INQ000092262
[263] SA/293 - INQ000564794
[264] SA/162 - INQ000226655
[265] SA/294 - INQ000564767

4.134. On 29 January 2021 the Minister for Care wrote to the Prime Minister to update on staff movement between care homes. The note stated that, using the Capacity Tracker, it was estimated that the actual number of residential care staff moving between settings was 6,000 of a total of 665,000 or 1%. The DHSC consulted care providers in November 2020 on potentially introducing legislation to ban staff movement. As was updated to COVID-O in December, respondents were "largely opposed" to the proposal, with it being too difficult to implement or putting providers' ability to maintain safe staffing at risk. The Minister for Care stated that given the increasing problem of staff shortages, and the responses to the consultation, "we have focused on supporting staff supply and continued strong communications to tackle staff movement rather than taking forward the legislation".[266]

4.135. On 1 March 2021, guidance was published by the DHSC which stated care home providers should continue to limit routine staff movement between settings to help reduce the spread of COVID-19 infection.[267] During the rest of the relevant period the DHSC and PHE/UKHSA reviewed guidance provided on staff movement between care homes, updating the Cabinet Office as appropriate, for example, in response to the emergence of the Omicron variant in December 2021.[268]

Inequalities in relation to the social care sector

The Equality Hub

4.136. 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, and the fostering of 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.

4.137. This overarching duty applied to the work of the Cabinet Office on the COVID-19 response and equality considerations arose across aspects of the COVID-19 response.

4.138. The Equality Hub was the unit responsible for cross-government policy on disability, race and ethnicity, gender equality, LGBT rights and the overall framework of equality

[266] SA/295 - INQ000110579
[267] SA/296 - INQ000518390
[268] SA/297 - INQ000257179

legislation for the UK (Equality Act 2006 and Equality Act 2010). It was 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.

4.139. In September 2020, the Equality Hub brought together existing units that were originally situated in different government departments: the Race Disparity Unit (RDU), the Disability Unit (DU)[269] and the Government Equalities Office (GEO)[270], and later the Social Mobility Commission (SMC) secretariat.[271] These units had their own areas of policy responsibilities, with a Deputy Director responsible for each policy area.[272] Once brought together under the umbrella of the Equality Hub, the units shared operational functions. This included data and analysis, communications, operations and parliamentary/correspondence functions. The exception to this was the SMC secretariat which had separate operational functions to maintain independence, as it reported to independent commissioners rather than ministers[273]. Deputy Directors within the Equality Hub reported directly to its Director, Marcus Bell. In October 2024 the Equality Hub was renamed the Office for Equality and Opportunity.

4.140. Responsibility for other policies related to equalities issues (including understanding the equality impacts of all policies) usually sit with the relevant government department. The Equality Hub did not have the capacity to engage on every issue but became involved on cross-cutting issues, or where an issue was a priority for No.10 or equality ministers. Priorities were reviewed with No.10 and equality ministers[274].

4.141. Individual government departments are responsible for understanding the equality impacts of their own policies through compliance with the PSED. The Equality Hub during the pandemic did not not routinely review or monitor other government departments' equality impact assessments or their approach to PSED[275].

4.142. The Equality Hub's key workstreams in relation to the COVID-19 response were related to ethnicity, disability and data and analysis[276]. More specifically, the Equality Hub's principal areas of involvement in COVID-19 were considering the

[269] 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
[270] GEO transferred from the Department for Education (DfE) in April 2019.
[271] The SMC secretariat transferred from DfE in April 2021 to be part of the Equality Hub.
[272] SA/298 - INQ000083932
[273] SA/299 - INQ000198850/2-3
[274] SA/299- INQ000198850/8
[275] SA/299- INQ000198850/8
[276] SA/299 - INQ000198850/1

disproportionate impact on ethnic minority people and the production of Covid Disparities Quarterly Reports; improving disability data; vaccine certification and exemptions; advice to departments on PSED and Equality Impact Assessments; understanding the impact on women; and providing general, ad hoc advice[277].

4.143. 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 to feed equality data, research and analysis into 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.

4.144. Data collection, research, and analysis about the way in which COVID-19 was impacting various groups, were 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[278].

4.145. 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 (reports outlined below). The working group membership consisted of health analysts from the main departments and organisations including DHSC, 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[279].

