The UK Covid-19 Inquiry

Written opening statement of the British Medical Association (BMA) on Module 4

Introduction

1. The BMA is grateful for its designation as a core participant in Module 4 and for the opportunity to contribute to the Inquiry's work in this module. The Chair and Inquiry team will be familiar, from the BMA's engagement as a core participant in Modules 1, 2 and 3 of the Inquiry, with the nature and aims of the organisation, and with the BMA's submissions in previous modules. However, in brief, the BMA is the professional association and trade union for doctors in the UK and has a membership of over 195,000 doctors and medical students. It advocates for outstanding healthcare and a healthy population; provides members with individual services and support throughout their lives; and as a trade union, is formally recognised for collective bargaining purposes at a UK, national and local level.

2. The overwhelming priority of the BMA's members is to ensure that they provide patients with the best possible care and treatment and in a way that is safe for them to do so. The issues raised in this statement, and elsewhere in the Inquiry proceedings, are all ultimately for the purpose of achieving this goal. The BMA's mission statement is, "We look after doctors so they can look after you".

3. The BMA views the COVID-19 vaccination programme as one of the biggest successes of the pandemic response. This is in large part due to the immense efforts of doctors, particularly GPs and their practice teams, the wider healthcare workforce and volunteers.

4. The unprecedented scale of the vaccination programme saved millions of lives globally. A study by the World Health Organization (WHO) found that countries who implemented vaccination programmes early – such as the UK – saw the greatest benefit in terms of number of lives saved overall through vaccination. In the UK, it is estimated that COVID-19 vaccination reduced mortality by 70% in adults aged 25 and over (INQ000472218).

5. Vaccination changed the context of the pandemic and allowed governments to move towards reopening society as COVID-19 became less of a risk for most of the population.

6. However, the UK's vaccination effort was not without its challenges. In this statement the BMA seeks to highlight certain aspects of the vaccination programme that were less

successful and/or posed significant challenges for the doctors and healthcare workers involved in delivering the programme, and to identify where there is learning for the future. This opening statement addresses the following broad areas:

a. the significant efforts of, and impact on, GPs and other healthcare workers in delivering mass vaccinations at pace, alongside caring for both COVID and Non-COVID patients;

b. the protection of frontline healthcare workers through vaccination, and vaccination as a condition of deployment; and

c. vaccine uptake among vulnerable and marginalised groups.

7. Despite the challenges outlined in this statement and in the BMA's Module 4 evidence to the Inquiry, GPs and their teams went above and beyond to deliver the majority of vaccinations within the vaccination programme in England. They also delivered at a phenomenally low cost to the public purse.

Across the UK, GPs, their practice teams, other healthcare workers and volunteers ensured the vaccination programme's success

8. The vaccination programme was, to a very large extent, delivered by doctors and other healthcare professionals. All four UK nations took a mixed-delivery approach, using a large network of vaccination sites including hospital hubs, GP surgeries, pharmacies, and mass vaccination centres.

9. The rollout was delivered with staff and volunteers working many additional hours to deliver the programme alongside a range of other demands. By the end of 2021, retired doctors wishing to return to service in England were encouraged to volunteer to help with the vaccination effort, whether administering jabs or assisting in consenting patients for vaccination.

10. General practice had a key role to play in the successful rollout of the vaccination programme and delivered a large portion of the vaccines alongside COVID and non-COVID care. By the end of October 2021, 71% of vaccines in England had been administered by GPs and their teams and community pharmacies, compared with 21% by vaccination centres and the remaining 8% in hospitals or other settings.

11. The BMA proactively made the case in England that the COVID-19 vaccination should be delivered by GP practices rather than a separate organisation, given the expertise of GP

practices in delivering vaccinations, such as the annual flu vaccination programme; their proximity to local populations; and their ability to respond to any concerns regarding vaccination. Vaccinations delivered by GPs were ultimately delivered at a much lower cost at £24 per dose in GPs and community pharmacies, compared to £34 per dose at vaccination centres.

12. As of Spring 2024, 47% of vaccines in Northern Ireland had been delivered by GP practices, 43% delivered by health and social care trusts, and 10% delivered by the pharmacy sector.

13. In Wales, health boards were formally responsible for delivery of the COVID-19 vaccination programme. By July 2021, COVID vaccinations were being delivered at 51 GP practices according to Welsh Government data.

