IN THE UK-COVID 19 INQUIRY

Before the Right Honourable Baroness Hallett D.B.E.

MODULE 4

THE WELSH GOVERNMENT'S MODULE 4 OPENING STATEMENT

Introduction

1. In Module 4, the Inquiry will consider a range of issues relating to the development of Covid-19 vaccines and the implementation of the vaccine rollout programme across the four nations, along with the development, trials and steps taken to enable the use of new and existing medications to treat Covid-19.

2. Commencing on 8 December 2020, the vaccination programme in Wales successfully delivered Covid-19 vaccines to those who required them at pace. Wales was the first country in the world to receive supplies of the vaccine. It was one of the first to begin the rollout of the vaccine to its population. As explained by then First Minister, Mark Drakeford:-

> "The vaccine roll out in Wales was a success because of the extraordinary efforts and commitment of the people of Wales, those in the Health Services who worked tirelessly in administering the vaccines, those in the military who supported the initial roll out but not least those who came forward for vaccination."[1]

3. As at 8am on 27 December 2020, 35,335 vaccinations had been administered by the Welsh local health boards[2]. By 16 February 2021, over 780,000 people in Wales had received their first dose of the vaccine[3]. By 9 March 2021, the number of vaccinated people had increased to one million people[4]. This meant that a higher proportion of the population had been vaccinated in Wales than in the other three UK nations. Shortly after, Wales was reported as having the third highest vaccination rate globally, behind only the United Arab Emirates

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[1] Para 3, Mark Drakeford Witness Statement M4 – INQ000474420.
[2] INQ000350144.
[3] INQ000057770.
[4] Gething (Module 4 statement), para. 283 – INQ000493687.

and Israel[5]. By 2 July 2021, all remaining adults had been offered a vaccination and, as of 22 July 2021, 90.1% of adults had received their first dose, whilst 78.8% had received their second dose, equating to more than two million people[6]. Reports have since confirmed that, by 1 June 2022, the number of people under vaccinated in Wales was significantly lower than in the other three nations (32.8% in Wales, compared to 49.8% (Northern Ireland), 45.8% (England) and 34.2% (Scotland)[7].

4. The Welsh Government recognised that successful deployment of the vaccination programme was fundamental to unlocking communities and restoring people's lives in Wales. Whilst the imposition of non-pharmaceutical interventions had been successfully deployed by the Welsh Government to protect Welsh citizens during the early part of the pandemic, the ongoing impact of these restrictions upon people, their lives and livelihoods had to be balanced against the need to protect the health and wellbeing of the nation. The need for a swift, efficient and effective development and roll-out of the vaccine programme (as demonstrated in the figures above) was the fundamental means that allowed the Welsh Government to ease non-pharmaceutical intervention, to return society to a greater degree of normality and to alleviate the impact of those early restrictions - lockdowns in particular - on all of society, but above all for the vulnerable and the young.

Decision-making structures and functions

5. As the Inquiry is aware, healthcare is a devolved function in Wales and has been since 1999. However, in relation to vaccines and therapeutics, the position is somewhat more nuanced with certain functions being reserved to the UK Government.

6. The regulation of healthcare professionals, medicines, vaccines and their authorisation, and vaccine damage payments are all matters in respect of which legislative competence is reserved to the UK Government.

7. The Medicines and Healthcare products Regulatory Agency (Medicines and Healthcare products Regulatory Agency) is the regulator for medicines, medical devices and blood components for transfusion in the UK, which includes all relevant vaccines and therapeutics in respect of Covid-19. Pharmacovigilance is also the responsibility of medicines regulators

[5] INQ000492870.
[6] INQ000057896.
[7] INQ000410152.

and is undertaken by the Medicines and Healthcare products Regulatory Agency on behalf of the whole of the UK. Whilst the Welsh Government did not have responsibility for such matters, pre-existing good working relationships between the Medicines and Healthcare products Regulatory Agency and senior Welsh Government officials, meant that the Welsh Government was kept abreast of developments relating to the authorisation of Covid-19 vaccines and therapeutics.