4.146. Most of the Equality Hub's analysis and research activities were focused on the impact of COVID-19 on ethnic minorities and disabled people[280]. Race and ethnicity research was centred around the Covid Disparities Quarterly Reports. This research 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

[277] SA/299 - INQ000198850/16
[278] SA/299 - INQ000198850/38-40
[279] SA/299 - INQ000198850/42-43
[280] SA/299 - INQ000198850/39

engagement with colleagues in other government departments[281].

Quarterly reports on progress to address inequalities in relation to COVID-19

4.147. In June 2020, following the publication of the PHE report 'Covid-19: review of disparities in risks and outcomes', the Prime Minister and Health Secretary asked the Minister for Equalities to lead cross-government work to address the PHE report's findings. The PHE report found that COVID-19 had replicated "existing health inequalities and, in some cases, has increased them", with a "particularly high increase" in all-cause deaths of those in a "range of caring occupations including social care and nursing auxiliaries and assistants".[282]

4.148. Under the terms of reference for this work[283], 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,[284] 26 February 2021,[285] 25 May 2021,[286] and 3 December 2021[287]. In October 2020, the Equalities Minister also appointed two independent advisers to: assist with the review of Covid-19 health disparities for ethnic minorities[288]; provide medical and epidemiological expertise; review and advise on the Covid-19 disparities project,[289] and quality assure the four quarterly reports. The quarterly reports were also informed by input from other government departments and wider stakeholder meetings. I have summarised these Quarterly Reports where relevant to the social care sector.

4.149. The first quarterly report was published on 22 October 2020 and updates on the Government's response to the recommendations in the June 2020 PHE report. These actions, where relevant to social care, were:

4.149.5. The report stated that "DHSC, working with NHS England and NHS Improvement (NHSEI) and NHSX/NHS Digital, is committed to improving the quality and completeness of ethnicity data collection in NHS and adult social care data sets". The report stated that work was underway to increase the representativeness of the adult social care surveys on users

[281] SA/299 - INQ000198850/39
[282] SA/300 - INQ000101218
[283] SA/301 - INQ000089741
[284] SA/302 - INQ000089742
[285] SA/303 - INQ000089744
[286] SA/304 - INQ000089776
[287] SA/305 - INQ000089747
[288] SA/306 - INQ000492283
[289] SA/307 - INQ000083926

and carers' ethnicity, and that "DHSC and key external stakeholders are developing a client-level dataset to record activity data, and it is proposed that local authorities record data on ethnicity using the ONS 2011 18+1 ethnicity categories.";

4.149.6. The report stated that the National Institute for Health Research (funded by DHSC) "announced in July 2020 funding of £4.3 million for 6 projects investigating the association between ethnicity and COVID-19 incidence and adverse health outcomes" with proposals for such projects having a focus on groups "who may be more vulnerable, such as frontline health and social care staff";

4.149.7. The report stated the publication of the DHSC's Adult Social Care Winter Plan 2020/21 (which I have referenced earlier in my statement) had put into practice "the recommendations of the Social Care Sector COVID-19 Support Taskforce, including input from a black, Asian and minority ethnic advisory group". According to the report the DHSC were also "committed to developing and implementing a Workforce Race Equality Standard (WRES) for adult social care which will require employers to demonstrate progress against indicators of workforce race equality, akin to NHS's WRES"; and,

4.149.8. The DHSC had issued a Risk Reduction Framework for employers, in response to "urgent demand from the sector for guidance to be put in place for reducing the risk to staff at higher risk".[290]

4.150. The second quarterly report was published on 26 February 2021. I have summarised the actions taken in relation to adult social care:

4.150.5. On 4 January 2021 the Minister for Equalities met with the BAME Communities Advisory Group (representing the adult social care sector) to consider their report on the impact of COVID-19 on ethnic minority people in receipt of social care services or working in the social care sector.[291]

4.150.6. The report stated the WRES in social care would be initially implemented in 18 local authority social work departments from April 2021. The standard would require organisations to demonstrate progress against indicators of

[290] SA/308 - INQ000086832
[291] SA/299 - INQ000198850

workforce race equality.[292]

4.151. The third quarterly report was published on 25 May 2021. I have summarised the actions taken in relation to adult social care:

4.151.5. The Minister for Equalities met with representatives from the BAME Communities Advisory Group to discuss vaccine uptake among those working in adult social care.