14. In Scotland, vaccinations were also the responsibility of health boards. The BMA Scotland GP committee agreed in November 2020 that GPs would not be the default delivery channel for vaccinations due to the need to maintain good IPC and appropriate physical distancing measures, which would be constrained by the capacity of general practice. Data from Public Health Scotland shows that of the 13,078,041 vaccinations administered in Scotland (up to June 2022), over two thirds (69%) of all vaccine doses administered were delivered using either mass or community vaccination centres. General practice, despite not being the default delivery channel, administered the second largest proportion of doses (12.7%).

15. GPs were also involved in efforts to increase vaccine uptake amongst their patients. Some GPs, with the support of their Clinical Commissioning Groups (CCGs), contacted individual patients from many of the at-risk groups personally about the vaccination to encourage uptake. Efforts were made by governments and by local health and care service leaders to address vaccine hesitancy with some success, but inequalities remained, and efforts were not always sustained.

Despite its success, the vaccination rollout was not without its challenges

Staffing and workforce pressures

16. The pre-pandemic understaffing of health services, as well as the pressures of the pandemic, and insufficient consideration given to workforce planning in connection with the vaccination programme, meant that the only way to deliver the vaccination

programme was through existing NHS staff, especially GPs and their teams working even longer hours to deliver vaccines and meet the Government's vaccination targets, while maintaining non-COVID and COVID care.

17. To support GPs in England to deliver the vaccination programme, the BMA repeatedly called on NHS England to free-up GP time, for example, through changes to the Quality and Outcomes Framework (QOF) (which is an awards and incentives programme for GP practices in England, Wales and Northern Ireland that grants funding by meeting QOF targets some of which have been widely criticised for being unachievable), and by removing other low-priority contractual targets. Many practices did not have the staff, capacity, or time to deliver the vaccination programme at scale, because of other work that they were contractually bound to do.

18. In England, the issue of staffing the vaccination programme was further compounded by slow and inefficient payment for the extra work conducted by GP practices, payment which was essential to maintain operations and deliver vaccines.

19. These combined pressures resulted in medical professionals reporting stress, burnout and fatigue, with 84% of GPs reporting in 2022 that their workload had "increased a lot" since the pandemic, and that this work was stressful in nature.

20. Respondents to the BMA's call for evidence in connection with its COVID-19 Review gave the following feedback:

    "We have been stretched so thin covering COVID centres and also delivering vaccine programmes, this has had a huge impact on our staff" (GP Contractor/Principal, Northern Ireland)

    "We worked all weekends delivering vaccine with volunteers, clinicians and patients and friends. Part time doctors became full time. Retired doctors revalidated and manned 119 etc, 5 receptionists resigned, unable to cope" (Medical Academic GP, England)

Omicron booster programme

21. The spread of the Omicron variant across the UK in November 2021, came at a time when general practice was under immense and sustained pressure. GPs were responding to rising workloads due to increased patient demand, exacerbated by care backlogs and the transfer of significant amounts of the secondary care workload to general practice.

22. At the same time GPs and practice staff faced significant abuse from members of the public, politicians and the media due to a perceived lack of face to face appointments. In fact, GPs were following the NHS England 'digital first' approach to appointments to reduce the spread of infection and seeing patients face to face whenever it was necessary to do so.

23. The BMA had written to the then Secretary of State for Health and Social Care in September 2021, highlighting that "*there were simply too few GPs and practice staff in under resourced premises to meet the huge surge in demand that practices are currently experiencing, which will be exacerbated by the Covid vaccination booster programme...*".

24. Given the spread of Omicron, on 30 November 2021, the Government announced that a COVID-19 booster vaccine would be offered to all eligible adults by the end of January 2022. Additional funding to deliver these vaccinations was announced by NHS England in recognition of the resource implications of delivering mass vaccinations in general practice, although in reality this did little to alleviate the pressures on general practice in light of workforce shortages, patient demand, time, and capacity. Nevertheless, GPs stepped up to the plate and delivered the booster vaccine at unprecedented pace and scale.

25. Against this background, the allegations made by the former Secretary of State for Health and Social Care, Sir Sajid Javid, at paragraphs 141 and 142 of his Module 4 witness statement, are inaccurate, offensive and unfair. The Inquiry will be aware that the BMA has responded to these criticisms within the fifth witness statement of Professor Philip Banfield (INQ000474589) and should Sir Sajid repeat these criticisms within his oral evidence to the Inquiry, the BMA will seek clarification on the specific work that he suggests was removed from the workload of GPs and their teams so as to provide such significant spare capacity within general practice that delivering the booster vaccination programme, at the speed, scale and complexity required, was not in fact additional work, and in his words merely "reprioritising" their time.