8. Separate and distinct to those reserved matters are those functions for which responsibility was devolved, but in respect of which a decision was taken to agree for the UK Government to exercise those powers on behalf of the Welsh Government, pursuant to Section 83 of the Government of Wales Act 2006. A key example of this is in relation to the procurement of Covid-19 vaccines, which was led by the UK Government's Vaccine Taskforce on behalf of all four nations. In so agreeing, the Welsh Government chose to allow its consequential share of vaccine funding to remain with the UK Treasury, with a Barnett share of the vaccine supplies guaranteed to Wales.[8] This matter will be considered further below.

9. The Inquiry has previously heard detailed evidence on the structure and governance of the NHS in Wales. The NHS in Wales consists of seven local health boards, three NHS trusts and two special health authorities. Each local health board is legally and operationally responsible for healthcare services in relation to a particular part of Wales, whilst NHS trusts and special health authorities provide specific services on an all-Wales basis. Responsibility for strategic decision-making, long-term planning and policy development lies with the Welsh Government, with Welsh Ministers able to direct NHS bodies to exercise functions in relation to the health service in Wales.

10. The Welsh Government's Covid-19 Vaccination Programme was established under the office of the Chief Medical Officer, alongside existing vaccination programmes. The Senior Responsible Owner for the Programme reported to the Chief Medical Officer and to the Director General of the Health and Social Services Group.

11. The operational delivery of the vaccination programme fell to Wales' seven local health boards. Each local health board had a Covid-19 Vaccination Senior Responsible Owner responsible for planning and delivery of Covid-19 vaccinations in the areas they serve. Each

[8] For example, Gething (Module 4 statement), paras.55, 67-74, 82-86 and 204-224 - INQ000493687.

local health board's Covid-19 Vaccination Senior Responsible Owner also participated in the governance structure of the Covid-19 Vaccination Programme and worked with the Chief Pharmaceutical Officer on vaccine logistics, the Chief Operating Officer of the Vaccination Programme on operational matters and the Deputy Chief Medical Officer on clinical matters. The local health boards were required to provide detail of working arrangements (including clinical, operational, technical and logistical considerations) that would be in place to deliver a programme of Covid-19 vaccination, with such plans being reviewed across the NHS in Wales' emergency planning and by the Wales Covid-19 Vaccination Board.

12. In June 2020, this Board was established to provide a forum for the Welsh Government, NHS partners, Public Health Wales and other stakeholders to develop, plan and implement the Covid-19 vaccination delivery for Wales. This later developed into the Wales Covid-19 Vaccination Delivery Programme Board, with a separate Stakeholder Forum. The Board, in each case, was the primary decision-making group in respect of deployment of the Vaccination Programme, taking advice from other groups within the governance structure and providing advice to inform Ministerial decision-making, where appropriate, along with commissioning and considering lessons learned exercises.

Delivery of Vaccination Programme

Preparedness

13. At the outset of the pandemic, Wales benefited from a well-functioning, well-tested and well-led existing vaccination programme in place. Alongside its annual flu vaccination programme, the programme had been utilised in relatively recent years for targeted vaccination programmes, such as the HPV vaccination programme. This existing programme had resulted in a long and successful history of vaccine deployment in Wales, with the knowledge accumulated in its creation and operation allowing the Welsh Government to plan and prepare for practical issues such as distribution, deployment, workforce preparation, patient contact and vaccine inequality issues.

14. In early April 2020, work began to consider how the successes of the existing vaccination programme could be significantly scaled up so as to ensure that distribution of the vaccine

could be effectively undertaken once it became available[9]. Despite the vaccine becoming available earlier than originally anticipated, Wales was well prepared for its rollout and commenced vaccination as soon as the vaccine became available.