4.151.6. In March 2021, DHSC commissioned the CTF Field Team in the Cabinet Office to undertake a review of the experiences of frontline healthcare workers during the first wave of the pandemic. DHSC were to analyse the results of the review and consider how these could be applied. The result of this review is exhibited[293];

4.151.7. Initiatives to drive up vaccination rates in social care workers included: opening the National Booking Service to all social care workers in February 2021, allowing easy access to booking vaccinations; conducting a 4-visit cycle to all older adult care homes in England, maximising opportunities for vaccination access across the country (resulting in 82.6% of staff and 95% of all residents in older adult care homes having received at least one dose of the vaccine); and a webinar with frontline adult social care workers was conducted, tackling misinformation about vaccination.[294]

4.152. The fourth quarterly report was published on 3 December 2021. I have summarised the actions taken in relation to adult social care:

4.152.5. The report summarised the changing understanding on risk factors in the UK as the available data and analysis evolved during the pandemic. The report stated that the understanding of COVID-19 risk factors for care home residents during the first and second waves was that the "early analysis of deaths concentrated on private households. Subsequently, data on deaths in care homes became available. Analysis of data including care home residents shows that after adjusting for residence type, the risk of dying from COVID-19 for all ethnic minority groups increased or remained similar (compared with the risk when not controlling for residence type)."

4.152.6. The report stated that disabled people in England had an increased risk of

[292] SA/303 - INQ000089744
[293] SA/309 – INQ000565851
[294] SA/304 - INQ000089776

mortality involving COVID-19 compared to non-disabled people. The report stated that there were explanations for this, such as that disabled people were more likely to be infected as a result of contact in care homes or with carers (between 20 March 2020 and 15 January 2021, care home residents accounted for 33% of all COVID-19 deaths in England), or may experience barriers in accessing care.

SECTION 5: INTERNAL REVIEWS AND LESSONS LEARNED EXERCISES

5. 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.

5.1. It is important to note:

5.1.5. 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".[295] 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 of the Civil Service Strategy Unit.

5.1.6. The learning of lessons more specific to the COVID-19 response was an important feature of the work, for example, of the CTF.[296] I provide some examples below.

[295] SA/310 - INQ000137267/1
[296] SA/237 - INQ000248852

5.1.7. It was the role of DHSC to ensure that specific lessons about the social care sector to COVID-19 were identified and learned.

5.2. 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.[297] The findings from the final report were summarised in a slide pack,[298] and in a note to the Cabinet Secretary and Permanent Secretary, Alex Chisholm.[299] The findings of the Innovations and Lessons Learned project have since contributed to work on Civil Service reform led by what is now called the Civil Service Strategy Unit.

5.3. 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 comprehensive. For example, the DHSC did not contribute to the Project.[300] The findings outlined below are therefore lessons learned at a high-level for the whole of government, rather than specific lessons learned on the adult social care systems response. This is consistent with the Cabinet Office not having a role in day-to-day decisions on the delivery of social care services.

5.4. 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[301] 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.

5.5. 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

[297] SA/311 - INQ000180306
[298] SA/312 - INQ000180305
[299] SA/313 - INQ000180304
[300] SA/313 - INQ000180304/1
[301] SA/314 - INQ000280034

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.

6. ANNEX A: CABINET OFFICE DECISION MAKING STRUCTURES

Governance structures: The first stage (up to 15 March 2020)

6.1. When 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 Cabinet Manual explains that COBR, run by the Civil Contingencies Secretariat (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."

6.2. The CCS Director chaired the first cross-government ad hoc senior officials meeting on the novel coronavirus on 17 January 2020.[302]

6.3. The first ministerial COBR meeting was on 24 January 2020. From that date, the CCS, with contributions from relevant government departments, circulated a Commonly Recognised Information Picture (CRIP) on the coronavirus.

6.4. The first discussion of the novel coronavirus at a formal Cabinet meeting was on 31 January 2020. COVID-19 was considered at further Cabinet meetings during the first stage. The Cabinet Secretary (Mark Sedwill at the time) was the senior official for Cabinet.