26. Moreover, the BMA - an organisation that represents the majority of doctors in the UK and whose membership has increased since the beginning of the pandemic - is not at odds with the views and wishes of its membership, as Sir Sajid has suggested previously.

Vaccine supply

27. Issues with the vaccine supply chain also presented a challenge for vaccination delivery. Calls for improvements to the vaccine supply chain were made at various stages of the

vaccine programme, and the BMA raised concerns that the approach to delivery and availability of vaccines had created uncertainty amongst GPs and healthcare teams regarding what they could provide to their communities, and when.

28. These issues were driven by variation in deliveries, despite doctors showing that they could very quickly administer vaccines if they were delivered, even in large quantities. Some places were able to get their clinics running very quickly, but in other areas, it took longer to set up. However, as vaccine supply was rightly then directed to areas that were slower starting vaccinations, some locations were left having to wait for deliveries (even though they had capacity and willingness to administer the vaccine) whilst provision was balanced across the country. In some areas vaccination sessions had to be cancelled at the last minute because vaccine was not available and had been directed elsewhere in the country.

29. A February 2021 BMA survey highlighted the issues regarding the supply of regular and sufficient COVID-19 vaccinations. Specifically, 16% of respondents reported vaccination sessions needing to be rearranged due to failed deliveries. Additionally, almost 30% of respondents stated that they could have administered more vaccines to patients had supply been greater. Such findings indicate the impact of operational inefficiencies during the early phases of the vaccine rollout.

30. In future, these issues may be addressed by increasing domestic manufacturing of vaccines, improvements to distribution methods and, and better communication with delivery sites.

31. The repeated short notice of vaccine supply has continued to be a problem with COVID-19 vaccination even in 2024, but it was a major problem in the early days with staff having to book large clinics with very little notice. There was also concern that services using the national booking service received more guaranteed supplies than GP practice run sites. The BMA has called for more to be done to improve the invitation and booking process.

<u>The BMA emphasised the need for frontline healthcare workers to be prioritised for vaccination</u>

32. The BMA canvassed the views of its members in connection with the vaccine rollout, and while 90% of doctors who responded expressed a favourable view of the vaccine programme, there were differing experiences across the medical profession during the

rollout, particularly for staff receiving their first dose. Some groups more commonly reported difficulties in accessing their first vaccination, particularly resident doctors, GP locums, medical students who were not yet deployed and doctors working in private practice. Other contributing issues included changes to advice, for example for pregnant clinicians, as well as difficulties booking the vaccination.

33. There were also indications of vaccine hesitancy amongst some ethnic minority healthcare staff. In July 2021, research published by UK-REACH found that healthcare workers from some ethnic minority groups (including Black African, Black Caribbean, and White Other) were more likely to be vaccine hesitant than their White British colleagues. The research also found that healthcare workers were more likely to be vaccine hesitant if they were younger, female, pregnant, or had already had COVID-19.

34. The BMA's view was that those most at risk of illness or death from a COVID-19 infection and frontline healthcare workers should be prioritised for vaccination. Frontline health and social care workers had a far greater risk of exposure to infection, due to their work caring directly and intimately for patients with COVID-19. Because health services were already operating with severe workforce shortages, it was imperative that doctors and other frontline staff be protected so they could continue providing services and the BMA was therefore pleased to see health and social care workers prioritised for vaccination.

The BMA voiced concerns about the decision to delay doses of the Pfizer vaccine

35. The BMA in all four nations raised member concerns with changes made to the dosing interval between the first and second dose of the Pfizer vaccine, which were not at the time supported by the manufacturer themselves and caused significant concern and anxiety to healthcare staff who had consented to a shorter dosing interval when receiving their first vaccine.

36. While the BMA appreciated the broad aim to protect the largest number of individuals and reduce the pressures on the NHS, the BMA's considered stance was this should only be achieved within the licenses and usage specification of the vaccine as it stood at the time.

37. The publicly available data from the Pfizer vaccine trial had covered second doses only up to six weeks; therefore, it was unknown at that time whether a longer interval would compromise immunity, and it was against Pfizer's own recommendation.