Delivery

15. The Welsh Government did not have regulatory or advanced purchasing responsibility or financial capability to undertake procurement separately for Wales. In non-pandemic times, the UK Government procures other nationally administered vaccines, such as the annual flu vaccine. This system worked well and the commercial benefits of relying on the UK Government's significant purchasing power were plain. Hence, the Welsh Government agreed for its consequential share of vaccine funding to remain with the UK Treasury to permit that central procurement to be undertaken by the UK Government on its behalf.

16. Whilst such a decision is one likely to be appropriate for vaccination procurement in any future pandemic-type situation, lessons may be learned from the process as undertaken during the relevant period.

17. The joint procurement approach worked particularly well. The UK Government's procurement exercise, via the UK Vaccine Taskforce, was able to place orders for large quantities of vaccine doses, spread across various candidate vaccines. The cooperation with the UK Government in this regard was a positive one.

18. However, it is recognised that reliance upon the strength of individual working relationships bears clear risks for any future situation should personnel change and / or such relationships not be in existence. Matters such as this should not turn on the personalities in post at any given time. Formal structures and lines of engagement established at an early stage would ensure that the devolved governments are able fully and properly to plan for vaccine delivery regardless of individual personnel in post at any given time.

19. Another area for the Inquiry's consideration is the basis upon which vaccine supply is shared between the four nations. In the circumstances of the pandemic as it progressed, a decision as to allocation of supply had to be made quickly and on a readily understandable basis. The only options available in the circumstances were for such sharing to occur either upon

[9] Drakeford (Module 4 statement), para. 86 onwards - INQ000474420.

a population basis or by reference to the Barnett formula, being already familiar to all Governments as the basis upon which block grants are calculated. But in order to ensure vaccines reach those in greatest need first, a needs-based formula is necessary to determine the allocation of vaccines in future. However, there was no realistic opportunity for this to be calculated, agreed and implemented in the time available. Now is the time to revisit this issue, to prepare for the next pandemic.

20. In the circumstances, the Barnett formula was applied. However, this created the potential for vaccine supply shortfall in Wales during the early stages of vaccine delivery as a result of Wales having a disproportionately larger share of the older population, who were a major part of the initial priority groups and cohorts that needed to receive the vaccine first.

21. Despite an express request made to the UK Government for Wales' share of the vaccine supplies to be front-loaded to address the realities of the vaccine delivery programme in Wales[10], such an agreement could not be reached and provision was not made for Wales' share of the vaccine supply to reflect the needs of the Welsh population.

22. It was due to the ingenuity of those in the Welsh healthcare service that a shortfall in supply was avoided - by the imposition of specific measures put in place in Wales to mitigate the impact of the imbalance between population size and allocation of vaccines to Wales. A fundamental measure in this regard included the steps taken to avoid vaccine waste. A particular innovation was discovering how to maximise the number of doses achieved per vial of the Pfizer BioNTech vaccine in Wales. This resulted in vaccinators identifying how to extract six doses per vial, instead of the originally intended five, and achieving this at scale. Such efforts avoided any slowing of the rollout of the vaccine in Wales to the most vulnerable in the first priority cohorts that might otherwise have resulted from the vaccine not having been allocated across the four nations according to need.

23. Further, the NHS in Wales structure facilitated a whole-Wales approach to rollout, which ensured that when supplies were limited, there was a managed and planned distribution across the seven local health boards in Wales that enabled limited stock to be efficiently utilised.

[10] Drakeford (Module 4 statement), paras. 53 and 112 - INQ000474420.

24. However, in future, consideration needs to be given by the Inquiry to the fairness and appropriateness of the Barnett formula in deciding population share of UK vaccine stock as it does not take account of the relative size of the population at risk in the different nations. That the problems created by not allocating vaccines according to need in fact drove the health sector in Wales to find innovative solutions is not the lesson to be learned here. Vaccines could and should, in future, be allocated according to the actual population size of the at-risk population. In the case of Covid-19 vaccinations, great importance was placed on age in determining the risk of Covid-19 and corresponding benefit of vaccination. Age profiles of the population in all four nations is available, so it should be feasible and practicable, in the future, to allocate vaccines according to need, based on age data at least[11].