6.5. From 4 February 2020, 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 governments.

Governance structures: The second stage (Mid-march - 27 May 2020)

[302] The minutes and actions are at SA/61 - INQ000097687, SA/62 - INQ000097689 and SA/63 - INQ000097688

6.6. As the scale of the crisis grew, 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).

6.7. During this stage, a daily 9:15 C-19 Strategy meeting of key ministers, officials and advisers chaired by the Prime Minister was the key forum for oversight of all issues and strategy.[303] At each 9:15 C-19 Strategy meeting: the COVID-19 Dashboard was presented; there were discussions of priority issues; and, a standing item covered the daily communications narrative and press conference. The Senior Secretary was Mark Sweeney.[304]

6.8. Following advice to the Prime Minister, four new Ministerial Implementation Groups (MIGs) were established to lead the Government's key lines of operation during this stage.[305] These MIGs had the status of Cabinet committees and took collective decisions. The MIGs reported into the 9:15 C-19 Strategy meetings and were each chaired by a different Cabinet minister. These structures were announced to the public via a press notice published on gov.uk on 17 March 2020.[306] The MIGs remained in place until late May 2020.

6.9. The four MIGs 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).

6.10. 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".[307] The Chair was the Health Secretary. The Deputy Chair was the Secretary of State for Housing, Communities, and Local Government. Relevant ministers from the devolved

[303] 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 C-19 Strategy meetings and the Quads.
[304] 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
[305] SA/315 - INQ000087166. The Terms of reference for each MIG are at: SA/316 - INQ000087167
[306] New government structures to coordinate response to coronavirus: 17 March 2020; available here: SA/317 - INQ000086849
[307] Terms of reference for each MIG SA/316 - INQ000087167

governments were invited to HMIG meetings as required. The Senior Secretary for the HMIG was Simon Ridley. I set out a summary of all HMIG meetings and topics discussed, elaborating on social care issues where relevant to Module 6:

6.10.5. 18 March 2020[308] - Three topics were discussed: Introduction and objectives of the committee, the shielding policy, and social care funding and the discharge process. The actions state that following discussion on the last item, "due pace would be given to discharging patients from hospital" supported by an "injection of new funding" to CCGs and local authorities. This was announced by the DHSC and MHCLG on 19 March 2020[309];

6.10.6. 20 March 2020[310] - The topics discussed were: an update on the Dashboard, shielding measures (implementation and key risks) and supermarket support for shielded people. It was noted in the minutes that "a plan to give PPE to social care providers would be completed the following week";

6.10.7. 22 March 2020[311] - Topics discussed were: an overview of the overall strategic approach to the pandemic by the CMO, a three-month healthcare strategy to tackle COVID-19 presented by DHSC and options for enforcing legislation requiring the closure of specified businesses and other venues during the coronavirus emergency. The actions of the meeting related to social care were: DHSC to undertake additional work on metrics for adult social care capacity and resilience; and, DHSC and NHSX to consider further metrics on adult social care bed and care package capacity to support discharges through to the care sector;

6.10.8. 24 March 2020[312]- Topics discussed were: the HMIG action tracker, healthcare supplies, and the support offer for the extremely vulnerable on medical grounds;

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[308] SA/318 - INQ000055919; SA/83 - INQ000055939; SA/85 - INQ000055912; SA/319 - INQ000055917; SA/320 - INQ000055918; SA/321 - INQ000055914; SA/322 - INQ000055916; SA/323 - INQ000055915
[309] SA/86 - INQ000564800
[310] SA/324 - INQ000055946; SA/325 - INQ000055935; SA/274 - INQ000055934; SA/326 - INQ000055940; SA/327 - INQ000055920; SA/328 - INQ000055924; SA/329 - INQ000055923; SA/330 - INQ000055947
[311] SA/331 - INQ000055941; SA/332 - INQ000055945; SA/88 - INQ000055942; SA/89 - INQ000055937; SA/333 - INQ000055927; SA/334 - INQ000055926; SA/335 - INQ000055925
[312] SA/336 - INQ000055929; SA/337 - INQ000055938; SA/338 - INQ000055943; SA/339 - INQ000055944; SA/340 - INQ000055931; SA/341 - INQ000055928