38. Given that healthcare workers already felt pressurised to maintain care in the presence of inadequate PPE, and outdated NHS estates that made it hard to isolate or distance

patients and staff appropriately or provide effective levels of ventilation, the sense that they were further unprotected and being put in harms' way by government decisions was understandably and repeatedly voiced by doctors to the BMA. Member feedback received at the time indicated that the decision had been extremely damaging to morale and wellbeing, and staff confidence in the vaccination regime itself.

The BMA strongly encouraged frontline healthcare workers to take up the vaccine based on informed consent

39. The BMA strongly urged doctors and frontline healthcare workers to be vaccinated, and uptake was high among doctors. For example, results from a February 2021 BMA survey found that – at the time – 93% of respondents had received the first dose of the vaccine. However, the BMA voiced concerns about policies put in place in England that made vaccination a condition of deployment among staff in older adult care homes (and as such included GPs and practices staff such as nurses visiting care homes), followed by the proposed expansion of the mandate to the health and wider social care sector. None of the devolved nations progressed similar policies.

40. The BMA's view was that vaccination should be voluntary based on the principle of informed consent, being respectful of individual rights and liberties and that any move away from the existing voluntary model would need to be properly justified and proportionate. The BMA's priority was to support doctors and other healthcare workers getting vaccinated while listening to and addressing any concerns staff may have, emphasising that vaccinations are safe and effective in protecting against the disease.

41. There are significant practical and ethical issues to consider in mandating vaccination. The BMA's view was that coercion was not the right approach for healthcare workers and could worsen the recruitment crisis and place unbearable pressures on the health system, if, for example, staff who refused the vaccine for personal or religious reasons, were no longer able to work.

42. Moreover, while the vaccination reduced symptoms of COVID-19 and there was some evidence that it reduced transmission, it did not remove the risk of infection and in these circumstances, alternative methods of reducing transmission, such as enhanced PPE/RPE, improved IPC and testing should have been considered. This reflects the views of Professor Chris Whitty, who has "*always been more cautious of mandatory vaccination in any situation*".

43. The policy in older adult care homes was later revoked and at the same time, the proposals to introduce mandated vaccination for the wider health and social care sector were abandoned. However, the negative impact of the policy is clearly visible in the social care sector, where the policy exacerbated existing staffing challenges and is estimated to have led to the loss of between 30,000 and 40,000 staff, many who did not return to the sector once the mandate was withdrawn.

Variation in vaccine uptake among vulnerable and marginalised groups was of great concern to the BMA

44. Issues with vaccine uptake in the wider population emerged across the four nations. Prior to the COVID-19 vaccination programme, it was known via studies on vaccination intention and learning from other vaccination programmes that there may be lower rates of uptake of the vaccine among some population groups, including some ethnic minority groups and those from deprived areas. When this became clear in early vaccination uptake data, efforts were made by Government, health and care systems and community leaders to overcome barriers to vaccine uptake, which were welcome. The BMA partnered up with an agency to address vaccine hesitancy among ethnic minority groups. However, significant disparities remain to this day, with root causes of vaccine hesitancy such as systematic racism still unaddressed.

45. On 2 December 2020, the JCVI released official priority groups for COVID-19 vaccination, which included a rollout based on age (with older people with the highest risk prioritised) and the prioritisation of other vulnerable groups such as the clinically vulnerable and health and care workers. The JCVI stated that the recommended age-based programme would likely result in faster delivery and better uptake in those at the highest risk.

46. The BMA agreed with JCVI's recommended prioritisation of vulnerable people and eligibility list within the wider population but stressed that the key to its success would be getting as many people vaccinated as possible and that this would need the support of local community leaders, local public health staff as well as the work of those medically trained.

47. People with a learning disability however were not initially included in the priority list of people to access the vaccine. The government's decision in February 2021 to include people with learning disabilities in the priority list was a welcome one, but only happened after a legal challenge. By the time the vaccine was available in December 2020, we knew

from a Public Health England report that people with learning disabilities had a death rate from COVID-19 up to six times higher than the general population. Prioritisation in the vaccine programme was a key policy to mitigate the effects of existing inequalities, and so it is regrettable it took so long to implement this policy for people with learning disabilities.

Inequalities in uptake emerged quickly and have persisted

48. While the overall uptake of the vaccine programme was high, the BMA expressed concern that progress was not equal across the UK. This overall rate masked significant disparities in vaccine uptake, particularly along the lines of deprivation and ethnicity.