25. Individual and collective effort, such as that applied in the face of limited vaccine supply, contributed to the successful delivery of the vaccination programme in Wales. The NHS in Wales model allowed a 'Team Wales' deployment approach to be adopted for the Covid-19 Vaccination Programme. This permitted an All-Wales, nationally coordinated service which was fronted by local health boards that were best placed to assess the local healthcare infrastructure in terms of strengths and requirements, geography and community partnerships. Consistency in deployment across all local health boards was ensured by the Wales Covid-19 Vaccination Board which defined various delivery models, with each local health board able to define the number and mix of delivery models required based on local demographics.

26. This included vaccination centres, capable of being scaled across a range of volume capacities and opening hours in a fixed location. Use was made of mobile vaccination teams with suitably equipped vehicles and vaccinators to visit locations such as care homes, detained estates and individual addresses for housebound patients or in remote locations. Occupational health vaccination teams were deployed from NHS provider premises to target frontline NHS and social care staff.

27. The pace and scale of delivery of the vaccination programme in Wales was also assisted by the ability of the Minister for Health and Social Services to issue a number of national protocols (the first being on 18 December 2020), following amendments made to the Human

[11] Rowlands - INQ000474558, Andrew Evans - INQ000474566.

Medicines Regulations 2012, permitting registered health care professionals and certain people who were not registered health care professionals to administer the Covid-19 vaccine. These protocols allowed healthcare workers who were not authorised to administer medicines other than in accordance with the directions of an appropriate practitioner, to administer Covid-19 and influenza vaccines subject to appropriate training and clinical supervision. This flexibility to provide additional workforce proved invaluable in the success of the vaccination programme in Wales. Close working relationships with local government and the third sector maximised the number of available venues and volunteer workforce.

28. The Welsh Government implemented a 'no one left behind' policy. This involved local health boards actively following up those who had not yet had their vaccinations in priority groups 1 to 4, whilst starting to issue appointments for those in groups 5 and 6. Where possible, several methods were used to ensure non-vaccinated individuals were given an opportunity to be vaccinated. Individuals were contacted a minimum of three times with an offer of a vaccine appointment and walk-in vaccination centres utilised where there was no need for an appointment.

29. The Welsh Government set targets for the rollout of the vaccination programme through the publication of the National Covid-19 Vaccination Strategy (and the updates thereto). Save for a short period during which inclement weather affected attendance by the over-80s in January 2021, these targets were met. Insofar as those who had missed their appointment as a result of the weather, those appointments were rapidly rearranged, with the number of vaccinated people in Wales increasing from 162,000 to 290,000 people in one week alone[12].

30. At the time of publication of the Welsh Government's updated Coronavirus Control Plan[13] on 19 February 2021, it was confirmed that take up of the vaccination was very high, exceeding the 80% target set for the first four priority groups, with some even exceeding 90% of take-up. However, such figures did not encourage complacency and active work remained ongoing to address concerns about lower levels of take-up amongst some groups and communities.

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[12] Drakeford (Module 4 statement), paras116-118 – INQ000474420.
[13] INQ000081858.

Eligibility, Prioritisation and the JCVI

31. The status of the JCVI's advice is advisory in Wales, and thus required Ministerial agreement. The Inquiry has received evidence from the Ministers for Health and Social Services responsible for the individual decisions made throughout the relevant period.

32. It is important to note that the Welsh Government was not mere recipients of JCVI advice. There was a co-opted member from Wales to provide expertise on implementation from immunisation programmes. Whilst this member was not a voting member of the JCVI, they were eventually able to make a valuable contribution to the discussion that enabled the needs and perspectives of the Welsh vaccination system to be considered in its decision-making. In the early part of the relevant period there had been concerns about discussions at meetings being largely focused on deployment of advice in England. Meetings thereafter evolved to include requests for Welsh representatives to present a Wales-focused view to the Committee to inform the discussion[14].