6.10.9. 31 March 2020[313] - Topics discussed were: updates on actions, shielding progress update, and coordination of volunteering efforts for the healthcare system. In regard to the last item, it is noted in the minutes that "the NHS had written out to all hospitals, GPs and pharmacies to ask them to register on the platform. Some volunteers could be used in roles as part of Project Nightingale. The NHS and the Department for Health and Social Care were working to develop other roles where volunteers could be used, such as in supporting those with social care needs". An action was given to DHSC and the NHS to "explore development of other roles within the NHS or social care to increase demand for volunteer support (e.g. rapid training to provide basic care)";

6.10.10. 2 April 2020[314] - Topics discussed were: ensuring a consistent UK-wide approach to COVID-19 and an update from DHSC on meeting public sector demand for PPE;

6.10.11. 7 April 2020[315] - Topics discussed were: an adult social care system readiness update presented by DHSC, an update on delivery of shielding support presented by MHCLG and the health impacts of social distancing policy. The update from DHSC can be summarised in the following points:

6.10.11.1. Work on collection of data to provide a clear picture of the state of the care home system had moved at pace with 70% of care homes being present in the NHS England Capacity Tracker.

6.10.11.2. The Secretary for State for Housing, Communities and Local Government and Minister of State for Care would take forward work to encourage leavers from social care professions to return to work during the pandemic.

6.10.11.3. Ensuring data reporting compliance from all care home providers was a priority.

6.10.11.4. The number of patients in hospital with a stay over 21 days had halved, so the "work on discharges was welcome".

[313] SA/342 - INQ000083629; SA/343 INQ000083700; SA/344 - INQ000083690; SA/345 - INQ000083628; SA/346 - INQ000083627; SA/347 - INQ000083685
[314] SA/348 - INQ000083689; SA/344 - INQ000083690; SA/349 - INQ000083632; SA/350 - INQ000083701; SA/351 - INQ000083636
[315] SA/97 - INQ000083693; SA/95 - INQ000083637; SA/98 - INQ000083640; SA/99 - INQ000083638; SA/100- INQ000083633; SA/101 - INQ000083639; SA/96 - INQ000083702; SA/102 - INQ000083694

6.10.11.5. Financial resilience of the care sector was vital to keep enough capacity in the NHS to deal with any potential uplift of admissions. The MHCLG and HMT were to work to "ensure cash flow issues in some lower-tier authorities did not disrupt provision of social care".

6.10.12. 9 April 2020[316] - Topics discussed were: expansion of swab testing for key workers and the plan for PPE. The minutes noted that "the social care sector was facing increasing numbers of staff in isolation, and would therefore need to be tested at the same levels as NHS staff". It was agreed at the meeting that DHSC's model for testing prioritisation would be used as follows: "a) patients in the Priority 1 category b) key health and social care staff c) wider group of key workers d) mass population testing."

6.10.13. 15 April 2020[317] - Topics discussed were: the NHS Volunteer Responders Programme and health impacts of social distancing presented by DHSC. The minutes noted that the R number "was less clear in hospital or residential care settings, but was likely to be higher than it was in the community";

6.10.14. 17 April 2020[318] - Topics discussed were: a review of actions and updates from the last meeting, the Dashboard, an update on shielding from MHCLG and an oral update on volunteering from the Health Secretary;

6.10.15. 1 May 2020[319] - Topics discussed were: a paper on 'Test, Trace and Certify' presented by DHSC and a shielding update from MHCLG;

6.10.16. 7 May 2020[320] - Topics discussed were: a review of actions and updates from the 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

[316] SA/352 - INQ000083643; SA/353 - INQ000083645; SA/354 - INQ000083647; SA/355 - INQ000083704; SA/356 - INQ000083705; SA/357 - INQ000083644
[317] SA/358 - INQ000083649; SA/359 - INQ000083655; SA/360 - INQ000083650; SA/361 - INQ000083706; SA/362 - INQ000083695
[318] SA/363 - INQ000083659; SA/364 - INQ000083661; SA/365 - INQ000083663; SA/179 - INQ000083660; SA/366 - INQ000083658
[319] SA/367 - INQ000083667; SA/368 - INQ000198077; SA/369 - INQ000083665; SA/370 - INQ000083707; SA/371 - INQ000083670
[320] SA/372 - INQ000083673; SA/373 - INQ000083671; SA/374 - INQ000083698; SA/375 - INQ000083677

6.10.17. 26 May 2020[321] - a paper on Test and Trace presented by DHSC was discussed.