49. Lower rates of COVID-19 vaccine uptake amongst some ethnic minority groups were seen across the UK, and throughout the different stages of the vaccination programme, with vaccine uptake highest among those from a White ethnic background. For example, in Wales, data from February 2021 show that uptake for the combined Black, Asian, Mixed and Other ethnic groups in people over 80 years old was 71.5% compared to 85.6% in the White ethnic group.

50. Disparities in vaccine uptake were also seen along deprivation lines, as referenced in the BMA's 5th COVID-19 Review report. As outlined in the report, data from 2022 showed that across England, Scotland and Wales, vaccine uptake was higher in areas of greater affluence and gradually decreased along deprivation lines.

51. ONS data published since the publication of the BMA's report, in March 2023, showed inequalities persisted in the COVID-19 vaccine booster programmes. People living in the most deprived areas were least likely to continue to a fourth vaccination (63.8%), with vaccination rates increasing as levels of deprivation reduced.

52. Pregnant women were another group which had needs that were not sufficiently met in relation to the COVID-19 vaccines. Changing government advice led to confusion amongst those who were pregnant, or those who were considering pregnancy, about whether they should be taking the vaccine. The confusion should have been avoided, as pregnant women were at higher risk of severe disease from COVID-19. It was not until April 2021 that the Government clarified the advice for pregnant women, offering the vaccine to everyone and clarifying its safety in pregnancy and effects on fertility. This changing advice left many pregnant women vaccine-hesitant and unprotected from COVID-19.

53. Despite efforts during the delivery of the vaccination programme, the BMA believes more could have been done to identify the needs of vulnerable groups ahead of its delivery, particularly in light of pre-existing health inequalities that were well known.

    a. Even prior to the COVID-19 vaccine rollout, it was well known that vaccine uptake by people from ethnic minority backgrounds was lower than for people from White British and White Irish backgrounds (INQ000479065). A systematic review published in 2022 also found several studies published before December 2020 that suggested an association between vaccine uptake and ethnicity.

    b. A paper prepared by the ethnicity sub-group of the Scientific Advisory Group for Emergencies (SAGE) that was considered in December 2020 shows that government advisers were aware that uptake of the COVID-19 vaccine may be lower in ethnic minority communities and stressed the necessity of community engagement (INQ000250215). The likelihood – or at least the potential risk - of disparity in vaccine uptake was therefore clear in the data before the vaccine rollout (based on intention to have the COVID-19 vaccine and evidence of uptake of other vaccination programmes).

54. In the BMA's view there were several key barriers to uptake of the COVID-19 vaccine:

    a. There were physical barriers to accessing vaccination sites, such as difficulties reaching the sites. For example, some mass vaccination centres were a considerable distance from people's homes or workplaces and could not be accessed via public transport routes. Accessing the vaccine was also challenging for those who were unable to leave home easily, such as elderly or disabled people. For those who were clinically vulnerable, many had a fear about leaving home and catching COVID-19.

    b. Not having an NHS number became a barrier to vaccine uptake for many people in the homeless population, as well as for vulnerable migrants. Despite there being no need for a fixed address to access the vaccine, there were reports that some people still faced this barrier.

    c. Communication barriers also existed for people who could not understand or access all the relevant information about having the vaccine, for example, in a linguistically or culturally appropriate way.

    d. A significant cultural barrier to accessing the COVID-19 vaccine has been the lack of trust in health services and, by extension, the vaccine amongst some ethnic minority

communities. People from ethnic minorities and deprived communities also had worse health outcomes before the pandemic, and with this in mind, there should have been greater consideration of these groups in planning the vaccine rollout.

i. In relation to ethnic minority communities, and Black communities in particular, the BMA argued that vaccine hesitancy in these communities has its roots in a mistrust of the medical establishment because of racial discrimination in the NHS, and historic abuse of international vaccine programmes. In our detailed response to the Commission on Race and Ethnic Disparities report, better known as the Sewell report, we argued that structural racism cannot be ignored when discussing racial health inequalities. In relation to mistrust of health services more generally, we also said that in addition to adequate translations of public health messages, building trust within different communities is an important way to reduce mistrust (INQ000118384).

ii. In Black communities, there is a deep-rooted mistrust of health services. People from ethnic minority groups have had historically different treatment and outcomes from their healthcare; Black women for example are five times more likely to die in childbirth compared to White women. Women and ethnic minority people have often been underrepresented in clinical trials meaning there is less confidence in their results among these groups and there are relatively recent examples that clinical trials have taken place in countries in Africa without informed consent.