33. Meetings in Wales involving policy, clinical, operational and pharmacy colleagues were held beforehand to ensure that all interests and perspectives were being fed in at the JCVI meetings.

34. Alongside the co-opted member, the Welsh Government also had a senior policy official in attendance with observer status at each meeting. This allowed the Welsh Government to consider fully what was discussed and decided at the meetings, which enabled responses to be undertaken at pace without having to await formal reporting of decisions. Since the relevant period, the appointment of a Welsh co-opted member to the JCVI has now been formalised, alongside an additional clinical observer from Public Health Wales and the Welsh Government observer[15].

35. Additionally, there would be occasions where ongoing discussion was required in respect of finely balanced decisions. One such example was the decision to vaccinate healthy 12-to-15-year-olds, which necessitated engagement by the Chief Medical Officers of the four nations.

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[14] Rowlands (Module 4 statement), para.379 - INQ000474558.
[15] Rowlands (Module 4 statement), para.381 - INQ000474558.

36. All of these actions permitted a more active and meaningful relationship with the JCVI where the Welsh Government was both able to influence and respond quickly to the decisions being made.

37. Further, and whilst a four nations approach was adopted following such advice (with no occasion when a view was taken that such advice should be departed from), an element of operational flexibility remained in its implementation in Wales in order to ensure that the vaccination programme reached the largest possible numbers whilst reducing waste. The ability to utilise this flexibility permitted the Welsh Government to take a broad interpretation of the JCVI's advice and to ensure that as high a proportion of appointments were filled and completed as was possible, which ultimately led to a very high efficiency rate and minimal vaccine waste.

Vaccination as a Condition of Deployment ('VCOD')

38. The Welsh Government sought to create a 'high trust' basis for the actions it was taking in Wales during the relevant period. In respect of the vaccination programme the ability to secure high levels of take-up was predicated upon creating such a 'high trust' environment. It was felt that a policy of mandatory vaccination as a condition of deployment would have undermined this approach and potentially risked the success achieved in vaccination deployment generally. However[16], detailed consideration of the various competing factors in support of and against the imposition of such a policy was undertaken.

39. There was much consistency in approach between the four nations on vaccine-related issues, but on this issue the relevant considerations and data involved in decision-making were significantly different between Wales and England. The rates of vaccination take-up in Wales amongst social care workers and care home residents were consistently and significantly above those rates advised by the Social Care Working Group of SAGE as being necessary to provide a minimum level of protection against further outbreaks in care homes for older persons. Accordingly, vaccination was not made a condition of deployment in Wales, but extensive work was undertaken in the health and social care sector to address any reluctance to take up the vaccine and to seek to support the positive response within the sector towards voluntary vaccination.

[16] For example, Drakeford (Module 4 statement), paras. 155-179 – INQ000474420.

Vaccination Certification

40. During the relevant period, the implementation of a vaccine certification or passport scheme was considered in Wales, in both the international and domestic context. The decision as to whether to introduce a domestic scheme in Wales was finely balanced. Again, the data on uptake in Wales was different from that in England, where the motivation for the introduction of a domestic mandatory vaccine-only certification was linked to the need to increase uptake of the vaccine among young people. In Wales, the uptake of the vaccine among young people was higher. But the decision to go ahead in England would have cross-border implications for Welsh businesses and citizens.