6.11. The other three MIGs were: the General Public Services Ministerial Implementation Group (GPSMIG), 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), set up to "coordinate and advise on business-related regional, sectoral and corporate-level issues relating to the C-19 pandemic"; and the International Ministerial Implementation Group (IMIG), 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. WHO, IMF, World Bank) organisations. I exhibit the chronologies previously provided by the Cabinet Office to the Inquiry for these MIGs[322].

6.12. Ministerial COBR meetings continued to review overall progress and make important decisions in this stage. This was the key forum to take strategic decisions on issues including Non-Pharmaceutical Interventions (NPIs). Meetings in this stage were, therefore, usually chaired by the Prime Minister.

6.13. Formal Cabinet meetings discussed COVID-19 on a weekly or other frequent basis during the 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.

Governance structures: The third stage (from 28 May 2020)

6.14. By early May 2020, the UK had passed the initial peak of the COVID-19 pandemic. The Government published the first Roadmap out of lockdown on 11 May 2020.[323] Consideration was given to how best to manage ministerial governance and decision-making structures given the likely longevity of the pandemic and government response.

6.15. On 22 May 2020, Simon Case, then Permanent Secretary in No.10 responsible for COVID-19, and Helen MacNamara, the Deputy Cabinet Secretary, submitted

[321] SA/376 - INQ000083680; SA/377 - INQ000083681; SA/378 - INQ000083682; SA/379 - INQ000083699; SA/380 - INQ000083683
[322] SA/381 - INQ000113575; SA/382 - INQ000113576; SA/383 - INQ000113578
[323] Our plan to rebuild: The UK Government's COVID-19 recovery strategy; 11 May 2020; SA/384 - INQ000089917, pages 22-29

advice[324] to the Prime Minister recommending more sustainable and streamlined governance structures, with clearer and more focused lines of accountability. These changes were agreed by the Prime Minister and communicated to Heads of Department across government on 28 May 2020.[325] I now briefly summarise each aspect of this third stage of governance.

6.16. COBR continued to meet periodically during this stage, particularly where issues required cross-UK action. An update on COVID-19 also continued to be taken at each weekly meeting of Cabinet.

6.17. 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.

6.18. 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, the SoS for the Home Department, the CDL, the Health Secretary, and the SoS for BEIS. According to its Terms of Reference, COVID-S was set up "to drive government's strategic response to COVID-19, considering the impact of both the virus and the response to it, and setting the direction for the recovery strategy". The meetings ran between 4 June 2020 and 21 February 2022, setting in place the overarching COVID-19 strategy, and meeting at key strategic junctures in the response to the pandemic.

6.19. 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 ToR,[326] COVID-O was set up "to deliver the policy and operational response to COVID-19." The meetings ran between 29 May 2020 and 29 March 2022. Meetings often started with data and science briefings either from the Dashboard team or key experts. The

[324] 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/385 - INQ000137221; SA/386 - INQ000137222.
[325] SA/387 - INQ000087165
[326] 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 at SA/388 - INQ000184027, and also the process for managing and running the Committee at SA/389 - INQ000087169.

devolved governments were invited to meetings where a UK-wide approach was needed, for example on border measures and vaccination.

6.20. Both COVID-S and COVID-O were supported by official-level meetings, chaired by a senior official in the CTF, depending on the policy area being discussed. In September 2022, COVID-S and COVID-O were formally stood down.

Additional relevant Cabinet committees during the Module 6 period

6.21. At various times during the period relevant to the scope of Module 6, there were additional Cabinet committees with remits that included social care as part of broader decision-making[327]. These included:

6.21.5. 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.

6.21.6. 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 chaired by the Health Secretary.

6.21.7. The Domestic and Economic (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.

6.21.8. 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 priorities through stock takes on: levelling-up; education; jobs and skills; health and care; crime and justice; and, net zero.

The COVID-19 Taskforce (CTF)

[327] SA/171 - INQ000089797

6.22. 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 necessarily been built at speed. It made sense to streamline these operations as the Government moved from the acute to the chronic phase of the crisis. The new CTF was formed in May 2020 and operated until March 2022. Other COVID-19 teams were ended, so that many staff were able to return to their previous roles.