55. Misinformation about COVID-19 vaccinations and anti-vaccination messaging in the press and on social media likely added to vaccine hesitancy.

a. The BMA believes that another key cause of vaccine hesitancy is around anti-vaccination messages and misinformation. The BMA called on the UK Government to take more action to tackle misinformation online and as mentioned above, launched a social media campaign to address vaccine hesitancy, particularly amongst ethnic minority groups.

b. Beyond the hesitancy and mistrust in the vaccine amongst Black and other ethnic minority communities in the UK, there were also pockets of society colloquially known as 'anti-vaxxers'. These include people who were and remain in total

opposition to any vaccinations, as well as those with a specific opposition to the COVID-19 vaccinations.

c. In cases of vaccine hesitancy, mistrust and anti-vaccination sentiment, the common theme is a lack of trust in governments and/or health services. This may be based on previous incidences of being let down or failed in some way by government or health services, either real or perceived as such.

56. The BMA made several recommendations to the UK Government to address the variation in uptake:

a. for the government to ensure information on COVID vaccines was distributed in multiple languages, with more 'innovative efforts' to engage with hard-to-reach communities, such as mobile vaccination units (INQ000479101).

b. for the need for vaccine uptake to be as universal as possible, by making it as accessible as possible (INQ000118318). The BMA advised Governments across the UK to put in place supportive arrangements to overcome the various barriers to vaccine uptake, which could include patient transport, specific access arrangements, and tailored messaging for certain groups alongside engagement through community leaders.

c. that any future vaccination programmes should consider the range of potential barriers to access and identify ways to ensure equitable access. The BMA recommended that people from ethnic minority communities should be involved in decisions and mechanisms to improve equitable access to the vaccine. For groups who share protected characteristics, the BMA called for urgent analysis to clearly set out any identified barriers to ensuring good vaccine access and uptake across all these groups. The BMA said that the Government should make clear how these barriers would be overcome, and how progress would be monitored to ensure the vaccine programme was successfully reaching these groups (INQ000118318).

d. that the Government make information available in as equally accessible a format as possible to ensure everyone had all the information available to make informed choices (INQ000479091). We said it was the responsibility of the authorities to make the information clear and accessible for whoever the intended recipient is and for whatever reason - and that a 'one size fits all' was not an acceptable communication strategy for the entire population of the UK (for example those with learning

disabilities, deaf people, or people who do not speak English - among others - have different needs).

57. The BMA also took action in response to concerns that vulnerable migrants, and homeless people may be deterred from seeking healthcare during the pandemic, including access to vaccines when they became available. In April 2020, the BMA, along with a broad coalition of health and care organisations, signed a letter from Doctors of the World to the Secretary of State for Health and Social Care and the Home Secretary calling on them to suspend the National Health Service (Charges to Overseas Visitors) Regulations 2015 and 2017 and all associated immigration checks and data sharing, which risked undermining the Government's pandemic response and deterring people coming forward for healthcare for fear of immigration enforcement (INQ000235275).

58. Whilst the BMA recognises the success of the vaccination programme, the significant disparities in uptake cannot be ignored. Barriers to vaccination, such as vaccine mistrust, must be addressed if the UK is to be prepared for any future pandemic.

Conclusion

59. The BMA generally viewed the vaccination programme as one of the biggest successes during the pandemic and recognised the immense efforts of doctors, the wider healthcare workforce, and volunteers who drove the rollout's effectiveness and efficiency. Without their commitment to administering doses, the UK would not have been the nation globally to have administered more first doses per 100 people than any other nation of comparable population size by February 2021.

60. However, as outlined in this statement, the success of the vaccine rollout was not without caveats for improvement. The Inquiry is invited to consider the inefficiencies within the supply and delivery of vaccines around the country; to reflect the strain that the vaccination programme placed on general practice and the healthcare workforce; to acknowledge the detrimental impact on the social care workforce of vaccination as a condition of deployment; and to make recommendations that address the disparities in vaccine uptake and access to healthcare more broadly, which the BMA says requires urgent improvement by governments across the UK.

13 December 2024