41. The distinction between the mandatory vaccine certification scheme originally proposed by the UK Government (before its postponement) and the NHS Covid Pass scheme introduced by the Welsh Government was particularly important in terms of the ethical and equity concerns that were raised. It was important to ensure that the introduction of any scheme did not constitute a barrier for those who had declined to be vaccinated on medical or other relevant grounds. The decisions made in Cabinet regarding the imposition and expansion of the NHS Covid Pass were some of the most closely balanced in the area of vaccination decisions that had to be made. The Welsh public were generally receptive to the introduction of the scheme, which provided a level of confidence to those returning to attending large scale events.[17]

Equalities and Public Messaging

42. The question of health, socio-economic and other inequalities has been a key focus of successive Welsh Governments since the outset of devolution in 1999, with the aim of addressing entrenched health and socio-economic inequalities through the law being a priority throughout that time. For example, the Wellbeing of Future Generations Act (Wales) Act 2015 promotes equality as an objective for society, not just equality of opportunity.

43. This prior focus meant that the Welsh Government's early understanding of Covid-19 was informed by an understanding that every widespread disease outbreak is more likely to produce disproportionately adverse impacts upon those already socio-economically disadvantaged or suffering from some other pre-existing health condition.[18] The Welsh

[17] Drakeford (Module 4 statement), paras. 285-286 – INQ000474420.
[18] Drakeford (Module 4 statement), para. 27 – INQ000474420.

Government was aware of, and acted upon, emerging evidence of the differential impact of the pandemic on the vulnerable and under-served communities from an early stage in the pandemic. Other modules have already addressed the Inquiry at length as to the work undertaken by the Welsh Government upon the issue of inequality at large throughout the pandemic.

44. The Vaccine Equity Committee was established in March 2021, with its impact and influence increasing as the pandemic evolved. It involved representatives from umbrella groups, the under-served groups themselves, and third sector organisations, as well as experts from Public Health Wales and the NHS in Wales to understand the barriers to the uptake of Covid-19 vaccinations in marginalised groups and work to remove those barriers. It served a variety of functions: monitoring and analysing vaccination uptake by reference to protected characteristics and under-served groups; considering emerging research and intelligence, and recommending areas of additional surveillance and research, on vaccine inequity; establishing and sustaining links to permit intelligence- and resource-sharing between groups and organisations working to improve vaccine coverage; and developing an action plan to reduce vaccine inequity.

45. At the same time, the Welsh Government also published a Vaccine Equity Strategy[19] with the purpose of providing advice to the Programme Board on how to ensure all people in Wales who were eligible for Covid-19 vaccination had fair access and fair opportunity to receive their vaccination, by addressing barriers to uptake which disproportionately affected under-served population groups.

46. The Vaccination Strategy (published in June 2021) also underlined the importance of understanding local needs with deployment models varying by local health board. The Vaccination Strategy made clear that every person must be given fair access to vaccination with equal opportunity to receive their vaccination and barriers to access removed. Additional and tailored support and reasonable adjustments were put in place for under-served groups and hard-to-reach individuals.

47. Local health boards used outreach models to set up hubs in under-served communities with mobile vaccination teams later being used for harder-to-reach communities to take the

[19] INQ000182538.

vaccine into these communities to improve engagement and increase accessibility of the vaccine and, ultimately, to seek to ensure such communities benefited from the protection afforded by the vaccine.

48. The Welsh Government implemented various measures to ensure the accessibility of the vaccine to, and encourage take-up amongst, those communities. Such measures included the appointment of outreach and engagement workers within each local health board to support with engagement and advocacy relating to the vaccination programme, and the use of 'community champions' or 'trusted voices' comprising faith leaders, community leaders, sports and cultural figures, health professionals, academics and peers of eligible / vaccine-hesitant groups in a range of communities. In addition to the Vaccine Equity Committee, a "DNA" (did not attend) working group was also set up to specifically target the issue of uptake and put action in place.

49. The Welsh Government also held specific events intended to target those harder to reach communities or those who were vaccine hesitant, including an online vaccination roundtable to permit representatives from multi-cultural faith, community and business organisations from across Wales to ask questions and hear from a panel of experts.