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

6.24. The CTF led the official advice in the centre of government to the Prime Minister, CDL and other ministers on the development and delivery of the 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 CTF also ran the government's COVID-19 Cabinet Committees. Officials in the CTF worked very closely with No.10 colleagues and with other government departments, most particularly DHSC and HMT, and experts, such as the CMO and GCSA.

6.25. The CTF 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).

6.26. The CTF coalesced over the summer of 2020. To meet the challenges of developing the Government's ongoing response and enabling the decision making required, the CTF 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.

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

6.28. Simon Case was appointed the Cabinet Secretary in September 2020. Simon Ridley and Kate Josephs led the CTF until James Bowler was appointed Second Permanent Secretary in the Cabinet Office with responsibility for leading the CTF from October 2020. Kathy Hall joined the CTF in October 2020 ahead of Kate

Josephs leaving in December 2020 for a new role. Rob Harrison joined the CTF 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 CTF senior leadership until July 2021.

6.29. 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 CTF 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). The CTF was stood down in March 2022.[328]

Strategic leadership and coordination

6.30. 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[329].

6.31. The CTF provided a coordination function to deliver a number of key announcements through the pandemic, working closely with the cross-government COVID-19 communications hub. The CTF also coordinated and published guidance to the public and businesses across the breadth of the pandemic response.

6.32. The CTF also led coordination and engagement across government and with the devolved governments.

Data and Analysis

6.33. During the summer and autumn of 2020, the relevant data and analysis teams in the Cabinet Office were progressively merged into a single entity within the CTF. This worked especially closely with DHSC, the Joint Biosecurity Centre, the ONS, HMT and the secretariats of SAGE and its sub-groups. This sought to ensure that the analytical effort across government and commissions to SAGE and its sub-groups were coordinated and aligned to the needs of policy development and

[328] SA/4 -INQ000092893/39-41
[329] Examples of government strategies supported by the CTF include: the November 2020 'COVID-19 Winter Plan', 'COVID-19 Response - Spring 2021 (Roadmap)' and 'COVID-19 Response: Autumn and Winter Plan 2021'.

decision-making. As part of this, in the summer of 2020, the CTF took on responsibility for running the Dashboard.

6.34. The CTF equipped decision makers with a single analytical picture that included the health, economic and societal impacts of COVID-19, as well as considering international comparators. Much (though not all) of the primary analysis was done by others; the unique contribution of the CTF was to commission and integrate the inputs into a single analytical picture.

6.35. Regular (often daily) Dashboard briefings to the Prime Minister had originally been led by the Civil Contingencies Secretariat from mid-March 2020 and were continued by the CTF. The meeting would typically also involve other senior ministers (CDL, Chancellor, Health Secretary and others as required) along with the CMO, GCSA, head of Test and Trace and JBC, and senior officials and advisers from No.10, the CTF, HMT and DHSC. These meetings complemented the policy-making process by developing a shared understanding of the data picture as it developed and building familiarity with the key indicators and trends. The Prime Minister also used dashboard meetings to ask questions and request follow-up briefing.

Delivery and development of policy

6.36. The Government's response to COVID-19 was a whole-of-government effort which evolved over time according to the path of the pandemic and continuously weighed the pandemic's health, economic and social impacts. The unique role of the CTF was to ensure the Prime Minister and other Ministers were equipped with rounded advice on the balance of these impacts. The CTF coordinated across departments to join up the response, bring stakeholders together, manage collective agreement and apply lessons learnt from each event to the next.

6.37. The CTF had a number of focused teams, including on health and adult social care (as described in Section 4), that worked with other departments on a range of areas in response to the pandemic. 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. 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, and aligned with the wider government strategy.

6.38. Areas covered by these teams changed over time according to the nature of the Government's response. Areas covered for significant periods of the response include the following (listed alphabetically): business and the economy; compliance and enforcement; disproportionately impacted groups; 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.

Meetings outside the ministerial committee structure

6.39. 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 social care.

6.40. 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.

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

6.41.5. **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 CMO and 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 C-19 Strategy meeting between 17

March and 15 May 2020. Subsequently, as the CTF was formed, the daily meeting evolved further into the Dashboard meeting.

6.41.6. **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 Health Secretary usually attended and at times, other ministers were present;[330]

6.41.7. **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;

6.41.8. **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;

6.41.9. **'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, testing and vaccines.

6.41.10. **International engagement**: The Prime Minister carried out a range of meetings within government and internationally to support his international engagement on COVID-19.

7. ANNEX B: RELATIONSHIP WITH OTHER BODIES

[330] As was the case with the daily 9:15 C-19 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.

7.1. I have provided a brief summary of the relationships the Cabinet Office had with other key organisations, but this is not intended to be an exhaustive account of all interactions or meetings with these bodies during the relevant period.

7.2. As set out in the executive summary of this statement, the Cabinet Office sits at the centre of government (sometimes referred to as 'the centre', and which also comprises HMT). The Cabinet Office 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.

7.3. HMT is the government's economic and finance ministry and contributes to Cabinet-level decision-making through the Chancellor. The Cabinet Office worked closely with HMT throughout the pandemic. As is normal, the Prime Minister and Chancellor had regular bilateral meetings, prepared by officials in No.10 and HMT, to discuss the pandemic, its implications for the economy and the government's response.

7.4. The DHSC is the government department with "oversight of health and social care policy".[331] DHSC is supported by two executive agencies, UKHSA (and its predecessor bodies, including PHE) and the MHRA, as well as partner organisations such as NHS England. The Cabinet Office worked extensively with the DHSC (including the Social Care Sector COVID-19 Support Taskforce, led by Sir David Pearson) and its agencies throughout the COVID-19 pandemic, as detailed within this statement.

7.5. The Cabinet Office regularly invited MHCLG ministers to Cabinet committees, as set out throughout this statement, and worked closely with the department at official level. MHCLG worked with the DHSC due to its significant role in relationships with the local authorities which commission and deliver some adult social care.

7.6. The devolved governments are the Scottish Government, the Welsh Government and the Northern Ireland Executive. The Cabinet Manual states that health and social care are devolved to the respective legislatures and administrations in Scotland, Wales

[331] SA/390 - INQ000421042

and Northern Ireland.[332] During the COVID-19 pandemic, devolved leaders were routinely invited to relevant committees or collective agreement forums.

7.7. The Local Government Association (LGA) is the national membership body for local authorities in England and Wales. Roundtables would be held occasionally with LGA leaders (e.g. on 18 March 2020 with the Prime Minister)[333] however the MHCLG primarily managed this relationship. The LGA was interviewed as part of the rapid review into adult social care conducted between 30 April and 4 May 2020 by the CCS and PMIU.[334]

7.8. The Association of Directors of Adult Social Services (ADASS) is a membership organisation for those working in adult social care. The DHSC, being responsible for social care policy, primarily engaged with ADASS and updated the Cabinet Office where appropriate. There were occasionally exceptions to this where the Cabinet Office engaged directly with ADASS. For example, the 18 March 2020 roundtable held with the Prime Minister[335], and the rapid review into adult social care conducted between 30 April 2020 and 4 May 2020 which included interviews with large care providers including ADASS[336].

7.9. Given that social care is devolved, the Cabinet Office's involvement with the Care Inspectorate in Scotland, the Regulation and Quality Improvement Authority in Northern Ireland, and Care Inspectorate Wales was limited. The Cabinet Office did, however, interact with the CQC via the DHSC, due to the department's responsibility for social care policy. For example the CQC would regularly provide data and information via the DHSC to assist decision making in COVID-O meetings, such as on the delivery of the Adult Social Care Winter plans.

7.10. Skills for Care is the strategic body for adult social care workforce development in England. The CDL met with the Chief Executive of Skills for Care, Oonagh Smyth, on 12 October 2021. The readout from that meeting is exhibited.[337]

[332] The Cabinet Manual sets out the main laws, rules and conventions affecting the conduct and operation of government. SA/5 - INQ000182315/63-64
[333] SA/266 - INQ000183900; SA/391 - INQ000564746
[334] SA/191 - INQ000564732
[335] SA/391 - INQ000564746
[336] SA/191 - INQ000564732
[337] SA/392 - INQ000564717

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: 27 February 2025