50. The Inquiry has received a statement in this Module from Dr Heather Payne, who chaired the Covid-19 Moral and Ethical Advisory Group Wales, which was set up in April 2020. It became apparent early in the pandemic that the UK-wide Moral and Ethical Advisory Group was only able to serve England effectively, because it did not address the different requirements of Wales and its different legislative frameworks. The Wales-focused group provided advice to assist the provision of public services in Wales on equity, moral, ethical, cultural and faith considerations relating to health and social care delivery. Policy officers within Welsh Government were encouraged to, and frequently did, bring policy proposals to the group for analysis and advice, in order to finalise policies in light of feedback received from the group. In addition to policy leads, the Wales Covid-19 Vaccination Board, and later the Wales Covid-19 Vaccination Programme Board, asked the group to advise on vaccine-related issues.

51. Vaccine misinformation was a concern and was consequently identified as a key theme in the All-Wales Equity Action Plan with significant efforts made to promote accurate information to the public in Wales which included the establishment of a Community

Engagement Group to work with community leaders and organisations representing particular communities.

52. The Welsh Government enjoyed relatively high levels of trust from the Welsh public, which meant the public were generally responsive to its public messaging on vaccine-related matters and ensured that Welsh Government measures were generally well-supported by the public.

Vaccine Safety

53. The Welsh Government was acutely aware of the need to ensure that vaccine safety concerns were monitored and taken seriously. It was important that people were able to make informed choices about the vaccine based on accurate and trusted information, especially as knowledge of the vaccine developed and where new cohorts were included for recommended vaccine uptake – including children. The Welsh Government worked with Public Health Wales and the NHS in Wales to make that information available to the public.

54. Ministerial statements were important in this regard. Transparency was a fundamental part of public messaging with the advice of the JCVI and Medicines and Healthcare products Regulatory Agency being communicated and signposted to the public, setting out the risks and benefits of vaccination.

Therapeutics

55. Powers regarding authorising clinical trials for, and the licensing of, new medicines are reserved to the UK Government and undertaken by the Medicines and Healthcare products Regulatory Agency. Accordingly, the Welsh Government did not play a direct role in the identification or development of treatment of, or prophylactic medicines for, Covid-19. The Welsh Government's primary role was in ensuring the routine deployment and availability of new and repurposed therapeutics to treat Covid-19. Wales made substantial contributions to clinical trial work. All decisions about eligibility for therapeutics were taken at the UK level[20].

Learning from the experience of the pandemic

[20] Evans (M4 statement) - INQ000474566.

56. Through the lens of experience drawn from the pandemic, the Welsh Government carried out an assessment of vaccination priorities and expectations for the future and published the National Immunisation framework on 25 October 2022[21]. The framework is intended to pave the way for a transformation of the vaccination programme in Wales, enabling exemplar delivery of vaccination and immunisation programmes with uptake and equity at its core. It aims to make it easier for people to know what vaccinations they are eligible for, and how they receive them, using digital vaccination records. There will be a targeted approach to ensure vaccine accessibility. Local health boards will be required to have a vaccine equity strategy and programme of work applying the framework's principles. To ensure that vaccine equity is considered at every stage and to protect the "no one left behind" principle, the Vaccine Equity Committee has been transitioned into the new governance arrangements and has an expanded remit for all vaccination programmes.[22]

57. The fair allocation of vaccines between the four nations is a principal consideration in the event of a future pandemic. Vaccine supply should be allocated between the four nations according to need, based on data available as to the size of the at-risk population in each of the four nations.

58. The Welsh Government acknowledges that there are lessons to be learned, not only from what went well in the rollout of the vaccine, but also what could have been done better. Alongside consideration of those successes and the determination of what should be retained in any system providing for future preparedness for pandemics, the Welsh Government welcomes the Inquiry's analysis of the lessons to be learned and improvements that can be made to ensure success of any national vaccination programme required in the event of a future pandemic.

Dated 12th December 2024

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[21] INQ000401577.

[22] Morgan (M4 statement), paras 246-247 - INQ000474509, INQ000489440, INQ000489441.